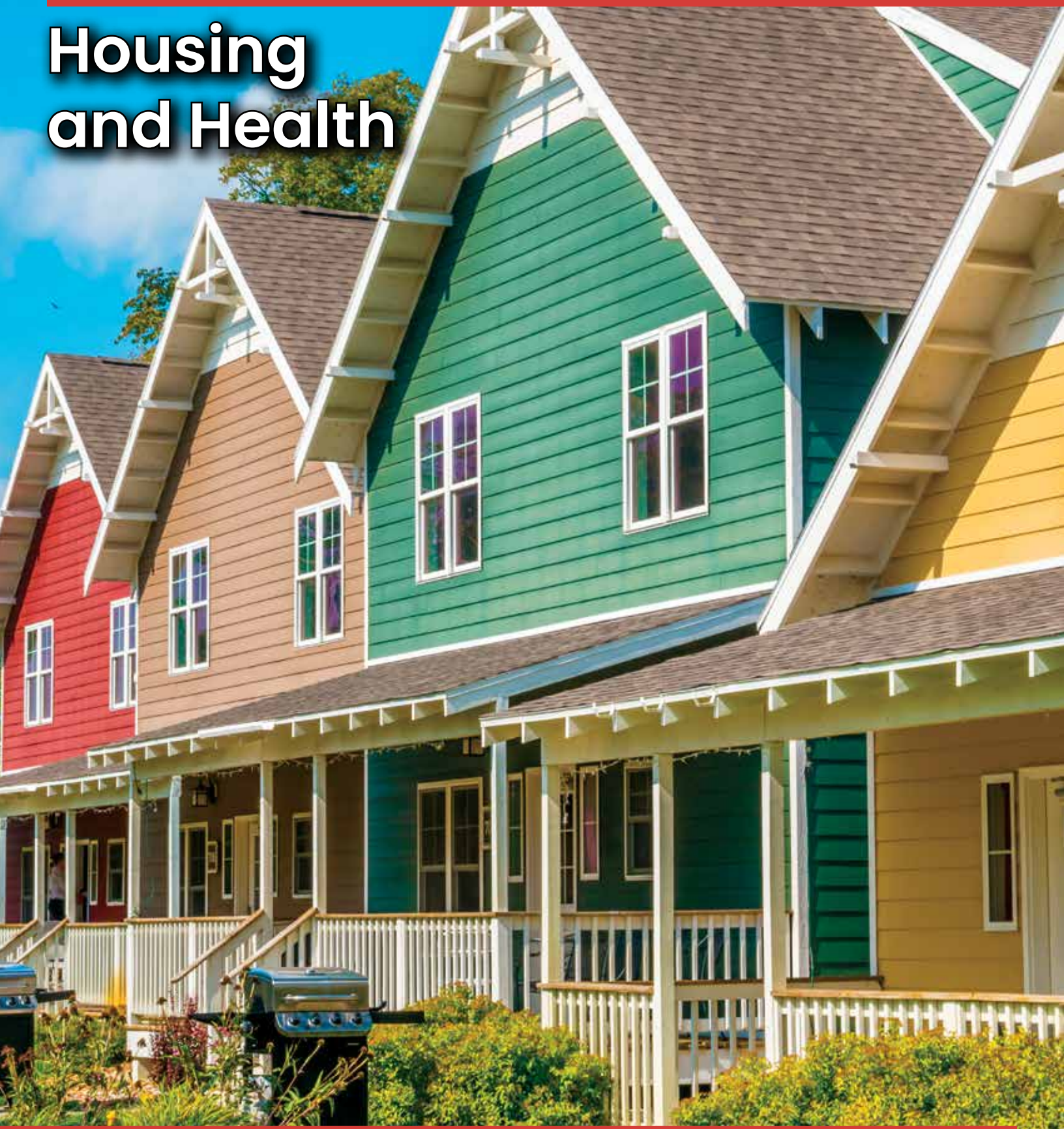
NEW HAMPSHIRE PHYSICIAN
A PUBLICATION OF THE NEW HAMPSHIRE MEDICAL SOCIETY

Housing and Health



Volume 3 | 2020

Trending Topics in Medicine 2020

NHMS Annual Scientific Conference, November 13-15, 2020
Wentworth by the Sea, New Castle, NH

Register Now at http://nhms.org/2020conference

Presentations will focus on issues including:

- **Social Determinants of Health**
- **Equity Issues in Health Care**
- **Novel Coronavirus SARS-CoV2 and COVID-19**
- **Pain Management and Addiction Disorder (3 credits!)**

We have worked closely with the Wentworth to assure that in-person attendees have every safety measure in place as recommended by the CDC and NH DHHS.

In addition, for the first time this year, we will be offering virtual and on-demand CME options for the full curriculum as well as certain portions or even individual sessions that can be accessed remotely for your comfort and safety through our new online learning management system.

HOTEL RESERVATIONS:
866-384-0709* or online via http://nhms.org/2020conference

*Be sure to mention **NH Medical Society** when booking to receive the group rate.

Room Rates: Single or Double $229.00++

Rooms and rate availability cannot be guaranteed after October 12.

Also in this issue...

New Hampshire Medical Society 2020 Legislative Session Wrap Up

Race (and Racism) as a Social Determinant of Health

With Social Media on the Rise, Be Mindful of Internet Grooming

New Hamphire Medical Society
7 North State Street
Concord, NH 03301
603 224 1909
603 226 2432 fax
nhmedicalsociety@nhms.org
www.nhms.org

