

NEW HAMPSHIRE **PHYSICIAN**

A PUBLICATION OF THE NEW HAMPSHIRE MEDICAL SOCIETY

Adverse Childhood Experiences



Volume 1 | 2020

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New Hampshire's WIC Implementation Project

Consider Food Security

HB 1539: Relocation of Children with Elevated Lead Levels



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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, and veterinarians 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. Sally Garhart @ (603) 491-5036 or email sgarhart@nhphp.org.

*Opinion expressed by authors may not always reflect official NH Medical Society positions. The Society reserves the right to edit contributed articles based on length and/or appropriateness of subject matter. Please send correspondence to "Newsletter Editor," 7 N. State St., Concord, NH 03301.

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Respondents with four or more reported ACEs had a significantly increased risk of alcoholism, drug abuse, depression, and suicide attempt in adulthood.

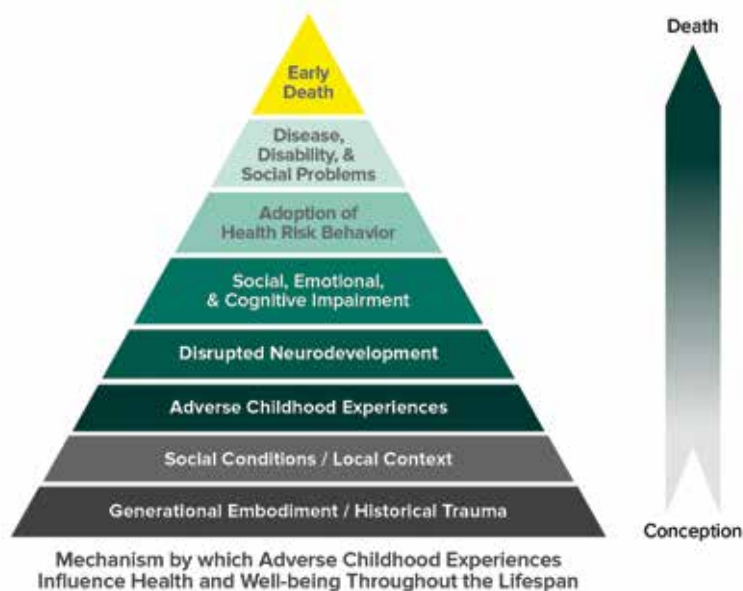
President's Perspective Adverse Childhood Experiences

Perhaps one of the most important and compelling ways that we can look at how the social determinants impact health is to consider Adverse Childhood Experiences (ACEs). ACEs are just as the name implies—traumatic events occurring in children and adolescents before age 18. These traumatic events generally fall into three main areas: abuse (emotional, physical, sexual), household challenges (domestic violence, substance abuse, mental illness, divorce, incarceration), and neglect (emotional, physical).

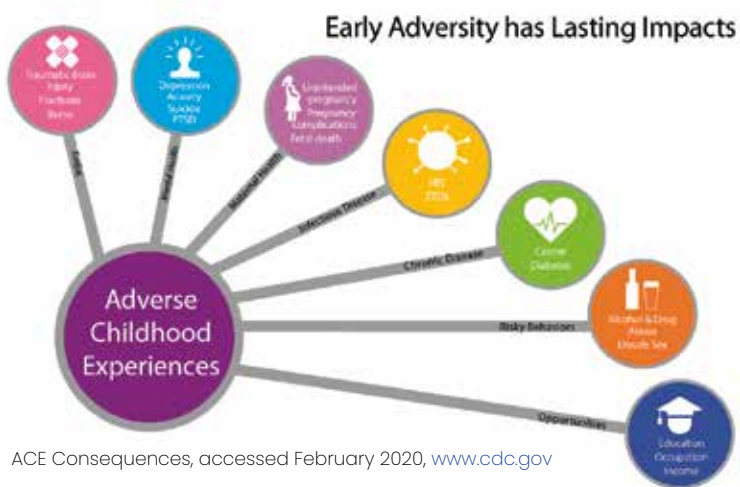
It seems fairly straightforward that these sorts of trauma would be harmful to the health and well-being of children, but what is fascinating and tragic about ACEs is how they affect not only the children at the time of the trauma, but have far-ranging consequences on the health of those individuals much later in life, and can even be passed down over generations.

The landmark study that showed the longitudinal effects of ACEs was done in the late 90s, the so-called CDC-Kaiser Permanente ACE Study.¹ This study showed for the first time the link between childhood trauma and poor health outcomes in these individuals later in adulthood. Patients (more than 10,000 Kaiser patients in Southern California) in the study were sent questionnaires that asked about seven categories of ACEs: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences reported by the patients (0-7) were then compared to their adult health outcomes.

