NEW HAMPSHIRE PHYSICIAN
A PUBLICATION OF THE NEW HAMPSHIRE MEDICAL SOCIETY

Keeping Options Open

Volume 3 | 2022

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Longterm Care FAQ

Northern NH Mobile Clinic

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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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Eric Kropp, MD
NHMS President

Keeping Options Open

Most of the weekends in my teenage years were spent traveling to and competing in road bike racing throughout the northeast. It is no surprise that I saw my orthopedist more than my pediatrician in those formative years. But after assisting with countless routine knee replacement surgeries during an extended orthopedic rotation in medical school, I confirmed that the specialty was not the fit I had hoped for. My drills, chisels, and saws would retain their place on the workbench -- serving me better as tools for woodworking as a creative expression. Instead, I learned that what appealed to me most was the regular interaction over time as I observed the longstanding and valued patient relationships of my Family Medicine preceptors. Still, it would be some time until I would find the practice model that would fulfill this vision.

Many physicians find their current practice very different from what they had imagined. Advancements in medical research and therapeutics combined with the application of the principles of evidence-based medicine have improved the care we provide. The practice setting, as well as the personal characteristics and preferences of physicians and patients, play a large part in determining success. All too often, factors outside of the actual patient care relationship detract from our effectiveness, and a poor practice fit can prevent us from achieving joy and satisfaction in our vocation and maintaining balance in our lives.

Many physicians find their current practice very different from what they had imagined.

With U.S. healthcare spending tipping the scales at a hefty 19.7% of the GDP, the trend toward large corporate and venture-capital-backed healthcare should come as no surprise, as players vie for a piece of the pie. It mirrors other sectors of the economy, where power is consolidated at the top tiers. The local mom-and-pop grocery stores are fewer and farther between. Corner hardware stores across the country have been supplanted by warehouse-sized chains sporting orange or blue shelves. Just last month, our local independent Penacook Pharmacy closed its doors after 53 years and three generations of owners, unable to compete with the power of the large chains that often occupy two or three corners of a single intersection in many towns. And hitting close to home, the rate at which physician practices are being acquired accelerated during the pandemic with a 9% increase in hospital-owned practices and an 86% increase in corporate-owned practices in the last three years.[1]

Not only is the consolidation of power and control changing the landscape of physician employment, but also the way in which healthcare is delivered, by feeding society's insatiable appetite for instant gratification. There has been an

unsettling proliferation of retail urgent care centers and telemedicine services for everything from sore throats to testosterone therapy. The long maligned direct-to-consumer drug ads pale in comparison to the outlandish if not false social media campaigns of the modern-day equivalents of snake oil.

We know there is no quick fix to what ails us as individuals and as a society. The larger threats of lifestyle diseases, social determinants of health, and health equity are inglorious, difficult, and costly to solve. It is easy to feel defeated and resigned to the daily experience of making widgets. The hundreds of billions of dollars a year spent treating preventable diseases are generating incredible profits across countless industries. But consider, if you will, that the success of healthcare companies depends fundamentally on the interaction between a healthcare provider, and a patient -- a relationship that distinguishes businesspeople, from the clinicians who actually provide the care.

A survey[2] from May 2021, by the American Board of Internal Medicine reported that 84% of patients trust their doctor, but only 72% trust the hospitals. Despite this fact, a growing proportion of patients name their main source of healthcare as an organization rather than an individual clinician. Perhaps not surprisingly, non-clinical entities such as insurers, government agencies, and pharmaceutical companies were trusted far less. The ABIM survey also reported that almost all physicians (98%) say that spending an appropriate amount of time with patients is important, but only 77% of patients think their doctor spends an appropriate amount of time with them.

For those who control the dollars and measure value by looking at physicians and patients as units of service divided by time, anything that lowers the value of that simple equation is a threat to their bottom line. When push comes to shove, we have to stand up for our worth as physicians and leverage our value to demand systemic change and offer hope to patients and each other that we will do better.

"Optimism doesn't mean that you are blind to the reality of the situation. It means that you remain motivated to seek a solution to whatever problems arise." -Dalai Lama

Between January 2019 and January 2022, the percentage of physicians employed by hospitals or corporate entities grew from 65% to 74%. To be successful, one must bring a penchant for organizational leadership to the table. Those who enjoy the process and rewards of system-based improvements will find plenty of opportunities and fulfillment. This stands in contrast to independent practices in which physician owners make the decisions both about the business and patient care. While perhaps liberating, it is not a skill set that many physicians have, or want, and unfortunately, these opportunities are shrinking.