John Klunk, MD
President

James G. Potter, CAE
EVP

Mary West
Editor

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

2019–2020 NHMS Council

President	John L. Klunk, MD
President-Elect	Kenton Allen, MD, MBA
Immediate Past President	Tessa J Lafortune-Greenberg, MD
Penultimate Past President	Leonard Korn, MD
Vice President	Eric A. Kropp, MD
Secretary	Maria T. Boylan, DO
Treasurer	Stuart J. Glassman, MD
Speaker	Richard P. Lafleur, MD
Vice Speaker	Daniel M. Philbin, MD
AMA Delegate	William J. Kassler, MD, MPH
AMA Alternate Delegate	P. Travis Harker, MD, MPH
Chair, Board of Trustees	Deborah A. Harrigan, MD
Trustee	Richard B. Friedman, MD
Trustee	P. Travis Harker, MD, MPH
Medical Student	Soham C. Rege
Physician Assistant	Linda L. Martino, PA-C
NH Osteopathic Association Rep.	Arlene F. Mrozowski, DO
Young Physician Rep.	Kenton Allen, MD
Young Physician Rep.	Anthony M. Dinizio, MD
Member-at-Large	Diane L. Arsenault, MD
Member-at-Large	Seddon R. Savage, MD
Member-at-Large	Doris H. Lotz, MD, MPH
Member-at-Large	Jonathan R. Ballard, MD
Member-at-Large	Linda Kornfeld, MD
Physician Member of NH Board of Medicine	David Conway, MD
Lay Person	Lucy Hodder, JD
Physician Rep. of the NH Dept. Health Human Services	Benjamin P. Chan, MD

Specialty Society Reps

• NH Chapter of the American College of Cardiology	Daniel Philbin, MD
• NH Chapter of the American College of Physicians	Richard P. Lafleur, MD
• NH Academy of Family Physicians	Gary A. Sobelson, MD
	TBD
• NH Chapter of American Academy of Addiction Medicine	Molly E. Rossignol, DO
• NH Chapter of Emergency Physicians	Thomas J. Lydon, MD
• NH Society of Eye Physicians & Surgeons	Purak Parikh, MD
• NH Pediatric Society	Skip M. Small, MD
• NH Radiology Society	Terry J. Vaccaro, MD
• NH Psychiatric Society	Becky Neal, MD
• NH Society of Anesthesiologists	Steve J. Hattamer, MD
• NH Society of Pathologists	Eric Y. Loo, MD
• NH Amer. College of Obstetricians & Gynecologists	Oge H. Young, MD
• NH Orthopaedic Society	Glen D. Crawford, MD
NH Med. Group Management Assn. Rep.	Dave Hutton

John Klunk, MD
NHMS President

...safe, stable, and affordable housing is a key factor in the good health of the patients we serve...

President's Perspective
Housing and Health

Housing is often seen as a key determinant of health that can in turn affect many of the other social determinants. Various aspects of housing—stability, affordability, conditions, and location—can all have significant impacts on the health of individuals and of entire communities.

Housing instability can have detrimental effects on health. The most extreme case of housing instability is homelessness. People without permanent homes may live on the street or in a vehicle or abandoned building, in shelters, or even have extended stays with family or friends. Homelessness is associated with increased rates of physical and mental illness, increased mortality, and shorter life expectancy by up to 30 years. On any given night, there are more than 600,000 homeless people in the United States, and more than a third of these are families.[1] Homeless children are more likely to have poor growth, developmental delays, and behavioral problems. Mental illness and substance abuse are extremely common in homeless populations, and can be both contributing and complicating factors of homelessness. Not surprisingly, homeless people have higher health care costs, not only because of their significant burden of co-morbidities, but also because their access to health care is limited and often restricted to costly emergency department visits or inpatient hospitalization. Recently we've seen the impact of COVID on the homeless population, who are at increased risk for contracting COVID due to lack of consistent access to simple measures like masks and handwashing as well as frequent overcrowding conditions. Due to their high burden of chronic diseases, many of these people are then at risk for more severe outcomes after contracting COVID. Here in New Hampshire, homelessness is not seen as a prominent problem as it is, for instance, in California, but in 2019, we had more than 1500 homeless persons, with the majority of them counted in Hillsboro County.[2]

Housing affordability is another significant factor that can impact health and even lead to housing instability and homelessness. Generally, if a person or family spends more than 30% of income on housing, this is considered problematic, as the cost burden of maintaining that housing starts to encroach on other expenses such as healthy food, heat and other utilities, medications and medical care, etc. Reviewing analyses done within the past few years, more than a third of the US population spends more than 30% of their income on housing, and that proportion goes up to nearly two-thirds in households earning <200% of the poverty threshold.[3] According to the CDC, in 2013, the proportion of renters who spent >50% of their incomes on housing was nearly 25%.[4]

The conditions of housing can have a substantial impact on health as well. Data compiled by the CDC for the Healthy People 2020 campaign show that poor quality housing is associated with various negative health outcomes, including chronic disease and poor mental health.[5] There are numerous potential health risks in poor housing conditions, from poisonings from toxins such as lead, to exposure to extremes of heat and cold due to lack of proper insulation or lack of adequate heating and cooling, to water leaks, poor ventilation, and pest infestation, which have been associated with poor health outcomes, particularly in respiratory diseases like asthma.[iii]

Finally, the location of housing has a profound influence on health. Housing in a neighborhood with limited access to public transportation is going to limit access to economic opportunities. Living in a neighborhood with limited healthy food choices or adequate green space limits opportunities to

adhere to a healthy lifestyle with an appropriate diet and regular exercise. Conversely, according to a review in Health Affairs from 2018, "In the modern era, researchers have found that the availability of resources such as public transportation to one's job, grocery stores with nutritious foods, and safe spaces to exercise are all correlated with improved health outcomes." Furthermore, the legacy of racist housing policies and the practice of redlining that began back in the 1930s, among other factors, have led to racially segregated communities, particularly in urban areas, with Black and Brown populations concentrated in areas high in poverty. The Health Affairs review notes that "neighborhood segregation…widens health disparities by determining access to schools, jobs, and health care; influencing health behaviors, and increasing crime rates in neighborhoods of color".

Traditionally, within the health care system, housing issues such as we've outlined here would be identified as a problem for individual patients, maybe when obtaining a social history, but weren't necessarily considered something that we in health care could actually help to solve. That is starting to shift. As health systems look toward improving the health of populations in the communities they serve, and with the recognition that social determinants have an outsized impact on the health of those communities, housing is one area that health systems have focused their efforts. In addition to improving health, there is a financial argument to be made for health systems to invest in safe, affordable, stable housing. With the growing move from fee-for-service reimbursement to value-based reimbursement and increased financial risk for health care organizations, health systems can no longer afford to look past housing and the other social determinants. Investments in these areas will have a substantial beneficial effect on health and ultimately decrease costs.