The results were staggering in both the number of respondents who reported having had at least one of these childhood traumas (>50%), and in the clear link with worsening outcomes later in life with an increasing number of adverse childhood experiences. Respondents with four or more reported ACEs, compared to those who reported none, had a significantly increased risk of alcoholism, drug abuse, depression, and suicide attempt in adulthood; moderately increased risk of smoking, poor self-reported health, ≥ 50 sexual partners, and sexually transmitted infections; and a slightly



ACE Pyramid, Content source: National Center for Injury Prevention and Control, Division of Violence Prevention, accessed February 2020, www.cdc.gov



ACE Consequences, accessed February 2020, www.cdc.gov

increased risk for physical inactivity and severe obesity. In addition, as the number of ACEs increased, the study showed a graded relationship to adult ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

Not only was having a history of one or more ACEs common across all respondents, but some populations were even more vulnerable to ACEs because of the social and economic conditions in which they lived, learned, worked, and played. These vulnerable populations included women, African Americans, and Hispanics.

In the 20+ years since this study, there has been extensive additional study of ACEs. A biologic basis has been found that explains some of the persistent effects into adulthood, and even some element of the apparent heritability of ACEs. The study of epigenetics has shown that toxic stress in infants and children can actually change the expression of certain genes (through mechanisms such as DNA methylation and histone acetylation) without altering actual DNA sequence. These changes can occur in early infancy or even prenatally if there is maternal stress, and can influence later stress responsiveness. Stresses in this vulnerable period can be seen as positive, tolerable, or toxic, and the type and duration of stress, as well as the availability of a caring and responsive adult to help manage the stress, have been shown to be critical to the eventual outcome. The stressors from the CDC-Kaiser ACE Study are capable of inducing a toxic stress response, which in infants and young children can actually cause permanent changes in brain structure and function. These structural brain changes, such as hypertrophy and overactivity in the amygdala and orbitofrontal cortex, as well as loss of neurons and neural connections in the hippocampus and the medial prefrontal cortex, provide a clear biologic basis for the subsequent detrimental effects on learning, behavior and health seen in children and ACEs.

The evidence demonstrating a basis for many adult diseases in childhood trauma clearly suggests that we

need to expand our thinking about disease prevention beyond the traditional risk factors to start to include systems that prevent adverse childhood events, and also provide the critical support needed to prevent permanent anatomic and molecular changes at the time of toxic stress. The CDC has proposed a framework² using the best current available evidence to attempt to prevent ACEs. There are six main strategies: strengthening economic supports to families, promoting social norms that protect against violence and adversity, ensuring a strong start for children, teaching skills, connecting youth to caring adults and activities, and intervening to lessen immediate and long-term harms. Each of these strategies then has multiple associated tactics, and many, such as promoting family-friendly work policies, leading public education campaigns, supporting high-quality child care and early childhood education, and treatment for substance abuse disorders, are measures that are within our reach right here in New Hampshire through advocacy efforts of the Medical Society, various partners in the state, and each of us if we choose to engage. Children who grow up without toxic stress grow up to be happier, healthier adults with more stable relationships, better job stability, and fewer unhealthy behaviors, who can then form healthier communities and a healthier state. ■

1 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4), 245–258. doi:10.1016/S0749-3797(98)00017-8. [https://www.ajpmonline.org/article/S0749-3797\(98\)00017-8/pdf](https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf)

2 Centers for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf>



Source: Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Accessed February 2020, www.cdc.gov



New Hampshire's WIC Implementation Project



... is now offering FREE developmental monitoring to families...

The New Hampshire Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in partnership with the New Hampshire Watch Me Grow (WMG) developmental screening system, is now offering FREE developmental monitoring to families, through the Centers for Disease Control's Learn The Signs. Act Early Campaign (LTSAE).

WIC families will be offered a checklist during their annual certification visit and 6 month follow-up visits. WIC staff will encourage the family to complete the checklist and review with the family. The nutritionists will link the discussion about development to nutrition and growth. If concerns are identified, the family will be encouraged to contact their primary care provider to share the concern and checklist. (Families may also choose to load the CDC Milestone Tracker App on their phone and may share the checklists with you on their phone.)

As the newly released AAP recommendations suggest, WIC strongly encourages families to talk with their primary care provider about their child's development and share the monitoring checklists at the child's visit.

- This checklist reflects milestones MOST children should meet by this age.
- Missing milestones can be an indication to administer a developmental screening. The American Academy of Pediatrics (AAP) recommends developmental screening between recommended ages if concerns arise. The checklist used in New Hampshire's WIC Implementation Project is not a substitute for a standardized, validated screening tool.
- If a developmental screening triggers concerns or you or the parent still have concerns following the screening, refer to your states' early intervention or preschool special education program and, at the same time, to a provider for further developmental and/or medical evaluation.
- For FREE resources to support developmental surveillance, visit www.cdc.gov/ActEarly/Healthcare
- To learn more about the WIC LTSAE project view a four minute video at https://www.youtube.com/watch?V=ievs67a_8j0.