Interestingly, even as more and more physicians opt for an employed position, one-third of those in the ABIM survey reported that they did not trust their own health organization's leadership. Clearly, finding the right fit is a challenge as 40 to 70% of physicians change jobs within 5 years. It is imperative that we ensure that as the healthcare system changes, we preserve and strengthen the opportunities for the physician to thrive in different settings.

Healthcare systems should promote longitudinal relationships, rather than fractured interactions. We must stop the incessant dependence on false snapshot measurements of quality or value; often only a narrative process can accurately reflect a patient's progress toward reversing decades of unhealthy habits and achieving long-term health. Practice models should support clinicians in spending the right amount of time with a patient, at the right time. The health and wellness of the clinicians and staff are paramount to the effectiveness and longevity of the care team.

There are shifts in other segments of society and the economy that are succeeding in pushing back against these trends of large-scale corporate homogeneity. While legions still seek the comfort and familiarity of an Olive Garden or Dunkin' Donuts, there is steady support for the locavore movement and growing numbers of people who seek out locally produced foods, and small-scale farms whenever possible. The growth of websites like Etsy underscores the value placed on individual craftsmanship and the demand for handmade goods rather than mass-produced imports in ubiquitous plastic clamshell packaging.

Admittedly, my bias as a Direct Primary Care family physician is that high-quality care can be done better at lower costs by eliminating the middlemen between patients and providers. But this can be said of independent practices in general.[3] The success of the Direct Primary Care movement, as well as transparent cash-pay facilities such as the Surgery Center of Oklahoma, demonstrate that Americans want an alternative to the cookie-cutter reliance on health insurance and freedom from red tape. I recognize that there is no one size fits all. Nevertheless, we must not allow corporate consolidation of healthcare limit competition and choice and subjugate physicians for their own profits.

The days of a physician graduating from medical school, hanging a shingle, and serving a local community for a 30- or 40-year career may be in our past. But opportunity still abounds. If we stay mindful that the purpose of a system of healthcare is to provide care for patients, we can find our place within it. So, whatever your strengths are from a business and practice management perspective, and however you seek to fulfill your passion for medicine and define success, chances are there is a practice model out there that suits you. It is important that we as a Medical Society support the spectrum of opportunities, especially independent physician practices before they disappear completely. ■

[1] http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

[2] https://www.norc.org/PDFs/ABIM%20Foundation/20210520_NORC_ABIM_Foundation_Trust%20in%20Healthcare_Part%201.pdf

[3] https://www.forbes.com/sites/sallypipes/2022/05/09/is-the-end-of-private-practice-nigh/?sh=148a27053bf5

Michael Padmore
NHMS Director of Advocacy

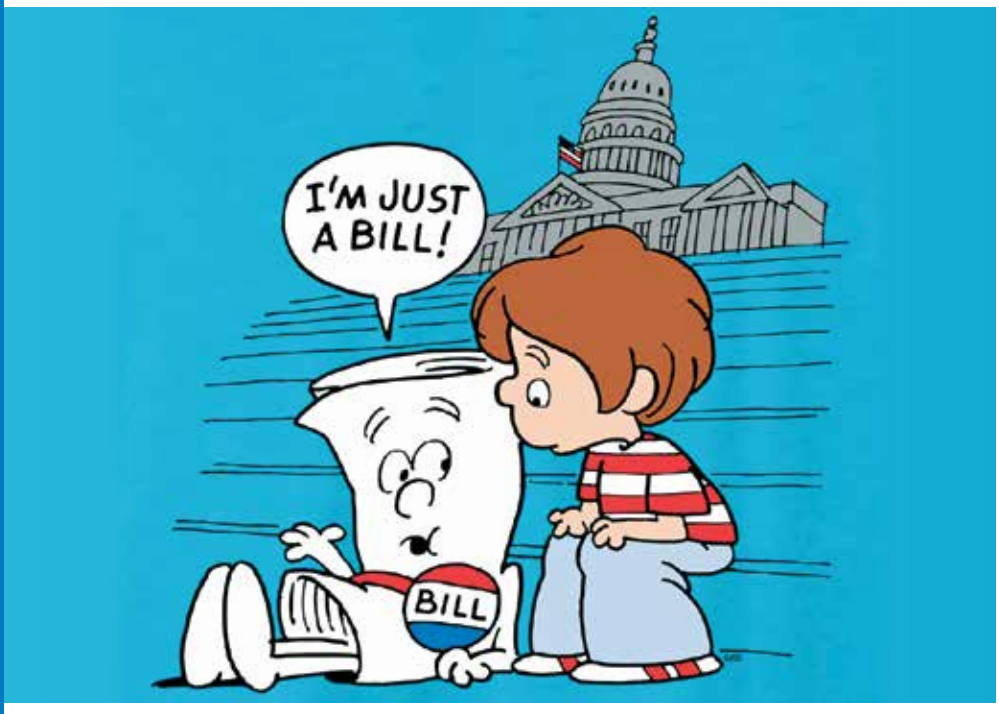
I'm Just a Bill. Yes, I'm only a Bill.