So what are some of the ways that health care is working to improve housing conditions in their communities? There are a number of evidence-based models. Public health interventions such as the HUD's Healthy Homes Initiative[6] addressing lead paint, mold, and pest control have been shown to be effective ways to improve health by improving the conditions within homes.[7]

Another housing model that supports health is medical respite housing, which is short term residential care for the homeless coming from an acute or post-acute care setting. These homeless patients need a safe place to recuperate from serious illness. These are not nursing homes or skilled nursing facilities but do provide some medical as well as social services. Studies of medical respite programs from around the country have shown decreased readmissions, reduced subsequent ED visits, and cost savings.[8]

Supportive housing is an evidence based model that combines safe and stable housing for the most vulnerable in our communities (typically the chronically homeless or people in nursing homes not because of medical needs but because they are too frail to live on their own without support) with service supports to enable them to remain stably housed and live healthier lives. Generally rental housing, subsidies are provided so that tenants pay no more than 30% of their incomes toward rent. There are no requirements for sobriety or continued attendance in treatment programs as some other housing programs require. People living in supportive housing also have access to health services including behavioral health supports, diet and nutrition counselors, and other support services to help achieve and sustain better health for the residents. Programs in Massachusetts and New York have shown better health outcomes and reductions in ED visits, hospitalizations, ambulance rides, and net significant healthcare savings.

Some health systems have actually moved to direct investing in housing, known as 'impact investing', which aims to generate a measurable social benefit alongside a financial return. In 2018, Kaiser Permanente, the largest integrated health system in the country, announced a $200 million affordable housing investment with a specific goal of reducing housing instability and improving health in the communities they serve. Closer to home, last year a group of health systems that comprise the Healthcare Anchor network, including UMass Memorial Health Care, pledged $700 million to help address social issues that impact health, including safe and affordable housing.

So safe, stable, and affordable housing is a key factor in the good health of the patients we serve, and providers and health systems are starting to recognize the benefits of not only identifying opportunities to improve health through housing, but actually taking action. There are a number of evidence-based models already, and there are sure to be more innovations to come, as we in health care continue to expand outside the four walls of our hospitals and offices to take a more comprehensive view of health for our communities. ■

---

[1] Maness, D. L, DO, MSS, & Khan, M., MD. (2014 April 15). Care of the Homeless: An Overview. *American Family Physician*, 89(8), 634-640. Retrieved from https://www.aafp.org/afp/2014/0415/p634.html.

[2] https://www.dhhs.nh.gov/dcbcs/bhhs/documents/pit-map-2019.pdf

[3] Taylor, L. (2018). Housing And Health: An Overview Of The Literature. *Health Affairs*. doi:10.1377/hpb20180313.396577.

[4] Search the Data: Healthy People 2020. (2020, February 19). Retrieved from https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=5257;.

[5] Quality of Housing. (n.d.). Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing #:~:text=Aspects of housing quality include, mold, asbestos, or lead.&text=Poor-quality housing is associated, injury and poor mental health.

[6] HUD's Healthy Homes Program: HUD.gov / U.S. Department of Housing and Urban Development (HUD). (n.d.). Retrieved from https://www.hud.gov/program_offices/healthy_homes/hhi #:~:text=In 1999, in response to, related health and safety hazards.

[7] Watts, B., MPH. (2020, June 18). Health and Homelessness - Before and After COVID-19. In *Homelessness & COVID-19: A Merger of Two Epidemics*. Retrieved from https://www.nihcm.org/categories/homelessness-covid-19-a-merger-of-two-epidemics.

[8] *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health* (Rep.). (2014). The Corporation for Supportive Housing. https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf.

Mike Padmore
NHMS Director of Advocacy

The COVID-19 pandemic caused the New Hampshire Legislature to reconfigure how they operated...

New Hampshire Medical Society 2020 Legislative Session Wrap Up

The COVID-19 pandemic caused the New Hampshire Legislature to reconfigure how they operated in order to continue their business during the 2020 Legislative Session. In a bizarre twist, New Hampshire House of Representatives failed to extend the legislative deadlines past June 30. Without an extension, any 2020 Senate Bill would die once it crossed over to the House. A solution was found by packaging multiple bills into larger omnibus bills that would only need a concur or non-concur vote from the House of Representatives and could be accomplished within the June 30 timeframe. The following is a breakdown of a few pieces of key legislation that have passed both chambers and await the Governor's signature (as of printing).

Please let us know if you have any questions. If you are interested in getting involved with our advocacy work, don't hesitate to call or email me at (603) 858-4744 or Michael.Padmore@nhms.org.

NHMS Legislative Priority Levels

1 – Lead: Help lead advocacy on these bills

2 – Collaborative: Work with coalition partners on these bills

3 – Monitor: Monitor these bills, engaging with lawmakers and partners when necessary

HB 1639 - Omnibus legislation relative to health care that included:

NHMS Position: Support Result: Awaiting Governor's Signature Priority: 1

- NHMS worked with a group of stakeholders ranging from NH Hospital Association, Dartmouth-Hitchcock Medical Center, the NH Psychiatric Society, the NH Society of Physician Assistants, and others to push forward this bill and ensure that it encompassed a variety of health care policies, including reform to prior authorization, chronic pain treatment, physician assistant licensure, and mental health parity. We expect this bill to be signed by the Governor.

I. SB 531 – Clarifies the prior authorization procedures under group health insurance policies

II. SB 546 - Defines chronic pain for the purposes of the controlled drug prescriptions

III. SB 598 - Adds physician assistants to the law governing advance directives

IV. SB 597 - Clarifies the licensure of physician assistants and provides for biennial renewal of physician assistant licenses

V. SB 620 - Ensures coverage for certain biologically based mental illnesses

HB 1623 - Relative to telemedicine

NHMS Position: Support Result: Awaiting Governor's Signature Priority: 2

- In the wake of the COVID-19 pandemic, NHMS heard loud and clear the need to have telemedicine visits reimbursed at the same level as in-person visits. This bill aims to do that, along with carrying over many of the facets outlined in the Governor's Emergency Order #8, including expanded site of service and increased reimbursement for audio only visits. It is anticipated that the technical component of telemedicine codes will be of substantial debate post pandemic on what is defined in the legislation as "reasonable compensation" that will likely require national recommendations through the AMA/Specialty Society RVS Update Committee (RUC) process to adjudi-

cate. We expect this bill to be signed by the Governor.