- To learn more about NH's Watch Me Grow Developmental Screening System visit www.watchmegrownh.org
- To learn more about the new AAP recommendations please read Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening found at <https://pediatrics.aappublications.org/content/145/1/e20193449>
- Identification, Evaluation, and Management of Children with Autism Spectrum Disorder found at <https://pediatrics.aappublications.org/content/145/1/e20193447>

The Goodwin Community Health Center's WIC program in Somersworth, New Hampshire, provides services to Strafford and Carroll Counties and is an excellent pilot for the project, as their staff are committed to providing this service as another avenue to strengthen their relationships with families. Integrating the Milestone Checklist Program into WIC has been shown to:

- Increase parental reports of learning about early child development;
- Increase early identification of children with developmental delays and disabilities so children and families can get the services and supports they need; and
- Enhance collaborative efforts between WIC and community service providers to improve screening and referral to early intervention services.

The goal is to have all WIC programs offering this service to families by 2021. By implementing the monitoring program we are hoping to see an increase in the number of children who are "caught" early and receive appropriate referrals. The WIC staff is excited to be part of this important activity. ■

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NHMS CAP is a paid membership program whose members meet criteria as posted at www.nhms.org

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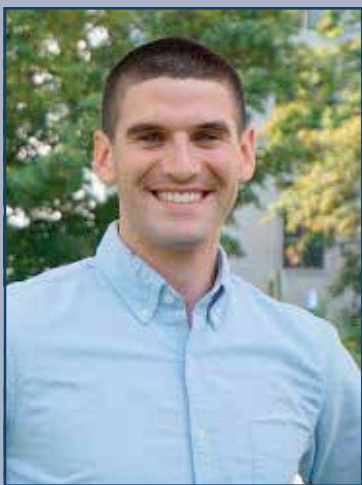
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NHMS Director of Advocacy

*Altogether, we
are tracking
roughly 200
bills.*

2020 New Hampshire Medical Society Legislative Preview

With each new year, come hundreds of new pieces of legislation. Some bills are entirely new and others can be different versions of bills that failed the year before. Altogether, we are tracking roughly 200 bills. After consulting our New Hampshire Medical Society Legislative Committee, I'm excited to have mapped out some legislative priorities. Here is a snapshot of a few big-ticket items we'll be working on this year!

Prior authorization reform has always been a point of interest among the physician community and this year we have decided to introduce a proactive piece of legislation, Senate Bill 531, to help address this issue. The three primary areas we hope to address in the legislation include:

- o Medically Assisted Treatment (MAT)
 - No requirement for prior authorization for MAT for treatment of opioid use disorder
- o Limitations of administrative denials of prior authorizations – to include:
 - No revocation, limitation, condition or restriction of prior authorizations if care is provided within 45 days from the date the health care provider received the prior authorization;
 - Allow a prior authorization to be valid for one year from the date the health care provider receives the prior authorization;
 - Notification/disclosures of prior authorization requirements and written notices of new or amended requirements within 60 days of the effective date;
 - Additional medically necessary services or procedures required during the course of otherwise authorized services cannot be denied or require additional authorization.



- o Emergency health care services necessary to screen and stabilize a patient/member will not be subject to prior authorization.
- Prohibit requiring prior authorization for medically necessary interfacility transports.

Late in 2019, we were approached by a group of different organizations, including AARP and New Futures, to join a coalition to introduce a series of pharmaceutical drug reforms. After a discussion with our NH Medical Society Legislative Committee, we decided to support all three bills.

o Senate Bill 685 - Importation

- SB 685 is an importation bill that would allow the state of New Hampshire to import certain high cost pharmaceutical drugs from Canada. Canada has been able to negotiate better prices for drugs than Pharmacy Benefit Managers and insurers have been able to do in the United States. If New Hampshire is able to import certain high cost drugs, the state could provide them to residents, insurers, and MCOs at a much lower cost than they are currently paying.

o Senate Bill 690 - Formulary

- SB 690 would prohibit an insurance company from requiring or forcing a beneficiary to change medications for non-medical reasons (e.g., there is a cheaper option). Insurance companies can do this by eliminating certain drugs from the formulary during the plan year or placing them on tiers that have high cost sharing so that a beneficiary is not able to afford the medication that is benefiting them.

o Senate Bill 687 - Transparency

- SB 687 would require manufacturers to notify the state if they have raised the price of a medication more than a certain percentage over the past 12 months. This bill would provide information to the state and its residents that would be useful in figuring out why drug prices continue to increase at enormous rates. Additionally, if a manufacturer knows that it must report increases over a certain amount, it could incentivize the manufacturers to raise prices to just under the threshold for reporting; thereby potentially keeping drug price increases lower than if there was no reporting requirement

Of course, these are only a couple of the campaigns we will be working on this year. If you are interested in getting involved in these campaigns or any others, or just have questions, please don't hesitate to email me at Michael.Padmore@nhms.org or call me at (603) 858-4744. ■



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

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GET HELP NOW!