As the 2022 New Hampshire legislative session wrapped up in June, I thought it might be helpful to walk through the process of how a bill becomes a law in New Hampshire. We all remember Schoolhouse Rock right? "I'm just a bill and I'm sitting here on Capitol Hill." New Hampshire's legislative process isn't quite the same as our friend Bill explains in Schoolhouse Rock, but it's pretty darn close. Cue the music!

First step – a member from either the House or Senate introduces a bill. For example's sake – let's call our sample bill House Bill 100 (HB100) – an Act relative to health care. Since it's a House bill – it will start in the House. From there, HB100 is assigned to one of the standing committees in the House. The committee assignment is based on the bill's subject matter. Bills pertaining to health care are generally assigned to the Health & Human Services (HHS) Committee. Next – HB100 will have a public hearing with the House HHS Committee where any member of the public is allowed to give testimony relating to the introduced bill. Committee members listen to each person's testimony and can ask questions of anyone who testifies. Following the hearing the committee has several options to consider. See below. They can also amend the bill if they believe it needs changes.

- Ought to pass (OTP) – positive recommendation from committee
- Inexpedient to Legislate (ITL) – negative recommendation from committee
- Interim Study – recommendation from the committee that the bill needs further study and should not move forward for the remainder of the session
- Retained (House) or Rereferred (Senate) – essentially tables the bill until the following session

New Hampshire's legislative process isn't quite the same as our friend Bill explains in Schoolhouse Rock, but it's pretty darn close.



After the committee makes their recommendation, the bill will head to the full chamber floor for a vote. Let's say HB100 received an OTP recommendation from the House HHS committee. The House floor can either vote to uphold this recommendation or choose not to by voting ITL or tabling the bill. To continue with our example – let's say HB100's OTP recommendation was upheld by the House floor. This means HB100 will now "crossover" to the Senate to start the same process it went through in the House.

Once in the Senate – HB100 will have a hearing and receive a recommendation from the Senate HHS Committee just as it did in the House. If the Senate floor passes the exact same version of HB100 that the House passed with no amendments, it will go directly to the Governor's desk where the Governor can choose to sign or veto the bill.

However, if the Senate amends HB100 in any way, it must go back to the House to either concur or non-concur with these changes. If the House concurs, the bill will go to the Governor's desk. If the House non-concurs, they can choose to either kill the bill outright or create a Committee of Conference to reconcile the two versions. A Committee of Conference (CoC) is comprised of members of the House and Senate chosen by leadership in their respective chambers. Once the members are selected, the CoC will meet to negotiate the differences between the two versions of the bill. If they can reach an agreement, the bill will go to the Governor's desk. If they cannot reach an agreement, the bill dies.

Once a bill reaches the Governor's desk, the Governor has two choices: sign the bill or veto it. If the Governor signs the bill, it becomes law. If the Governor vetoes the bill, it will have to go back to each chamber's floor for a vote. If the bill receives a 2/3 majority vote separately in both chambers, the legislature overrides the Governor's veto and the bill becomes law. However, if it does not meet that 2/3 threshold, the bill dies.

