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Older Adults and Transportation

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Helping Family Caregivers Self-Identify

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

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John Klunk, MD
NHMS President

President's Perspective

Older Adults and Transportation

Over the course of this year, we have explored various social determinants and their significant impacts on the health of our patients through the lifespan—from adverse childhood experiences (ACEs) in infants and children, to the impacts of education on the health of children and into adulthood, to the importance of access to affordable and stable housing for working age adults and their families. This progression was intentional, since as a med-peds physician working in primary care, all of these patients are people I see every day in my practice, and only by understanding the impacts of trauma, education, housing, and other factors, will we be able to truly improve the overall health of our patients and our communities. And so this brings us to older adults.

One of the social determinants that has a significant impact on older adults is access to affordable and reliable transportation. There are a number of considerations with transportation that are unique to older adults. With aging, many adults begin to have declining vision, decreased reaction times, and some begin to have cognitive decline that eventually make driving less safe. Many older adults live in rural or suburban communities that don't have extensive access to public transportation, so being able to drive is key to being able to access community resources outside of the home. Even for older adults who live in more urban areas and have access to public transportation, they are more likely to have mobility assistance needs such as canes, walkers, and wheelchairs, or cognitive and memory issues, that still may make even public transportation inaccessible to them. Combine these transportation limitations with the fact that the vast majority of older adults surveyed indicate that they would prefer to 'age in place' and stay in their own homes as they age, rather than move into assisted living or long term care facilities, and we can begin to realize the significant impact this can have on our older patients.[1]

Here in the Granite State, transportation for older adults is a particularly impactful issue, as we have the second highest median age in the country,

One of the social determinants that has a significant impact on older adults is access to affordable and reliable transportation.

second only to Maine, with about 20% of our entire population over age 60. A study commissioned by Transportation for America in 2011 looked at cities of various sizes across the United States and projected what percent of the older adult population would lack access to consistent public transit.[2] Included in that analysis were New Hampshire's two largest cities, Manchester and Nashua. For Manchester, the prediction for 2015 was that 15,362 adults aged 65-79, or 54% of that population would have poor access to public transit, and for Nashua they predicted that 21,017 older adults in that age group, or 72% of that population, would have poor access to public transit.

If an older adult cannot drive and does not have access to public transportation, then they may have to rely on friends or family to bring them grocery shopping, pick up medications, get to doctor's appointments, or to attend social events and see friends and family. For those without friends or family who can help, and especially for low income older adults who might not be able to afford other transportation options, the situation is even more dire. Not only does the loss of mobility lead to a loss of independence, but in very practical terms it limits the ability of affected older adults to access the basic necessities of life such as healthy food and medicine, which in turn can have a profound effect on their health. Lack of transportation for older adults who are 'aging in place' can also lead to social isolation, which we know is associated with increased rates of depression, anxiety, and other adverse health outcomes.[3]

The current coronavirus pandemic has highlighted the effects of social isolation in our older patients. In my own practice, even older adults who don't have transportation limitations, or who have family members who can reliably help, have been voluntarily isolating themselves due to concerns about contracting COVID-19 and the potential for more severe illness that we have seen in adults over 65. And for others, family members and friends who typically had been able to help are now unable to do so due to constraints related to COVID. In some cases, pre-COVID these patients had displayed some normal cognitive and memory decline that can be associated with aging, or the beginnings of mild cognitive impairment (MCI). The social isolation they have experienced these past months due to the pandemic appears to have accelerated their cognitive deterioration at an alarming rate. This is anecdotal, but I am seeing it and I know from talking to many of you that many of us are seeing this around the state. Knowing what we know about the affects of social isolation in this population, it seems reasonable that their isolation is contributing to this cognitive decline. (Read more in Dr. Marie Ramas's article on page 12.)