I. Ensures reimbursement parity, expands site of service, and enables all providers to deliver services through telehealth for Medicaid and commercial health coverage

II. Including audio-only visits

III. Enables access to medication assisted treatment (MAT) in specific settings by means of telehealth services

IV. Amends the Physicians and Surgeons Practice Act to expand the definition of telemedicine

V. Amends the Nurse Practice Act to expand the definition of telemedicine.

VI. Enables the use of telehealth services to deliver Medicaid reimbursed services to schools

HB 1280 - Omnibus legislation relative to pharmaceutical reform

NHMS Position: Support Result: Signed into Law Priority: 2

➢ NHMS worked with a larger coalition made up of New Futures, AARP, and NH Public Health Association, among others to pass a series of pharmaceutical reforms that would create a drug importation program from Canada, address cost transparency issues, and ensure coverage for vital medications such as insulin and epinephrine.

I. HB 1280 - Requires insurers to cap the total amount paid for prescription insulin for covered persons and provides that prescription insulin drugs not be subject to any deductible

II. SB 687 - Establishes a prescription drug affordability board to determine annual public payor spending targets for prescription drugs, develop and implement policies and procedures for the collection of prescription drug price data, implement a register of drug manufacturers for drug pricing data, and establish funding for the board by reasonable user fees and assessments

III. SB 685 - Establishes a wholesale importation program for prescription drugs from Canada by or on behalf of the state and establishes the New Hampshire prescription drug competitive marketplace

IV. SB 688 - Clarifies the pricing of generic prescription drugs under the law governing consumer protection

V. SB 690 - Regulates prescription drug formulary changes during a contract year under the managed care law

VI. HB 1281 – Requires insurance coverage for epinephrine auto-injectors

HB 1520 - Establishing the New Hampshire health professionals' program (PHP) administration fund

NHMS Position: Support Result: Awaiting Governor's Signature Priority: 1

In early June, NHMS advocated against a PHP contract to an out-of-state vendor (driven by budget constraints in the state budget) that the NH Executive Council voted 0-5 not to support. Subsequently, the Medical Society helped draft an amendment introduced by Senator/Dr. Tom Sherman to create a PHP dedicated, non-lapsing fund to be supported through annual fees from the 13 participating board licensees which should create more equitable annual fees (likely about $10, versus the current $25 fee charged to physicians) that would not be subject to cyclical state budget fluctuations. Additional health and trade professions board licensees may be added in subsequent years. We expect this bill to be signed by the Governor

HB 1266 - Makes temporary changes to the absentee voter registration, absentee ballot application, and absentee voting processes in response to the COVID-19 disease

NHMS Position: Support Result: Signed into Law Priority: 2

➢ This bill aims to make voting in New Hampshire's September primary election and November general election safer for voters by making the absentee process easier to access and submit.

HB 687 – Relative to Extreme Risk Protection Orders

NHMS Position: Support Result: Awaiting Governor's Signature Priority: 2

➢ HB 687 establishes a procedure for issuing extreme risk protection orders to protect against persons who pose an immediate risk of harm to themselves or others. After being tabled last year so it could be studied further, HB 687 was passed by both chambers and will go to the Governor's desk for his signature. We expect this bill to be vetoed by the Governor.

HB 712 - Establishes a system of paid family and medical leave insurance

NHMS Position: Support Result: Vetoed by the Governor Priority: 2

➢ HB 712 aims to create a paid family & medical leave insurance program for New Hampshire. NHMS worked with a variety of advocacy organizations to outline the need for this program and the benefits it would offer families across the state.

SB 179 – Pharmacist Administration of Vaccines

NHMS Position: Oppose Result: Inexpedient to Legislate Priority: 1

➢ This bill was promoted by Merck pharmaceuticals to expand the ability for pharmacists to administer vaccines to adults. NHMS intervened at an early stage to push back on this bill, outlining the challenges that physicians are already having in receiving patient vaccine information from pharmacists. NHMS urged them to reconsider this bill and instead focus on establishing a working vaccine registry for New Hampshire. Merck agreed and recommended that to the Senate's Health and Human Services Committee. ■

Douglas Phelan, DO, MPH
Attending Family Medicine and Preventive Medicine Physician practicing with Elliot Family Medicine at Bedford in Bedford, NH

If healthcare is to govern itself, then it starts with us to address these inequities and improve the health of our patients.

Race (and Racism) as a Social Determinant of Health

Conflict Of Interest Statement: I write this piece as a cis-gender white male in the United States of America.

In medicine, we are very familiar with the "conflict of interest" (COI) statement. It helps us to know with what biases a presenter or author might bring, and is standard practice in our educational experiences. And while my epigraph is not typical of a COI Statement, it is not entirely unwarranted.

We have, for years, had mountains of evidence tell us that, in addition to our zip codes and reliably sustainable food, transportation, and housing, our race also can determine our health. This simple fact can bring about many important questions. What is race but a social construct? Furthermore, why do we typically omit it when we think about "social" determinants of health? How do I acknowledge my own race and ethnicity when I think about patient care?

For a current example, examine the data regarding COVID-19. The CDC[1] demonstrates that both "Non-Hispanic American Indian or Alaskan Native" Americans and "Non-Hispanic Black" Americans have a prevalence nearly five times that of "Non-Hispanic White" Americans. For "Hispanic and Latino" Americans, this same comparison yields a four-fold higher rate. The data is the same here in New Hampshire. In a recent NHPR story relating the data, "Latinos account for 7% of those cases; and African Americans for 5.6%. As a percentage of the population, New Hampshire is 3.9% Latino and 1.4% black."[2]

As I depict the above data, verbatim from the CDC, these words of Nobel Laureate Toni Morrison come to mind: "In this country American means white. Everybody else has to hyphenate." This is one small, but important, example of "institutionalized racism" in medicine – the way that we talk about race is even baked into how our CDC displays statistics.