And that folks, is how a bill becomes a law in New Hampshire! Stay tuned for a Legislative Wrap Up in an upcoming issue that will summarize what happened during the 2022 NH Legislative Session. If you have any questions in the meantime, please don't hesitate to reach out to me directly at 603-858-4744 or Michael.Padmore@nhms.org. ■

Patrick C. Magnus, MD, MPH, FACC, FSCAI

The Heart of the Matter

The current pandemic has stretched the government, manufacturing, financial and heath infrastructure to their limits. This has been a stress test on every sector and in particular, the public health infrastructure, health systems, individual hospitals and each and every healthcare worker, including physicians. On an individual level, the pandemic has been a stress test of our emotional and mental well-being; a stress test of the mind.

As a cardiologist, stress testing is one of the most important diagnostic tools I employ in the assessment of heart health. Until recently, I had not given as much thought to provocative emotional and mental health assessment.

The relationship between the heart and the mind predates modern medicine and can be seen in Chinese philosophy as Xin, as well as in Buddhist philosophy as Citta (Sanskrit) or Kokoro (Japanese). This is more than a philosophical construct and manifests as broken heart syndrome, Takatsubo cardiomyopathy, or as depression and anxiety after a myocardial infarction.

No one fails or passes a stress test. The test is a risk assessment of current cardiac status and the potential for a future problem. Likewise, the results from the stress of the pandemic provided each of us with an assessment of current mental well-being. The challenges of the past two plus years have allowed some to take stock of what is important in life and given many an opportunity to reassess values and life goals.

After fellowship, I moved with my family to Concord, New Hampshire, and joined a hospital-based cardiology practice at Concord Hospital. This gave me the opportunity to practice evidence-based medicine in a collegiate environment, focus on my patients and spend valuable time with my family. Despite the improved flexibility in my schedule relative to that in residency and fellowship, one of the biggest challenges was the lack of autonomy that comes with accepting a hospital-based position. For a long time, I struggled with reconciling this with my hopes for the long-term goals of building a practice and program development.

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The pandemic heightened some of these concerns as the healthcare system was stretched and re-challenged at every level, time and time again. However, through the uncertainty, I had a chance to reflect on the results of my own mental stress test. Medical training taught me how to be a good physician and even provided key insights to have a successful career, but not on how to achieve a balanced life. There was uncertainty, fear, worry and anxiety, but there was also resolve and reaffirmation of the important role of physicians at every level of healthcare and the need for more engagement and participation not only in patient care, but in the systems that facilitate delivery of this care. My definition of success evolved to be broader and more inclusive of work, home and self.

Amid the daily challenges of providing care within the current environment, I can look back to appreciate past experiences and look forward to when things will be "normal" again, finding happiness in each day. There is fulfillment in caring for my patients and my family. Success is helping to rebuild and strengthen the local health care system as part of a team. Success is appreciating the time I have outside of work, balancing both mind and heart. ■

EXTRA! EXTRA!

Missed an issue? Want an extra copy to share with friends or family? NHMS has lots of extra print magazines! Send your request to mary.west@nhms.org.

NHMS Welcomes New Members

Yaroslav Basyuk, MD
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Ross A. McEntarfer, MD
Jerry R. Rittenhouse,MD
Keith M. Shute, MD
Geoffrey E. Starr, MD
Kristen Larissa Stupay, MD
George Christian Vorys, MD

WANTED

Internal Medicine, Orthopedic, Neurologic, General or Family Practice Physicians interested in providing part-time or full-time staff medical consultant services for the Social Security Disability program, through the state Disability Determination Services office in Concord NH. Staff work involves reviewing disability claims on-site and requires no patient contact. SSA Training is provided.

OR

Physicians interested in performing consultative examinations in their office for the Social Security Disability program, through the state Disability Determination Services office. Compensation is provided per exam. All administrative aspects are performed by the DDS and no billing is required. Free dictation service and a secure web portal is provided for report submission.

Any interested physician must be licensed by the state of NH and in good standing. Please email inquiries to Anne.Prehemo@ssa.gov

New Hampshire Insurance Department Issues FAQ Regarding Long Term Care Rate Increases

On February 18, 2022, the New Hampshire Insurance Department (NHID) released a Frequently Asked Questions document with information for consumers regarding rate increases on Long Term Care insurance policies. In March, the NHID hosted an online meeting to discuss the topic with consumers.