The NH Professionals Health Program (NHPHP) is a confidential resource available to all NH licensed physicians, PAs, dentists, pharmacists, nursing licensees, and veterinarians who are experiencing difficulties with:

- alcohol, drugs or other substances of abuse
- depression, anxiety or other mental health issues
- professional burnout or work-related conflict
- marital or family life matters

For a confidential discussion call NHPHP Medical Director,
Dr. Sally Garhart at (603) 491-5036

LEARN MORE @ WWW.NHPHP.ORG



Dr. William Kirmes presents the NH Osteo Service Award to Dr. David Duval at its



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NHAFP CME 2020



Topics include: Physician leadership, heel pain, congestive heart failure, updated pap guidelines, migraines, suicide prevention, NHPDMP, cancer & heart disease prevention in first responders and more...



In an effort to make physicians more themselves, their patients and public their voices do make a difference, NH with NHMS, held Advocacy Day on Jan the opportunity to learn about legisla Representatives and Senators, hear b
Left to right: Drs. Matt Squires, Ryan P Olivia Fournier, Sam McCord, Bryan H



Psychiatric Association's Distinguished
Recent Winter Symposium.




comfortable advocating for
health policy, and to show them that
Psychiatric Society, in conjunction
January 21. Medical residents had
tion, speak to New Hampshire
ills being presented and testify.
ate, Kathleen Duemling, Patrick Ho,
lybki, and Brian Rosen.

FREE SCREENING! ALL WELCOME!

THE KIDS WE LOSE

A DOCUMENTARY FILM




When: Wednesday, March 25th, 2020
Doors open at 6:30, film at 7:00 pm
**Where: The Rialto Theater, 80 Main St.,
Lancaster, NH 03584**

The White Mountains Regional School System's System of Care Office in partnership with NFI North and the Rialto Theater are proud to present the film documentary *The Kids We Lose*.

A collaboration between Lone Wolf Media and the non-profit Lives in the Balance, *The Kids We Lose* is a 90-minute documentary film about the human side of being a child or student with behavioral challenges, and the struggles faced by parents, educators, staff in facilities, mental health clinicians, and judicial and law enforcement professionals in trying to ensure that these kids receive the help they need. *The Kids We Lose* also exposes the often brutal, inhumane ways in which kids with social, emotional, and behavioral challenges are treated in schools, inpatient psychiatry units, residential facilities, and prisons. Their hopelessness, misery, and frustration are palpable. The human toll is hard to fathom. But these are also the most expensive kids in our society. Doing the wrong thing costs a fortune. When we don't help our most vulnerable kids, we all lose.

FREE Light snacks available! Supplies limited!




NH Alcohol and Drug TREATMENT LOCATOR

Are you looking for alcohol
or drug treatment?

Visit: www.nhtreatment.org

Treatment is available.
Contact a provider in your area today.

e-Communication with Patients: e-mail, texting, portals and networks Part II



Electronic communication (e-communication) has increased significantly and is no longer limited to e-mail on the desktop. Smartphones and tablet computers make it possible to access information and send and receive messages anywhere there is a cell signal or wireless network. Mobile communication technologies have spread with remarkable speed.

Privacy and Security

- Conduct electronic communication with patients over a secure network. Encrypt electronic protected health information from the point of creation, through transmission to the point of receipt. Instruct providers not to transmit protected health information over public networks such as airport, hotel or coffee shop



Wi-Fi hotspots. Patient portals are one of the most secure methods of communicating.

- Establish clear mechanisms to authorize and authenticate patient users.
- Require passwords and current antivirus (malware) protection for all devices including providers' personal devices.
- Develop and enforce password requirements.
- Establish a mechanism to ensure user access termination in a timely manner when appropriate (patient or provider leaves organization, uses technology inappropriately, etc.).
- Inventory all portable devices used by providers to communicate protected health information. Ensure the ability to lock or remote wipe the devices if lost or stolen.
- Include a disclaimer on all outgoing messages. For example: This communication may contain health information that is private and solely for the use of the intended recipient.