One perusing the data need only choose a sub-specialty to find any of a number of racially-divided disparities in care:

- Obstetrics: Pregnancy-Related Mortality Ratio for Black and American Indian or Alaskan Native women over 30 is 4-5 times higher than for white women.[3]
- Psychiatry: While the rates of mental illness are similar across race and ethnicity, 8.7% of black adults, vs. 16% of white, receive treatment for mental health concerns.[4]
- Primary Care: Hypertensive control is best-achieved in non-Hispanic white Americans, least-achieved in non-Hispanic black Americans.[5]
- Pain Medicine: Half of white medical trainees believe myths such as black people having thicker skin or less sensitive nerve endings than white people.[6]
- Addiction Medicine: Black and Hispanic patients have been found less likely to maintain medication-assisted treatment (MAT) with buprenorphine.[7]

For some, this information may be new – in which case we can point to the objective data. However, in the past, brief educational offerings seem to have been the end result rather than part of the process; an easier patch to the hard problem: Healthcare in America tolerates these disparities.

As the United States currently experiences a great reckoning with ongoing racism and inequity, it feels apropos that we in healthcare reckon with these disparities as well. If healthcare is to govern itself, then it starts with us to address these inequities and improve the health of our patients. ■

1. Centers for Disease Control and Prevention. COVID-19 in Racial and Ethnic Minority Groups. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html. Updated 6/25/2020. Accessed 7/13/2020.
2. New Hampshire Public Radio. COVID-19 Data Shows Racial Disparities in N.H. Cases. https://www.nhpr.org/post/covid-19-data-shows-racial-disparities-nh-cases#stream/0. Updated 4/30/2020. Accessed 7/13/2020.
3. Centers for Disease Control and Prevention. Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html. Updated 9/5/2019. Accessed 7/13/2020.
4. SocialWork@Simmons. Racial Disparities in Mental Health Treatment. https://socialwork.simmons.edu/racial-disparities-in-mental-health-treatment/. Updated 3/2/2017. Accessed 7/13/2020.
5. Saeed, A. et al. Racial Disparities in Hypertension Prevalence and Management: A Crisis Control? American College of Cardiology. https://www.acc.org/latest-in-cardiology/articles/2020/04/06/08/53/racial-disparities-in-hypertension-prevalence-and-management#:~:text=Data%20from%20a%20Centers%20for,%2C%20and%20NHAs%20(43.5%25). Updated 4/6/2020. Accessed 7/13/2020.
6. Sabin, J. How we fail black patients in pain. https://www.aamc.org/news-insights/how-we-fail-black-patients-pain. Updated 1/6/2020. Accessed 7/13/2020.
7. Weinstein, Z. et al. Long-Term Retention in Office-Based Opioid Treatment with Buprenorphine. Journal of Substance Abuse Treatment. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5312773/. Published 12/30/2016.

NHMS CORPORATE AFFILIATE PROGRAM SERVICES

Billing Services
Business Management
Collection Service
Dental Benefits
Electronic Medical Records
Electronic Payment Systems
Employee Benefits
Financial
Insurance
Legal
Office Supplies
Pharmaceuticals
Practice Management
Telecommunications
Uniforms, Apparel & Linens
Web-based Billing

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

NHMS Welcomes New Members

Melissa Martinez-Adorno, MD
Alexandra L. DeBlasio Bonesho, MD
Mary F. Brunette, MD
Frederick W. Burgess, MD
Ann C. Cabot, DO
Rex G. Carr, MD
Mark K. Detweiler, MD
Gerard Duprat, MD
William B. Feldmann, MD
Rodney A. Felgate, MD
Mona P. Feng, MD
Genevieve M. Kelley, MD
Jan McGonagle, MD
Mark N. Messier, MD
Richard A. Moore, MD
Harry W. Pollock, MD
Anil K. Prasad, MD
Stephen T. Rust, MD
Victoria Trump Redd, MD
Yvonne M. Tsai, MD

ACP American College of Physicians
Leading Internal Medicine, Improving Lives
New Hampshire Chapter

Scientific Meeting Program October 23, 2020

07:30-08:00 Zoom Registration/Verification

07:45-08:00 Opening Remarks and Welcome: William Palmer, MD, FACP

08:00-09:00 COPD Management Made Easy: Graham Atkins, BSc, MBChB, MRCP

09:00-10:00 The Science and Practice of Effective Brain Health Promotion: John Randolph, PhD, ABPP

10:00-10:30 BREAK & View Posters

10:30-11:30 M&M: Kenton Powell, MD, FACP

11:30-12:30 "ACP Vision of US Healthcare": Robert McLean, MD, FACP

12:30-01:30 LUNCH and View Posters

01:30-02:30 Sex, Death and Burnout; Shared Topics in Which We Talk Poorly: Adam Schwarz, MD, FACP

02:30-03:30 Frailty: What is it? Can we Measure it? Can We Do Something About it? Daniel Stadler, MD

03:30-04:15 Resident Poster Competition

04:15-04:45 Town Hall Meeting

04:45-05:00 Wrap-up

SAVE THE DATE! October 23, 2020
More details to follow
Catrina.watson@nhms.org

Telephone Triage Systems for the Office Practice

Medical Mutual
INSURANCE COMPANY OF MAINE

Telephone triage, when done effectively, can improve access to the appropriate level of care, practice efficiency, patient satisfaction, and patient/provider communication. However, it is not a replacement for medical care. Staff and patients need to be aware of the limitations of telephone communication.

Triage systems that involve screening of patient symptoms and subsequent clinical advice should utilize registered nurses with the appropriate background, training, and clinical experience. Written clinical protocols should be in place to guide this process.

Triage systems for practices solely staffed by medical assistants should have protocols in place that guide how questions are handled and addressed, both clinical and non-clinical.

Because the provider is responsible for any information staff provide to patients, written protocols, for nurses and medical assistants, should be reviewed and approved annually by the providers in the practice.

I. Improve Telephone Communication

The following recommendations will assist in the development of a structured telephone triage system.