Long Term Care (LTC) insurance is one way that individuals can pay for nursing-home care, home-health care and personal or adult day care services. This type of insurance, introduced in the 1980's as nursing home insurance, may pay the service provider directly or provide reimbursement to the policy owner.

In 2018, the New Hampshire Insurance Department implemented a rule that would limit the premium rate increase an issuer could impose based on the insurer's attained age. However, a 2021 New Hampshire Supreme Court decision invalidated this rule. As a result, a number of companies have sought increases that had been previously denied under the prior rule.

Long Term Care (LTC) insurance is one way that individuals can pay for nursing-home care, home-health care and personal or adult day care services.

Rates for LTC insurance are increasing for several reasons. Issuers make assumptions regarding the number of policyholders who will let their coverage lapse (i.e., stop paying the premium before making a claim), and the premiums paid by lapsing policyholders become available to support persisting policyholders who don't lapse.

"Issuers are finding that fewer policyholders are lapsing than what they had expected," said Keith Nyhan, Consumer Services Director at the NHID. "This means there are fewer dollars from lapsed policies to support persisting policyholders; more policyholders who are likely to make a claim; and fewer policyholders, since some have already lapsed, to absorb dollars needed to be raised in order to ensure the vitality of the block of business."

"Our goal at the NHID is for residents of the Granite State to be able to properly manage risk in a changing world," said Commissioner Christopher Nicolopoulos. "Recent court decisions have affected the way that the NHID can approve rate increases in the LTC market, and our department has produced this Frequently Asked Questions document to provide consumers with the information that they need to make informed decisions in a dynamic marketplace."

The Frequently Asked Questions document is located at https://www.nh.gov/insurance/consumers/documents/ltc-consumer-faq-2022.pdf.

The web meeting can be viewed at https://www.youtube.com/watch?v=tJcxbZLdW70.

For general information regarding LTC insurance, visit NHID's Senior Services page at https://www.nh.gov/insurance/consumers/senior.htm. ■

The New Hampshire Insurance Department's mission is to promote and protect the public good by ensuring the existence of a safe and competitive insurance marketplace through the development and enforcement of the insurance laws of the State of New Hampshire. Contact us with any questions or concerns you may have regarding your insurance coverage at 1-800- 852- 3416 or (603) 271-2261, or by email at consumerservices@ins.nh.gov. For more information, visit https://www.nh.gov/insurance.

Policy and Procedure Manual in Practice Management

The office policy and procedure manual serves as a resource to optimize the quality of care and operations of the practice.

When writing office policies and procedures, consider what is required by law or regulation because exceeding it can be a source of liability. For example, if the law allows medical assistants to give injections under certain circumstances, but your policy states injections are given by registered nurses only, the medical assistant would be in compliance with the law, but in violation of your policy. In addition, policies related to the standard of care provided to patients should be written with caution because detailed instructions that exceed the medically accepted standard of care may create possible malpractice liability.

For practices that are either hospital-owned or hospital-based, policies and procedures within the practice may need to be revised to reflect an integrated health system.

Guidelines:

- Begin with an introduction that describes the purpose of the manual.
- State the office philosophy and the expectation that employees will adhere to the policies set forth.
- Include an organizational chart with lines of authority by position.
- Write realistic policies and procedures that avoid detailing matters related to the standard of care. Do not be restrictive by being too specific, yet avoid ambiguity and vagueness. A policy should be practical in carrying out the day-to-day operation of the practice.

- Use straightforward language and avoid terms such as "shall", "will" or "must" in the policy or procedure, and do not use superlative words such as "highest quality" or "perfect."
- Use a bullet point or numbered step format for ease in reading. A staff member should be able to quickly navigate the policy.
- State the procedure step-by-step, following a logical sequence. Briefly outline who, what, when, where, and how of procedures.
- Address patient/staff safety and health needs as priorities.
- Ensure that the policy/procedure applies to all locations of a practice, when appropriate.

Maintenance:

- Record the date when each policy or procedure is adopted.
- Keep an up-to-date index or table of contents.
- Perform reviews every three years for relevancy and compliance with current state and federal laws, or more frequently as new rules or laws become known or changed. If revisions are necessary, place revision dates on the new policy.
- Retain a copy of each revised policy for the period of time commensurate with your state's statute of limitations for filing a medical malpractice claim.
- Obtain signatures for policy approval from responsible parties.
- Obtain input from an attorney to ensure reasonable and achievable policies have been established.