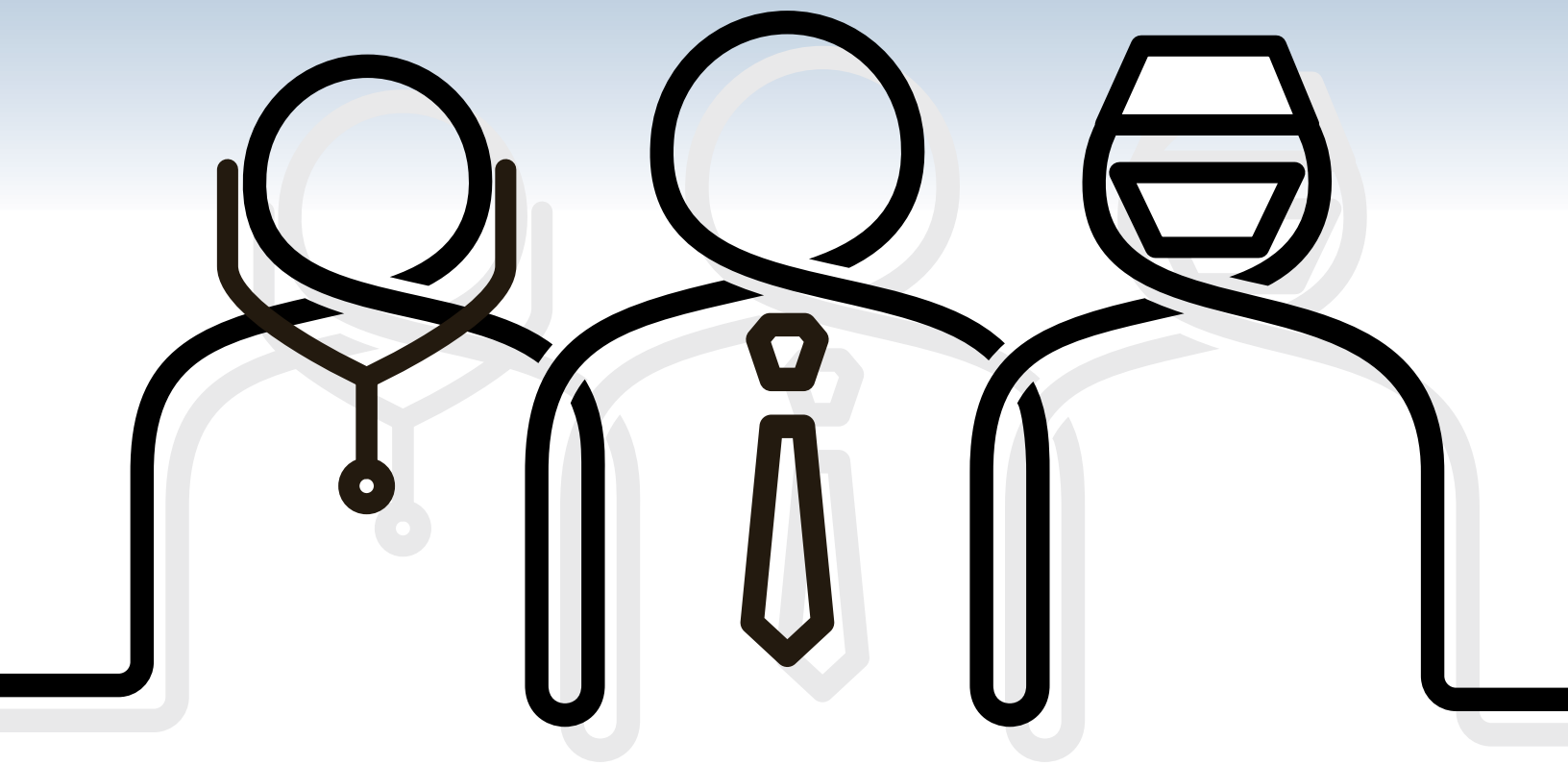
Policies and Procedures

- Evaluate current confidentiality and information security policies and update to reflect e-communication with patients.
- Determine whether providers will be limited to organization provided devices for e-communication or will be permitted to bring their own devices (BYOD).
 - Develop and enforce clear policies if personal devices are permitted. Prohibit the storing of protected health information.

- Determine the types of e-communication that will be used and establish guidelines.
- Include e-communication in current documentation policies. Clinical e-communication exchanges should be incorporated in the patient's medical record.
- Determine whether attachments such as photographs or videos are supported by the platform (portal, private network, mobile device) and if use will be permitted. For example: patient photographs of skin rashes and video of behavioral outbursts or seizure activity. Specify how the images will be stored and made part of the medical record.
- Provide education for physicians and staff on the e-communication policies and procedures including the establishment of a clear delineation between personal and professional use of e-communication.
- Include e-communications in the organization's "legal hold" policy. When a claim is anticipated and/or a request for information or subpoena includes electronic communications, specific action is required to preserve electronically stored information (such as e-mails). Notify users of the potential claim and direct that all patient communications and documentation (including e-mails) may not be deleted or modified. ■

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.

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Chris Peterson, MD
Pediatrician
Londonderry, NH

...almost 8 percent of New Hampshire households experienced food insecurity during the three-year period of 2016-2018...