- Establish a written policy that defines the telephone triage system to include the following:
  - Define Scope: Describe what the program will cover.
  - Define Purpose: State the intent of the program.
  - Define Personnel: Define required staff qualifications and duties.
  - Define Hours of Operation.
  - Define Program Components: Telephone call management process, written clinical protocols, documentation process and quality review.
- Provide staff education annually and as needed.
- Standardize documentation through the use of a telephone encounter form or EMR template.
- Practice consistent management of patient telephone communications.
- Monitor the program regularly; educate staff on findings.

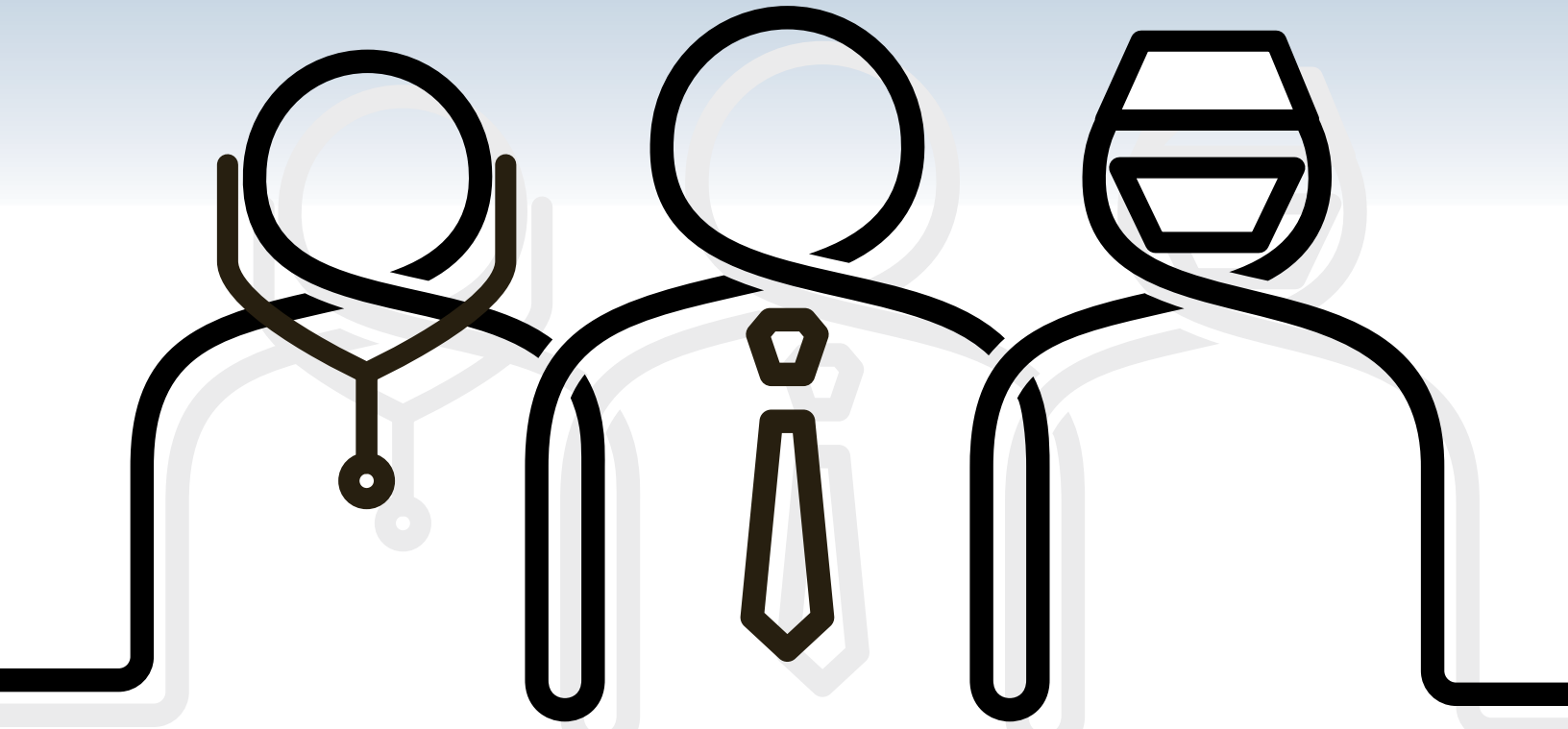
II. Minimize Professional Liability

A telephone consultation poses the same level of professional liability risk as an office visit. The duty to provide care is legally established from the moment the patient seeks advice. Minimize professional liability by practicing the following:

- Utilize written protocols as an adjunct to, not a replacement for, critical thinking and clinical decision making.
- Document an explanation when deviation from written protocols occurs.
- Return patient calls in a timely manner according to defined parameters. Inform patient when to expect a call back.
- Require provider review of triage documentation as defined by policy, including time, date of the review, and provider signature. In the EMR, assure the system reflects provider acknowledgement of the triage documentation.
- Document telephone communications immediately; utilize standard encounter form or EMR template.
- Document patient understanding of advice given. Advise the patient on steps to take if symptoms worsen ■

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.

Partners in patient safety & medical liability protection



Medical Mutual
INSURANCE COMPANY OF MAINE

www.medicalmutual.com

Benjamin Mitchell
Baystate Financial

BAYSTATE FINANCIAL
Guidance. Insight. Results.™

Estate Planning expertise is needed to help clients address the financial and legal issues surrounding end of life.

Fiscal Fitness for Your Life
Bringing Order to Chaos

I suspect that the trials of these past few months in the medical, financial and social arenas have caused everyone to pause for just a moment – or two or three, or maybe even longer – to contemplate our relationship with:

- Ourselves;
- Our futures;
- Our families;
- Our professions; and
- Our communities.