Staff education:

- Provide training to explain pertinent policies. Utilize policies and procedures as part of competency for staff as applicable. Consider an ongoing review of practice policies at staff meetings.
- Obtain employees' signatures on a form indicating their review of the manual.
- Enforce established policies. Monitor compliance with policies as part of quality improvement efforts.
- Remind employees of their obligation to know practice policies and procedures and to follow them. ■

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.

Michael E. Genetti, CLU, ChFC
Baystate Financial

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Why not decide to treat your family's fiscal well-being with the same standard of care you provide for your patients' physical well-being?

Balance

Professional, Personal, Financial
The keys to a fulfilling life

For the past several years, as New Hampshire's physicians and greater medical and healthcare communities battled through the COVID pandemic, Baystate Financial has attempted to provide timely and insightful information regarding important financial planning matters to the *New Hampshire Physician* readership.

This issue touches on the search for a newfound balance that allows them to redefine a sense of success and a path to a fulfilling life.

A lack of autonomy and a lack of understanding of how to proceed in that search speaks to the need for physicians to find a balance between the financial responsibilities to repay medical school loans, meet family commitments, and plan for post-career living, all while still enjoying living life today. For as each of you have come to realize, life is not all about the money, but we would be naïve to not understand that there is a monied component to most things in life!

So, the question is, "how do I attain that balance?" so that financial stress does not impinge upon fulfillment both at work and away from it. One of the challenges we encounter in our financial work with physicians is how to help them create a process for informed decision making, one which is consistent with how they routinely make decisions regarding patient care. Once a baseline profile has been established, financial risk modeling is similar to a stress test. Financial risk modeling helps you pinpoint the source of a problem and how it might best be addressed.

As we establish financial planning relationships with physicians, we often find that they are not where they imagined they would be financially, and most have had factors outside their control negatively impact their ability to make headway towards their financial priorities. As our conversations develop with clients, we often uncover an incongruency between their

articulated values and their actual behavior. Bringing these divergent realities into congruence is key to finding balance and a sense of professional and personal fulfillment.

The reality of healthcare systems treating physicians and patients as economic equations, which is perceived as necessary in order to achieve "efficiency" can be antithetical to creating a culture of "effectiveness" in serving patient needs. As a member of the American College of Healthcare Executives (ACHE) I read a continuous stream of articles related to burnout and resilience… from the system perspective. The central theme that pervades these articles is that they are system centric, not physician or medical professional centric. What healthcare systems will hopefully come to realize is that physicians will naturally bring more value to the system if the system is dedicated to creating an environment in which physicians believe that their professional aspirations and personal fulfillment can best be attained. It needs to be an environment which values the 'craftsmanship" of the practice of the art of medicine equally with the science of the delivery of healthcare.

Burnout can be the result of the physician's constant battle with resistance in a system that hinders their ability to practice medicine in a fulfilling manner. Our mission, as financial advisors, is to help clients overcome the ever-present resistance that hinders their efforts to create a financial infrastructure that supports a fulfilling personal life. Physicians leverage their financial future to gain skills which they use to live fulfilling professional lives. They also leverage their personal financial future to enjoy life today. However, these actions add stress to their lives. We help physicians mitigate the stress that occurs with an "out of balance" state of finances. If not addressed, this permeates all aspects of their lives and seeps into their professional life, because work is the source of the money needed to meet the responsibility of managing that financial leverage.

Just as a work environment, supportive of your being most effective, leads to professional fulfillment, creating a financial environment for yourself which supports the realization of the hopes and expectations you have for yourself and your family leads to personal fulfillment. Creating these environments is no easy task and demands that you first understand what you value about your career and personal life so you can make informed decisions and successfully execute a plan of action.