A global pandemic notwithstanding, there are some solutions to solving the lack of access to transportation for older adults. Certainly for many, the support of family and friends provides consistent and reliable access to transportation, with the added benefit of some social interaction. There are also taxis and ride-sharing services such as Uber and Lyft that may be appropriate for some. For those who have access to public transportation and don't have mobility or cognitive issues that pre-empt their use of these services, public transport can be an inexpensive and reliable means of getting to appointments and accessing stores and other services. There are a number of federal and state funded programs for transportation for older adults, from 'dial a ride' programs that provide rides at a certain time, to volunteer ride programs, to assisted transportation programs for older adults who have additional mobility and/or cognitive needs.[4] In addition, for low income older adults on Medicaid, transportation for medical appointments is covered as part of their insurance benefits. In New Hampshire, a centralized resource through the Department of Health and Human Services (DHHS) called ServiceLink provides on-line access to various aging resources available in the state, including transportation options. Another DHHS site, NH Care Path, has specific state resources available for transportation.[5]

As might be apparent here, there is a patchwork of various resources but there is not a comprehensive, fully coordinated, or universally accessible approach currently. There are models and case studies out there showing the effectiveness of coordinating various transportation services between the private and public sectors, developing comprehensive community-based transportation programs, and even designing entire communities with accessibility for older adults of critical services factored right into the planning.

Ultimately, as our state and our nation continue to age, we'll need to find innovative solutions to enable appropriate transportation for older adults to support their desire to age in their own homes, or design attractive communities that can meet all their needs in a way that will inspire them to relocate, in order to support their mental and physical well-being and help them to age in optimal health. ■

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[1] Binette, Joanne and Kerri Vasold. 2018 Home and Community Preferences: A National Survey of Adults Age 18-Plus. Washington, DC: AARP Research, August 2018. https://doi.org/10.26419/res.00231.001.

[2] DeGood, K. (2011). Aging in Place, Stuck Without Options: Fixing the Mobility Crisis Threatening the Baby Boom Generation (Rep.). Transportation for America. https://t4america.org/docs/SeniorsMobilityCrisis.pdf.

[3] Keyes, C., PhD, Michalec, B., MA, Kobau, G. R., MPH, Zahran, H., MD, Zack, M., MD, & Simoes, E., MD. (2005, May 6). Social Support and Health-Related Quality of Life Among Older Adults–Missouri, 2000. CDC Morbidity and Mortality Weekly Report, 54(17), 433-437. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5417a4.htm.

[4] Older Adults & Transportation. (n.d.). Retrieved September 14, 2020, from https://www.nadtc.org/about/transportation-aging-disability/unique-issues-related-to-older-adults-and-transportation/.

[5] https://www.nhcarepath.dhhs.nh.gov/transportation/index.htm

Michael Padmore,
NHMS Director of Advocacy

Family and Medical Leave: Supporting Older Adults and Caregivers

Last year, I wrote an article about how lack of paid family and medical leave policies disproportionately impact women. (See New Hampshire Physician 2019 Volume 4, at http://nhms.org/newsletters). However, these impacts do not stop there. With this edition's focus on older adults, and the ongoing COVID-19 pandemic, I thought it timely to revisit this issue. The New Hampshire Medical Society's support for paid leave policies stems from the wide-ranging positive impact that these policies have on our population's public health. One critical subset of that impacted population is older adults and their caregivers. A 2017 study done by Kate Bahn and Joelle Saad-Lessler, two labor economists, found that "seventy percent of people turning age 65 can expect to need some form of medium- to long-term care during their lives that would require a family member to take leave from work beyond what would be covered by paid sick time off." As public health professionals, it's our responsibility to advocate for policies, like paid leave, that can improve health outcomes and support families throughout the lifecycle.

Dr. Ken Dolkart, a practicing geriatrician at Dartmouth-Hitchcock Medical Center, offered his perspective to our state's legislature when he testified on behalf of two bills that would have enacted a paid family and medical leave insurance program for New Hampshire, Senate Bill 1 and House Bill 712.