Consider Food Security

Tangential light of the early morning sun paints the tops of the tallest trees orange as she settles into the green, faux-leather seat. Chattering din retained in the yellow, metal hull is easily eclipsed by the thick yet pungent warmth which begins to penetrate a body too used to cold. Peering out the rectangular window at buildings and yards and cross streets and parked cars and meandering pets awash in long shadows of the rising sun, focusing on every detail, a strategy learned to not dwell on the present. Brick building with two shades of black cursing it's trim, dented door on a white car missing a hub cap parked too close to a red rusting hydrant, details to quell the rising anticipation. Anticipation which surely feels to overwhelm, a longing understood unfortunately by too many. Mondays were, of course, the worst. So much time to pass since Friday, trying to avoid the angst of a deprivation for which you know you hold no responsibility. Awaiting the time when once again there is food to eat. Real food. Warm food. Food without guilt. Only 3 of the 72 hours between Friday and Monday school lunch left. Focus out the window, focus out on the details and not on the hunger.

USDA cites that almost 8 percent of New Hampshire households experienced food insecurity during the three-year period of 2016-2018, with 2.8 percent of households having very low food security.¹ USDA defines low food security as "reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake" and very low food security as "reports of multiple indications of disrupted eating patterns and reduced food intake."² Children who live in a household headed by a single woman are at increased risk of food insecurity.

Federal food assistance is not a direct indicator of food insecurity. However, it can be a surrogate risk marker. According to the New Hampshire Department of Education, 25% of New Hampshire students in grades 1-12 (excluding charter schools) were eligible for free or reduced lunch in the 2019-2020 school year.³ Last school year, in New Hampshire, more than 30 million meals were reimbursed by the USDA through the free and reduced



lunch program. The USDA reports that more than 38,000 New Hampshire families received Supplemental Nutrition Assistance Program (SNAP) benefits in 2019.⁴ In 2019, the Women, Infants and Children Nutrition Program (WIC) served approximately 12,000 New Hampshire participants per month.

Consider, and if you already do, continue, asking your patients about food security. Both New Hampshire Healthy Families and Beacon Wellness have provider trainers which can assist you and your staff to assess food security and other social determinants of health.⁵

Resources

The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) is the Nation's largest domestic food and nutrition assistance program for low-income Americans. Apply at: <https://my-food-stamps.org/snap-how-to-apply/new-hampshire/>

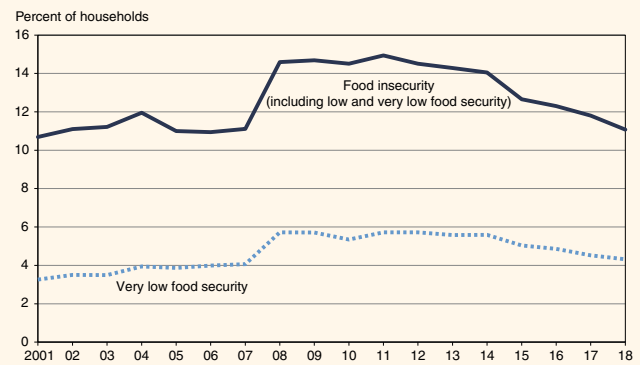
Women, Infants and Children Nutrition Program (WIC) provides services for: pregnant women through pregnancy, breastfeeding women up to one year, non-breastfeeding postpartum women for six months, infants up to their first birthday, children up to their fifth birthday. WIC has income eligibility rules. Participants must live in New Hampshire. WIC does require proof of citizenship or alien status. Apply at: [SignupWIC.com](https://www.signupwic.com)

The Summer Food Service Program (SFSP) provides reimbursements to participating programs to serve nutritious meals to children in residential camps, day camps, open site locations, closed site locations, schools and non-profit organizations. https://www.education.nh.gov/program/nutrition/food_svc.htm

The Commodity Supplemental Food Program (CSFP) is a nutrition program that provides free food and nutrition information to promote good health for seniors age 60 and over. <https://www.dhhs.nh.gov/dphs/nhp/wic/csf.htm>

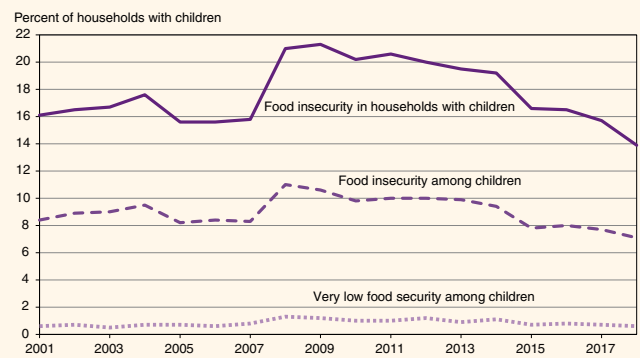


Figure 3
Trends in the prevalence of food insecurity and very low food security in U.S. households, 2001-2018



Source: USDA, Economic Research Service using data from U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey Food Security Supplement.

Figure 4
Trends in the prevalence of food insecurity in households with children, 2001-2018



Source: USDA, Economic Research Service using data from U.S. Department of Commerce, U.S. Census Bureau, Current Population Survey Food Security Supplement.