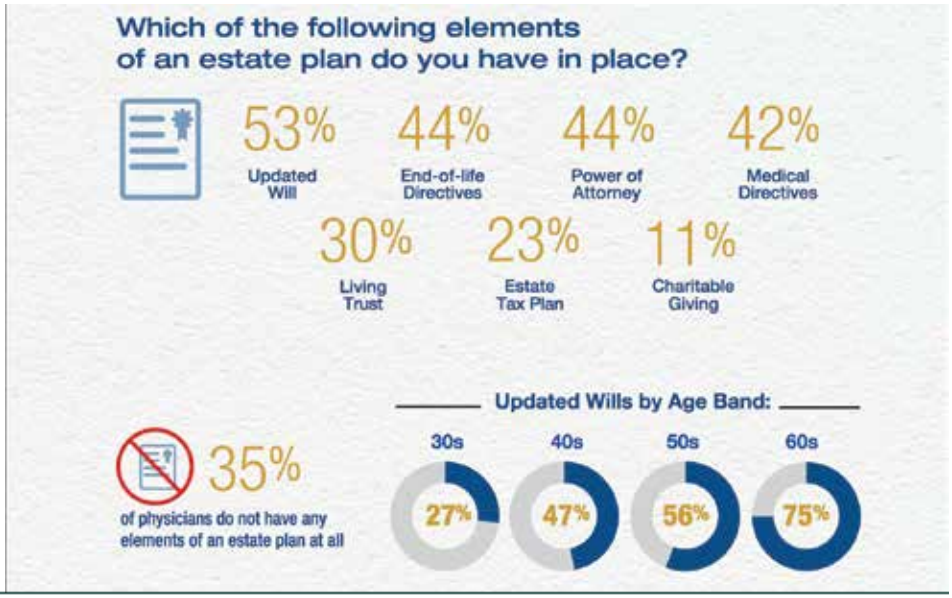
The challenge before each one of us is, from what perspective or in what context we will approach these new realities of our lives. In our work with physicians, much of our focus is on the here and now, assisting them in making informed financial decisions as to how to best meet today's financial challenges.

There is, however, a nagging question which needs to be addressed. How does all this play out in the end? Death is inevitable for all of us. Only its timing is an uncertainty. One of our focuses with clients is how to ensure that they and their families are prepared to meet the challenges which accompany death.

If we can be frank for a moment, our deaths create an intersection of three extremely complex and powerful systems: medical, financial and legal. Left unattended, this intersection will bring a chaotic clash of opposing, non-aligned forces, placing a tremendous amount of stress upon the family we have left behind. However, with a bit of planning, with a little allocation of your time, your emotional and intellectual energy, as well as your financial resources, you can bring order to this chaos!

The healthcare system has responded to this chaos by introducing Palliative and Hospice care protocols to help patients address the medical issues surrounding end of life. Estate Planning expertise is needed to help clients address the financial and legal issues surrounding end of life.

The following is a snapshot of how physicians themselves are doing in addressing these financial and legal issues.



Resource: 2016 AMA STUDY

The seriousness of these issues demands a best effort. Your training and experience support your putting forth a best effort in addressing your patients' needs when they are facing difficult end of life decisions. At Baystate Financial, we have the training, expertise and resources our clients need to address the legal and financial issues.

For close to a decade now, Baystate has been providing Financial Educational opportunities for members of the Maine Medical and Osteopathic Associations, and more recently for members of the New Hampshire Medical Society and Osteopathic Association. Whether it has been through published articles, sponsorship of events, informational webinars, or CME conference presentations, we have always attempted to bring to members an informed perspective on the financial challenges in your lives.■

Benjamin Mitchell is a registered representative of and offers securities, investment advisory and financial planning services through MML Investors Services, LLC. Member SIPC. OSJ:200 Clarendon Street, 19th & 25th Floors. Boston, MA 02116. 617-585-4500. CRN202203-262316

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

Marie Ramas, MD

With Social Media on the Rise, Be Mindful of Internet Grooming

While we are all physically distancing, internet predatory behavior is a wolf in sheep's clothing. In a recent Forbes Magazine article[1] reviewing the rising use of social media in the face of the pandemic, we recognize the potential positives and inherent risks as youth and young adults spend more time on the screen. Facebook, and its other platforms, dominates social media use amongst adolescents and young adults. While technology has helped maintain social connection during this pandemic, it is important to recognize that internet predatory behavior is still prevalent. According to the definition[2] used by Homeland Security "human trafficking involves the use of force, fraud or coercion to obtain some type of labor or commercial sex act." Although thought to be an international problem, human trafficking cases have been reported in all 50 states, contributing to the industry's fastest growing[3] crime rate in the world with the median age of entry into the life being 15 years old. While people of all races, socioeconomic backgrounds and cultures are affected, a history of child abuse, foster care or running away does increase the susceptibility of becoming a victim of sex trafficking.

A study[4] of 25,000 consumers spanning across 30 markets shows engagement during the pandemic increased more than 60% over normal usage rates. Messaging across Facebook, Instagram and WhatsApp increased 50% in countries hardest hit by the coronavirus. In a small cohort, 55% of victims of human trafficking admitted to never personally meeting their abuser, but rather meeting them on a social media platform. With an estimated 150,000 new escort ads added daily,[2] it is important as physicians to recognize potential signs of human trafficking within our offices. In educational materials put forth by Guardian Group,[2] five key observations should alert clinicians of potential human trafficking.

Since, predators prey on those with low self-esteem and history of neglect or abuse, the first alert to potential harm would be sudden change in

Victims are everywhere. Know what the indicators are and be willing to report what you see...

behavior, lower grades, anger or appearance. Another indicator of concern would be sudden influx of cash, new or expensive gifts and purchases or electronics. Some clinicians or parents may discover a fake ID, while others may hear of references to a new modelling, music video job or even an older boyfriend. Monitoring of social media accounts may demonstrate uncharacteristic promiscuous behavior or references in person or on social media to sexual situations. While others may experience sudden truancy from school or a drop in grades.

Victims are everywhere. Know what the indicators are and be willing to report what you see to local law enforcement or the National Hotline for Human Trafficking (888-373-7888).