"Like many of you in this room, I have personally needed to attend to the care of a parent whose health may be punctuated by sudden crisis. In a time when we are lucky enough to have our loved ones remain in their own homes into advanced years, it has become increasingly common that working sons and daughters are called upon to attend to their parents

Paid family and medical leave would go a long way in alleviating the stress that these families face.

Ken Dolkart, MD, far left, testifies on behalf of family and medical leave – SB 1 and HB 712.

needs when medical issues arise. Both as a physician who cares for the old and their families, and as a baby boomer, I can attest how emotionally and financially stressful it is for many working people to grapple with the sudden needs of a spouse or aging loved one.

Employees are called upon when a spouse or parent suddenly can no longer manage unassisted in their home – more monumental tasks arise with the care necessities of a family member with serious illness. A hip fracture, a pneumonia complicated by delirium, a stroke, a cancer diagnosis and treatment, a surgical procedure or other acute illness often result in things falling apart. Once someone returns home from a hospital or facility, visiting nurses or hospice nurses can only provide so much, and grasping new care responsibilities, filling a pill planner, arranging therapy and new living arrangements are often required. Aides may be expensive, limited in hours and often difficult to locate in many communities.

"Apart from the emotional stress in the setting of hospice care is added the financial stress related to unpaid absence from work to devote the time to doctor's visits and care at the end of a loved one's life. Financial worries often compound the family worries."

On top of an already stressful situation, the COVID-19 pandemic has undoubtably complicated caregiving responsibilities for families across the state and nation. This is only compounded further by the fact that older adults are among the most impacted population from this disease. As families are figuring out the best way to navigate their caregiving responsibilities, it's vital that, as a society, we are providing the best resources available. Paid family and medical leave would go a long way in alleviating the stress that these families face.

In my column last year, I mentioned that the first attempt to pass a paid family and medical leave bill was made by the late Representative Mary Gile more than 20 years ago. Her efforts were aided by past New Hampshire Medical Society President, Dr. Oge Young, who testified countless times in front of the legislature to make the case for such a policy. While both Senate Bill 1 and House Bill 712 were vetoed by Governor Sununu, there is hope for the future. Data from a University of New Hampshire, Carsey School of Public Policy study, tells us that paid leave policies are overwhelmingly popular, "with 82 percent of New Hampshire residents saying they support a paid family and medical leave insurance program." I am confident that there will be another bill introduced in the 2021 New Hampshire legislative session and another bill after that if need be. I want to stress how important your voices are in this process. Please call me at (603) 858-4744 or email Michael.Padmore@nhms.org if you are interested in this work. Together, I am certain that we can make a difference. ■

Tiffany Fuller, MS
Consumer Outreach Coordinator
NH Insurance Department

Aging Adults, Chronic Disease and Health Insurance on a Budget

Access to health insurance coverage can be challenging at many stages in life, but especially for aging adults and those with limited incomes and chronic health conditions.

If we are fortunate, we get to live a long life without a chronic health condition or major ailments, but for the majority of us, as we age, chronic health conditions will creep into our lives. Having access to affordable health insurance will become more important than ever. We know where we live, learn, work and play, also known as our social determinants of health, will contribute greatly to our health outcomes. According to the Centers for Disease Control and Prevention (CDC), 6 out of 10 adults in the U.S. have a chronic disease and 4 out of 10 adults in the U.S. have two or more chronic diseases.[1] One in four Medicare beneficiaries has less than $15,000 in total savings and one in 12 have zero in savings or are in debt.[2]

Fortunately, there are options available for your aging adult patients with limited incomes. As you are aware, Medicare is available for individuals over the age of 65. Medicare offers Part A and Part B coverage. Part A coverage is for hospital expenses and Part B is for medical expenses, but you may want to remind your patients that there is a penalty for signing up late. According to Medicare.gov, if an individual does not sign up for Part B when eligible, their monthly premium may increase 10% for each 12-month period they could have had Part B, but didn't sign up. During the open enrollment period, individuals are also eligible to purchase a Medigap policy. Your patients may be able to get better pricing and more plan choices, regardless of their existing health conditions during open enrollment. Medigap insurance can be purchased to help cover any costs not covered by Medicare Part A or B.