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Household Food Security in the United States in 2018, ERR-270
USDA, Economic Research Service

Cash Assistance is provided through the Bureau of Family Assistance (BFA) in two general program areas, the Financial Assistance to Needy Families (FANF) Program and State Supplement Program (SSP). <https://www.dhhs.nh.gov/dfa/cash/index.htm>

Summer Food Rocks finds nutritious free meals for children and teens 18 and younger throughout the nation while school is out of session. <https://www.fns.usda.gov/summerfoodrocks>

Other New Hampshire food source services include, [NHFoodBank.org](https://www.nhfoodbank.org), [MealsOnWheelsNH.org](https://www.mealsonwheelsnh.org), and [CC-NH.org](https://www.cc-nh.org) (Catholic Charities-New Hampshire). <https://nheasy.nh.gov/#/services/Food%20Assistance> ■

1 Coleman-Jensen, Alisha, et al. Household Food Security in the United States in 2018. USDA Economic Research Service, ERR-270. Sept. 2019. <https://www.ers.usda.gov/webdocs/publications/94849/err-270.pdf?v=963.1>

2 <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/>

3 <https://www.education.nh.gov/data/documents/lunch-district19-20.xls>

4 <https://fns-prod.azureedge.net/sites/default/files/resource-files/30SNAPcurrHH-1.pdf>

5 <https://www.dhhs.nh.gov/dphs/nhp/wic/eligibility.htm>

HB 1539: Relocation of Children with Elevated Lead Levels

Christine Arsnow, MD

The House Judiciary Committee recently heard testimony from many childhood and environmental advocates regarding HB 1539. The bill was sent to a subcommittee hearing and will be heard by the Judiciary Committee in the coming weeks.

The New Hampshire Medical Society supports HB 1539 because it protects children in our community whose families do not have access or means to relocate when threatened by toxic lead exposure in their homes.

As we know, exposure to even very low levels of environmental lead can cause learning, memory and attention difficulties. At high levels, effects are even more dangerous and potentially lethal. Because these effects of toxic lead exposure can be difficult to discern from ADHD or other learning disabilities, the American Academy of Pediatrics recommends routinely testing children for lead toxicity at one and two year well child visits. While some effects of toxic lead exposure are irreversible, removing lead from the child's environment can prevent further damage.

When a child's lead level meets the criteria for lead poisoning, the Healthy Homes and Lead Poisoning Prevention program (a division of NH HHS) takes action. The HHLPP assigns a home inspector to measure lead levels in the family's domicile and an RN caseworker to support and educate the family. Families are educated about areas of risk (e.g., chipped paint, worn painted floors, and dusty areas) and ways to reduce lead exposure in a home with high lead levels (e.g., putting duct tape over areas with chipped paint).

Landlords have several months to make renovations and repairs to a home that has toxic lead levels. In the meantime, a child with lead poisoning will continue to reside in a home with toxic lead levels and risk re-exposure, unless the family has the resources to move out. House Bill 1539 addresses this dangerous situation. The bill commands landlords to facilitate tenants' transition to a safe housing environment without financial penalty as soon as toxic lead levels are detected.

In most cases, removal of environmental lead will be enough to bring a child's level down. In some cases of severe lead toxicity, children must undergo chelation therapy. Several years ago I was involved in the care of a child in New Hampshire whose lead level reached the threshold for chelation therapy. She had to travel to Boston Children's Hospital for this expensive treatment. Unfortunately, her family could not afford to move out of their lead-ridden apartment, so she returned from the hospital to a high risk area and soon had toxic levels of lead in her blood again. She had to return to Boston Children's for repeat therapy. This case illustrates why it is both dangerous and expensive if this bill does not pass.

Landlords are obligated to provide safe dwellings for their tenants. Exposing children to toxic or hazardous lead levels violates this obligation.

If you are interested in engaging on this issue, please email NHMS's Director of Advocacy, Mike Padmore at michael.padmore@nhms.org. ■



Dr. Christine Arsnow testifying in support of HB 1539 concerning lead paint poisoning prevention and control at a House Judiciary Committee hearing.

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James G. Potter
NHMS Executive Vice President

These updated rules detail the BOM duties, licensure requirements of physicians and PAs...

Summary of Amended NH Board of Medicine Rule Changes

The following is a summary of the 35-page amended Med 300-600 Rule adopted by the New Hampshire Board of Medicine (BOM) that became effective January 10, 2020. You can view a copy of this summary along with the highlighted text of substantive changes in its published form to better assist physicians, PAs and facilities where they practice in grasping the adopted BOM changes. Deleted language and sections are explained in the summary, but do not appear in the new rule. The new Med 300-600 rule can be found at <https://www.oplc.nh.gov/medicine/documents/med-300-600-adopted-rule-20200108.pdf>.