As you now take time to reconnect to those values you hold most dear, you may find that a financial planner can provide you with the necessary information and insight to allow you to have confidence in your decision making as to how best to allocate your financial resources to gain fulfillment from the practice of medicine, and to enjoy life more fully today, confident that you will get to enjoy the future you hope for." ■

Michael E. Genetti is a registered representative of and offers securities through MML Investors Services, LLC. Member SIPC. www.SIPC.org 200 Clarendon Street, 19th & 25th Floors. Boston, MA 02116. 617-585-4500. CRN202505-2426596

James G. Potter
NHMS Executive Vice President

Expanding Access to Care through Innovative Northern NH Mobile Clinic

Through our Bowler-Bartlett Foundation – 501(c)3 organization of the NH Medical Society – this Northern NH Mobile Clinic Program offers a community-based care option for those individuals in northern rural areas of the Granite State (northern Coos County, New Hampshire) who otherwise would face geographic and economic challenges in accessing health care. Scheduled to launch in August, the Medical Society serves as the fiscal agent for the program that has raised more than a million dollars, plus a day use fee commitment from each of the healthcare partners utilizing the mobile clinic.

What makes this program different than other mobile clinics today is its novel application. This program was built through the community collaboration of four area rural hospitals, including Littleton Regional Hospital and the three hospitals comprising North Country Health – Androscoggin Valley, Upper Connecticut Valley and Weeks Medical Center, Point32Health Foundation (Harvard Pilgrim), the NH Charitable Foundation, US Department of Agriculture, Fidelity Investments, local public health agencies and the New Hampshire Medical Society — all invested in breaking down access to health care barriers of those in the community. With this level of cross functional commitment and deep understanding of social determinants of health differences across the region this mobile clinic program will align programs and services of most need in the different communities.

This mobile clinic program is the brainchild of Dr. Bill Brewster, currently NHMS Vice President, from a discussion he and I had early in the COVID pandemic about creating mobile clinics as a collaborative care tool for underserved communities in the Granite State. In one of his last

The purpose of the grant funds is to assist in the purchase and start-up support costs of a Mercedes 4x4 Sprinter 3500XD van that is built to handle North Country winters.

projects before retiring, Dr. Brewster marshalled a half-million-dollar matching grant from what is now the Point32Health Foundation (merger between the Harvard Pilgrim and Tufts health plans and their foundations) and contributions from each of the four rural hospitals serving northern Coos County.

The NHMS Foundation stepped in late last summer to receive the funds and become fiscal/governance agent for the project when the local public health organizations serving Coos County were undergoing staff leadership changes. Since that time, the Bowler-Barlett Foundation has secured grants from the US Department of Agriculture through its Rural Emergency Development Grants program, the New Hampshire Charitable Foundation and Fidelity Investments.

The purpose of the grant funds is to assist in the purchase and start-up support costs of a Mercedes 4x4 Sprinter 3500XD van that is built to handle North Country winters. It will extend places of care by fostering immunization and preventative screening services at often underutilized local sites across rural northern New Hampshire, such as schools, community centers or organizations (VFW/American Legion and Elks Lodges, churches, public libraries, not-in-use store/business buildings, and temporary tented clinics in parking lots) for COVID-19 initial vaccinations and boosters, monoclonal antibody treatment or pop-up COVID-19 testing.

Mobile preventative screenings services are envisioned to include primary care evaluations and physicals, monitoring of blood pressure and glucose levels, telehealth specialty care coordination through mobile Wi-Fi capabilities and computer access, wellness education, nutrition, smoking cessation programs, health literacy on topics such as importance of continuity of care and having a primary care physician (medical home), medication adherence, and connections to local providers and community services for behavioral health and SUD programs.

The NHMS Foundation convenes monthly a governing body made up of the representatives from the four hospital partners – Dr. Ed Duffy, Scott Colby (former NHMS EVP), Michael Lee and Michael Peters, Kathryn Skouteris from Point32Health, and Alia Hayes with the State of New Hampshire Department of Health and Human Services. Karen Trierweiler and Carla Villacorta from Point32Health have also been of great assistance in the planning of the mobile clinic. The North Country Health Consortium has agreed to be the operations agent for the mobile clinic.

Delivery of the sprinter van is anticipated for late July with launch/ribbon-cutting events at each of the four participating hospitals scheduled for Wednesday, August 17th. A ribbon-cutting event is also planned for the following week in Concord with local dignitaries and elected officials.

If you are interested in learning more about the Northern NH Mobile Clinic Program or starting a similar mobile clinic in your area, please email me at james.potter@nhms.org or call 602-224-1909. ■

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