... 6 out of 10 adults in the U.S. have a chronic disease and 4 out of 10 adults in the U.S. have two or more chronic diseases.

If an individual is under the age of 65 and fortunate enough to have had employer sponsored health insurance, but was recently laid off or lost coverage, there are options available. For no- or low-income individuals under the age of 65, Medicaid is available. HealthCare.gov has Special Enrollment Periods (SEP) for people under the age of 65 who may have recently lost their coverage. Three-quarters of New Hampshire residents insured through the Marketplace qualified for financial assistance. For assistance go to localhelp.healthcare.gov.

Insurance is complex, but the NH Insurance Department is here to help. The mission of the New Hampshire Insurance Department 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. The NH Insurance Department is committed to doing so in an honest, effective and timely manner. If you feel you or your patients have been treated unfairly or have had a problem using health insurance, contact the NH Insurance Department at: consumerservices@ins.nh.gov or call 1-800-852-3416. This is a free service for all New Hampshire residents.

For information on Medicare, visit Medicare.gov or call toll free (800)-MEDICARE. To find out if you or someone you know might qualify for Medicaid visit nheasy.nh.gov or call (800) 852-3345. ■

[1] https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

[2] http://files.kff.org/attachment/Issue-Brief-Income-and-Assets-of-Medicare-Beneficiaries-2016-2035

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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.

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* Rooms and rate availability cannot be guaranteed after October 12.

Marie-Elizabeth Ramas, MD, FAAFP
Medical Director, GateHouse Treatment Center and NHAFP Vice President

Loneliness, the Overlooked Diagnosis

COVID-19 has posed a gargantuan burden on our society on multiple levels. Our aging population[1] presents an intersection between their higher morbidity from the virus and heightened effects of prolonged isolation. The Centers for Disease Control and Prevention recently noted that 8 out of 10 deaths due to COVID-19 are people 65 years old or older, with mortality dramatically increasing as patients exceed 85 years old. The primary mode of protection from acquiring coronavirus is physical isolation and mask wearing. While these measures are to protect, they are not without consequence.

Social isolation and loneliness in the elderly are also linked to higher rates of cardiovascular disease, dementia and depression.[2] Now, over one hundred days since the first string of coronavirus infections, we are seeing more causality from isolation within the aging community. Anecdotally, I have seen more complaints of headaches, insomnia, anxiety and confusion amongst my geriatric population. Some who live in retirement communities also speak of the void left by no longer interacting with neighbors. Of course, as with our younger population, those in the aging community also are at risk of food insecurity. With caretakers unable to visit the elderly, assist with meals, get groceries or take them out to restaurants, often the elderly lack a lifeline. In a similar manner, I wonder how many social and emotional lifelines have been broken due to this pandemic. For example, the lack of in-home care, due to COVID, has also complicated the experience of many in the geriatric community, both medically and socially. For those who receive such assistance, the professionals that go into their home act as my point of contact for the patients, as well as giving the aging person a means to connect to the world around them. In recent months, with New Hampshire case prevalence lowering, I have taken advantage of seeing their patients in person. However, families still need support in creating ways to stay connected.

Social isolation and loneliness in the elderly are also linked to higher rates of cardiovascular disease, dementia and depression.