How do we educate our patients to identify whether they are being groomed? ECPATUSA[5] is the country's oldest nonprofit against sex trafficking. They describe "grooming as a practice by means of which an adult "befriends" a child (often online, but offline grooming also exists and should not be neglected) with the intention of sexually abusing her/him."[6] Currently, only EU Directive 2011/93 sets forth that attention must also be paid to offline grooming and that states should criminalize such practices as well. It is no doubt why human traffickers prey on those who have low self-esteem or are already experiencing increased insecurities during adolescence. For this reason, it is key to educate both parents and children of signs of grooming. It is also important to understand that, in most cases, these relationships take time to develop and cumulatively build a false sense of trust for the assailant. Young users should be weary if a user showers them with inappropriate and sexualized compliments. An adult who is requesting increasingly more attention from the child/adolescent or seems to delve into personal information, should be deleted and reported. An adult or older user who shows possessive or jealous characteristics over a young user should be considered a potential abuser and blocked. If an older user requests or suggests provocative subjects, this is a red flag.

As we survey the effects of social determinants of health on our patients, let us remember that each of these determinants have a direct effect on the health and wellness of the people we serve. ■

[1] Holmes, R. (2020, April 24). Is COVID-19 Social Media's Levelling Up Moment? Forbes. https://www.forbes.com/sites/ryanholmes/2020/04/24/is-covid-19-social-medias-levelling-up-moment/#62e0334a6c60.

[2] What is Human Trafficking? (n.d.). Retrieved from https://guardiangroup.org/what-is-trafficking/?gclid=Cj0KCQjw6ar4BRDnARIsAITGzlDc5u5C4ymgkcjmrAwwJZKdXUZ5Ae1ijk_8KJnMSe5UjPoxS761EMAaAjhZEALw_wcB.

[3] Bouché, V., Ph.D. (2018). *Survivor Insights: The Role of Technology in Domestic Minor Sex Trafficking* (Rep.). Thorn. https://www.thorn.org/wp-content/uploads/2018/06/Thorn_Survivor_Insights_061118.pdf.

[4] COVID-19 Barometer: Consumer attitudes, media habits and expectations. (n.d.). Retrieved from https://www.kantar.com/Inspiration/Coronavirus/COVID-19-Barometer-Consumer-attitudes-media-habits-and-expectations.

[5] https://www.ecpatusa.org/

[6] Greijer, S. and Doek, J. (2016, June). Terminology Guidelines for the Protection of Children from Sexual Exploitation and Sexual Abuse. Interagency Working Group in Luxembourg. ECPAT International. https://www.unicef.org/protection/files/Terminology_guidelines_396922-E.pdf.

Oge Young, MD

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
Angell

The porch was crowded with women and children. The sun beat down, but a frail roof provided shade. A morning breeze drowned some of the clamor. Excited voices and laughter filled the waiting area. They were patient, appreciative that we had come to provide them with basic medical care. I stepped out of the door in my scrubs to ask for the next woman on my list.

Unable to pronounce her last name, I called out 'Angel.'

A young woman stood timidly and made her way to where I was standing. She followed me in. As the door closed there was a pleasant hush. "I am Dr. Young," I said. She replied, "I am Angell, with two L's" as she offered her coarse, strong hand. She smiled, lips quivering slightly. White teeth shone against her dark face and tight-curled black hair.

At thirty-five, she lived with her four children- a son, 18, and three daughters 17,15 and 11, all delivered at home. Each had a different father, long gone, 'more trouble than they were worth.' Also, Angell shared her home with her mother who had suffered a stroke. She sold chickens for a living. I pictured her yard with a tin-roofed dwelling and a gutter collecting rainwater. Like her neighbors inhabiting the lush, porous hills surrounding the village of Chantilly in central Jamaica, she spent her days thankful for a garden with good soil and an occasional rainstorm. "No problems," she said. "Just want an exam. A friend told me you were nice."

Undressing behind the shower curtain hung in the corner of the room, she fit loosely into a large, cotton blue gown. She sat down at the end of the exam table covering her lap with a white drape. I stood in front of her, feeling her eyes fixed on me as I looked down at her thick, worn palms and dirt-filled nails. No thyroid nor lymph nodes were palpable beneath the thin, taut skin covering her neck. Well-nursed breasts hung limp and soft, with no cystic changes, so common in our country. She laughed when I told her that her heart was still beating. A firm abdomen bore abundant stretch marks, purple hearts from her pregnancies.

Bending her knees to bring her heels to the end of the table, a pelvic exam revealed no scarring nor prolapse, remarkable after four births. She had some mild tenderness on deep palpation.

Angell denied having been abused. I wondered if she really understood. Her lower legs were indented with scars. Calloused feet hardly needed shoes. She appeared surprised when I helped her sit up. "You are perfect my friend. You deserve a man who loves you more than himself." She laughed again, shaking her head… maybe embarrassed, but flattered.

She returned to the makeshift dressing room. I jotted a few notes. Dressed, we sat. I had gifts of pads and medication for her menstrual periods. Condoms provided a

reminder that she could still bear another child and unprotected sex had other risks. I gave her extra toothbrushes, floss and tubes of toothpaste which I suspected she would sell.

Then we stood. She looked down, quietly thanking me. For what? For affirming her health, her strength, her beauty…her humanness? Did she feel my eyes fixed? "Will you be back next year?" she asked. "God willing," I replied. She thanked me once more, as she disappeared into the sounds of others on the porch. Calling my next patient, I wondered who felt more grateful. ■

NHPS Annual Spring Meeting,
Awards, Scientific CME Presentation
and Poster Contest

Transgender Mental Health For the Practicing Psychiatrist

A. Evan Eyler, MD, MPH

September 2, 2020, at 6:30 via Zoom

Contact catrina.watson@nhms.org for more info

New Hampshire
MEDICAL SOCIETY
ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

Prsrt Std.
U.S. Postage
PAID
Concord, NH
Permit No. 1584

7 North State Street
Concord, NH 03301
603 224 1909
603 226 2432 **fax**
nhmedicalsociety@nhms.org
www.nhms.org

ADDRESS SERVICE REQUESTED

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

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

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

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.

Printed on recycled stock using soy-based inks.

MY MASK PROTECTS YOU.
YOUR MASK PROTECTS ME.
#MASKUP
NEWHAMPSHIRE

#MaskUpNH

The Medical Society is helping coordinate a voluntary Mask Up! social media campaign with NH hospitals, businesses and consumer organizations to help continue bending the COVID-19 curve in NH this summer. Download the toolkit from maskupnewhampshire.com. Please consider sharing your masked photo with #MaskUpNewHampshire