These updated rules detail the BOM duties, licensure requirements of physicians and PAs which are the basis for application and renewal questions, the functions of the Medical Review Sub Committee (MRSC) and process for investigations, procedures for immediate license suspension, reciprocal disciplinary actions and settlement agreements, standards of conduct requirements for licensure, continuing medical education requirements, and the New Hampshire Professionals' Health Program. No changes were made to the Med 502 Opioid Prescribing rule at this time or other sections of physician and PA regulations.

Med 300-600 Changes

- 1) The definition of "Clinical medicine" now includes "Direct involvement in medical decisions impacting population health." [Med 301.01(e)(5), page 1]
- 2) Based on wording supported by the Federation of State Medical Boards (FSMB), two key questions for physician and PA licensure initial applications and renewals have been updated to reflect "current" impairment from medical conditions and current and past addiction monitoring other than through a New Hampshire approved monitoring program. [Med 301.03(a)(21-22), page 4 and Med 401.03(9-10), page 15; [Med 604.01 (a)(11-12), pages 30-31] *The previous NH licensure application and renewal questions required self reporting of any treatment for substance misuse, or treatment for physical or mental disability in the past 24 months. Concerns had been raised in a joint working group that current ques-*



tions caused NH physicians and PAs to avoid needed mental health and addiction treatment thus adding to higher rates of depression, suicide, moral injury, burnout and addiction in practicing PAs and physicians.

- 3) Initial New Hampshire licensure applications now require original letters of reference on letterhead from the “chief medical officer or president of the medical staff” in every hospital in which the applicant currently holds staff privileges, or from two practicing physicians. *The new rule removes hospital administrators as a reference source and reduces by half the number of practicing physicians’ reference letters required from four to two.* [Med 301.03(a)(26), page 4]
- 4) Locum tenens license applicants have a new requirement to disclose any medical malpractice suits brought against him or her and any claims settled on his or her behalf in the last ten years and mirror the same reference letter requirements as noted above for initial licensure. [Med 305.01(b)(8) and (13), page 7]
- 5) As part of physician and PA renewal applications, all licensees will be required to complete a New Hampshire health professions survey issued by the NH Department of Health and Human Services. *However, licensees also have the opportunity to complete and submit a survey opt out form in lieu of completing the survey at <https://www.dhhs.nh.gov/dphs/bchs/rhpc/documents/hpsurvey-optout.pdf>.* [Med 401.03(d-g), page 14 and Med 608.01(d-g), page 32]
- 6) The new rules include the BOM policy for completing 3 credit hours of category 1 continuing medical education (CME) for the opioid prescribing competency requirement pursuant to RSA 318-B:40. *These rules are referenced in the NH physician biennial CME reporting information at <http://www.nhms.org/cme-reporting>.* [Med 402.01(o-p), page 17]
- 7) A late fee will be assessed for licensees who do not complete required CMEs by December 31 of the fi-

nal year of their biennial cycle. *This late fee will apply going forward for the biennial CME cycle ending December 31, 2020. The late fee may be excused by the BOM for good cause and not merely neglect, including accident, illness, hardship or other circumstances beyond the control of the licensee.* [Med 402.02(b), page 18]

- 8) A monitoring contract voluntarily entered into between a licensee and an approved professionals’ health program for the treatment, rehabilitation, or improvement of a licensee will no longer require BOM approval and will not be disclosed to the BOM unless the licensee relapses or violates the terms of the monitoring contract or it is incorporated into a public settlement agreement or disciplinary action. The term “director” replaces “proctor” in this section. [Med 407.01-.03, pages 20-22]
- 9) A patient will have the right to have his or her request for their medical records by either themselves or an authorized agent promptly honored within 30 days, unless the nature of the medical treatment requires an immediate response. The term “responsible party” replaces “licensees’ in several places when referring to an employed physician or PA licensee denoting the responsibility of the employer of organization in transferring copies of the medical record. [Med 501.02(f)(1-7), pages 26-27]
- 10) Initial PA license applicants are now required to have a signed, notarized affidavit stating that they are a graduate of an approved PA program and have “never been an inmate in an institution for the treatment of insanity, drug addiction, or inebriety.” [Med 604.01(a)(15), page 30]

Please read the entire sections of the new rule to understand the full context of these changes.

Should you have any questions or need further information, please do not hesitate to contact me at james.potter@nhms.org or call 603-224-1909. ■



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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.

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The New Hampshire Medical Society envisions a State in which personal and public health are high priorities, all people have access to quality healthcare, and physicians experience deep satisfaction in the practice of medicine.

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In early February, NHMS President Dr. John Klunk, NH AMA delegates Drs. Bill Kassler and Travis Harker, and NHMS EVP Jim Potter traveled to Washington, DC, for the AMA National Advocacy Conference. They even ran into Bill Nye (the science guy!) in the hallway of the Cannon House Office Building and were able to thank him for his work on advocacy for supporting vaccination as a public health imperative. Read more in Dr. Klunk's February 16 NHMS President's blog: <http://nhms.org/presidents-blog>.