A recent article from Massachusetts General Hospital[3] discussed some helpful ways to stay connected with the elderly while keeping them physically protected during this season. An interesting generational characteristic presented in the article was the tendency to hide their emotions, particularly those who have "lived through economic depression, wars and other hardships". Similarly, those from different backgrounds can also have varied degrees of value placed on family or community interaction. For instance, where multigenerational and communal living is part of the heartbeat of their culture, the concept of "household member" can go beyond those who live within the person's home. Particularly, this COVID season, I find tremendous value in speaking with closer relatives or friends of my multi-ethnic patients, making sure to be specific and culturally sensitive in describing concepts of physical distancing. In doing so, appropriate expectations of experience can be created within a community context. As a family physician who has practiced in both rural and more urban settings, these considerations are integral in providing a safe and practical approach to protecting the mental, emotional and physical well-being of the elderly. Additionally, giving permission to express and sometimes even providing the vocabulary of emotions is vital to helping our aging community cope with this new social normal. Often using descriptive experiences of depression or anxiety can help an older person identify their feelings, as opposed to simply saying that they are depressed or anxious.

While this season has presented many obstacles, it also has forced us to be creative and innovative in our daily lives. Helping our elderly loved ones to learn and try new things will open a space to spend time with them and empower them to engage with others in new ways. Of course, not all of our aging population has the luxury of a supportive community. As physicians, many of us can share stories of older patients who lack a supportive structure outside of their medical home, and we know that we are not out of the woods yet with coronavirus! With New Hampshire being the second oldest state in the United States, our state needs to work on creating a latticework of support to meet the needs of the most vulnerable population, as it relates to COVID. Perhaps as focus on social support for our seniors grows, our job to reduce the toll of this virus on our patients will also become more efficient through work in an integrative patient-centered partnership. ■

[1] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

[2] Morris, B. (2020, July 20). Isolating the Elderly is Bad for Their Health. *The Wall Street Journal*.

[3] Helping Seniors Manage Loneliness and Anxiety during the COVID-19 Crisis. (2020, May 20). https://www.massgeneral.org/news/coronavirus/helping-seniors-manage-loneliness-and-anxiety-during-covid-19.

Jennifer Rabalais,
Co-Director of the Center on Aging and Community Living (CACL) and Coordinator for the NH Alliance for Healthy Aging

Caregivers often take care of themselves last...

Helping Family Caregivers Self-Identify Connects Them to Support and Resources

In New Hampshire, approximately 177,000 family caregivers provide an estimated 148 million hours of care annually for a family member or friend.[1] While many caregivers report positive aspects of providing care, the role also comes with financial, social, and physical stressors. Caregivers often take care of themselves last, for example, missing their own medical appointments and neglecting their health to care for another. Given the responsibilities and burdens of caregiving it is surprising that many caregivers do not self-identify as such. For some caregivers, identification comes late in the caregiving journey and for others it comes only when a crisis occurs. A lack of caregiver self-identification can lead to a delay in seeking out supports and resources and ultimately reduce wellbeing of the caregiver and care recipient.

For more individuals to self-identify as a 'family caregiver,' we need our healthcare professionals, corporations, and spiritual communities to help make the connection. Healthcare professionals can play a critical role in helping to identify caregivers in their primary practices, or that are supporting patients in their primary practices, through simple screenings or displaying resources in waiting areas. Since many caregivers do not necessarily connect tasks they are doing with the role of caregiver until the later stages , asking questions such as "Do you assist with shopping, personal care, managing finances, or medical care for a loved one?" or "Does someone assist you with shopping, personal care, managing finances and arranging medical care?", can help identify caregivers that may be in need of support.

A flyer[2] created by the New Hampshire Alliance for Healthy Aging, a statewide coalition of stakeholders focused on the health and well being of older people in New Hampshire, is a tool to connect caregivers to the tasks of caregiving and increase awareness of resources available in New

Hampshire to support caregivers. In New Hampshire, the Service-Link Resource Centers provide statewide programs to support family caregivers.

Services can include:

- Information about community programs and local resources.
- Assistance in assessing individual caregiving needs, help in identifying options, and accessing local providers.
- Individual counseling and access to support groups.
- Education and training to help develop caregiving skills.
- Respite care services to provide a temporary break for eligible full-time family caregivers, and limited services that complement the care the family caregiver is providing.

In recent years, federal policy has been implemented that acknowledges the need to support family caregivers. These policies include:

- The RAISE Family Caregivers Act enacted by Congress in 2018.
- Expanded Medicare reimbursement for services that benefit family caregivers.
- Supplemental benefits under Medicare Advantage that now include Long Term Services and Supports (LTSS). Managed LTSS programs have begun to recognize and support family caregivers.

On a state level, the Caregiver Advise, Record, Enable (CARE) Act was passed in 2016, and requires hospitals to 1) Record the name of the family caregiver on the medical record of the patient; 2) Inform family caregivers when their loved one is to be discharged; and 3) Provide the family caregiver with education and instruction of the medical tasks they will need to perform for the patient at home.

While these policies provide structures for supporting caregivers, more needs to be done on both a policy and practice level to identify and support family caregivers. Strengthening the role of the healthcare professional, and in particular the primary care physician, in identifying family caregivers, could improve outcomes such as caregiver health, better care for the care recipient, and satisfaction with care. ■

[1] Reinhard, S., Feinberg, L. F., Houser, A., Choula, R., & Evans, M. (2019, November 14). Valuing the Invaluable 2019 Update: Charting a Path Forward. Retrieved September 15, 2020, from https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html.

[2] https://nhaha.info/wp-content/uploads/2017/09/aha_caregiving_flyer_final.pdf

NHMS Welcomes New and Returning Members

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Closing Your Practice

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Circumstances may lead a physician to end his/her current practice arrangement. A carefully executed departure plan promotes continuity of patient care, avoids allegations of abandonment, and fulfills contractual and regulatory obligations.

Staff

- Inform staff three (3) months in advance of closing date.
- Outline a severance policy and benefits plan.
- Negotiate staff retention if the practice is acquired by another physician.
- Fulfill legal requirements related to employment retirement plan.
- Determine obligations for employees' health insurance coverage.

Patients

High Risk

- Advise each patient with a chronic or complicated medical condition to promptly secure a new physician. Emphasize that his/her medical condition requires ongoing medical attention. This may be done by phone, in person or by letter (registered, return receipt requested).
- If notification was done by phone or in-person, send the patient a follow-up letter summarizing the discussion.
- Document discussions and place copies of all correspondence in the patient's medical record.

Active

- Three (3) months prior to closing, send active patients a notification letter and enclose a records release authorization form.
- Place a copy in each patient's medical record.

Insurance

- Contact your professional liability insurance carrier to discuss purchasing tail insurance.

Newspaper Advertisement

- Publish an announcement several times within a month in area papers serving your patient population. Include the following information:
  - o Office closing date.
  - o Last scheduled appointment date.
  - o Process to transfer medical records (copy) to another physician.
  - o Process to obtain a copy of medical records.

Key Entities to Notify

- State licensing board
- State and local medical societies
- Drug Enforcement Administration (DEA)
- Hospitals
- Associates
- Medicare
- Medicaid
- Third-party payers, MCOs, workers' compensation
- Professional associations
- Insurance companies

Medical Records

- Retain the original medical record. Provide a copy to the new physician once a valid, signed authorization form has been received.

Storage of Medical Records

- Retained records must be secured, protected from water, fire, insects, etc., and retrievable by authorized persons.
- For practices with electronic health records, determine contractual arrangements with cloud-based or server-based systems to assure future access.

Destruction of Medical Records

- Review your state's retention requirements. Medical Mutual's Practice Tip Medical Record Retention Recommendations for Physician Office Practices and Hospitals provides an overview of the standards for ME, NH, VT, and MA. When destroying records, disposal must ensure patient confidentiality.

Additional Considerations

- Review current contracts with an attorney to ensure compliance with regulatory requirements.
- Destroy prescription pads and letterhead after your last appointment.
- Discard controlled drugs in accordance with DEA procedures.
- Maintain an answering service for 90 days after you close to remind patients of the office closure and to direct them to appropriate care providers.
- If a contracted service is utilized for storage or destruction of medical records, obtain a HIPAA business associate agreement.

Resources:

American Medical Association. ■

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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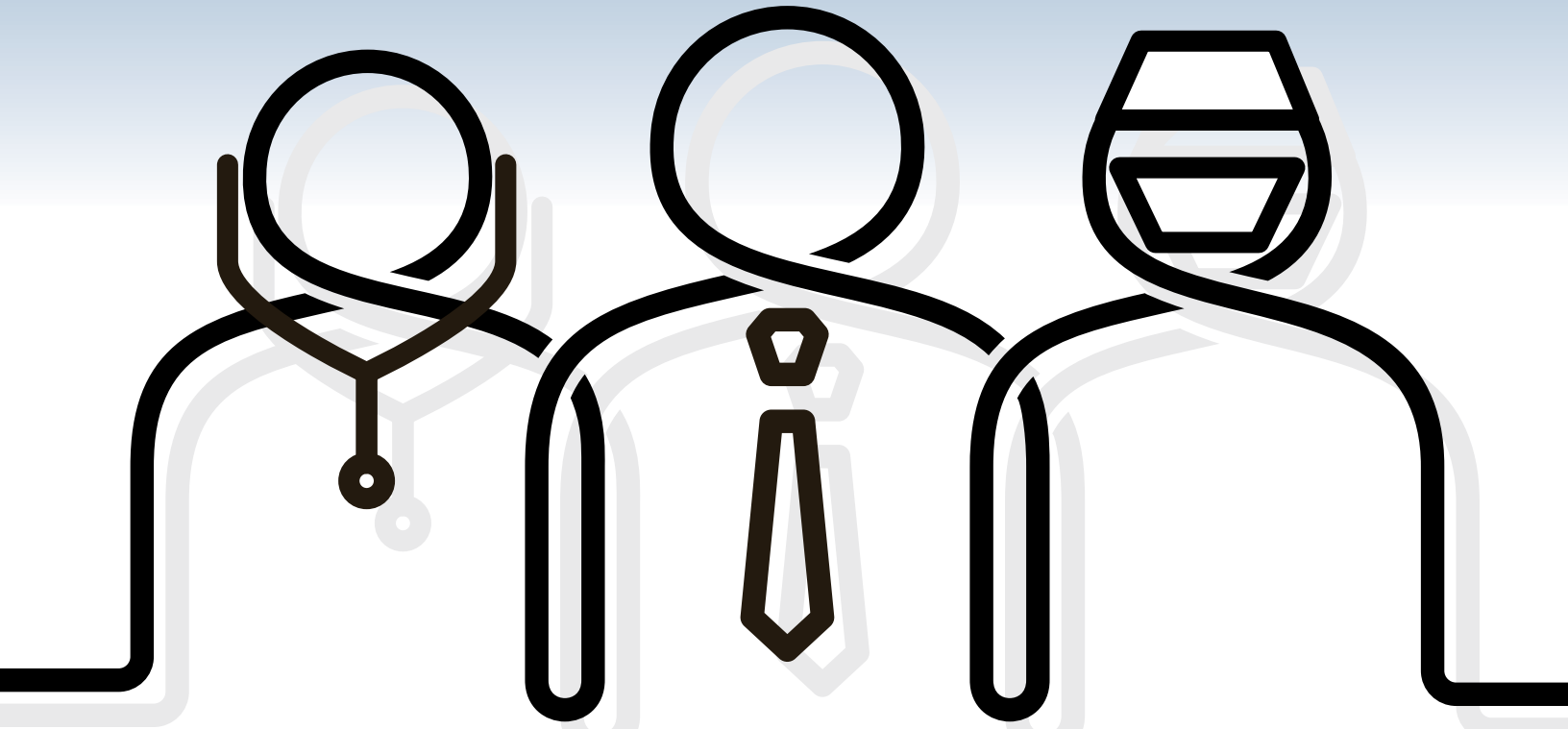

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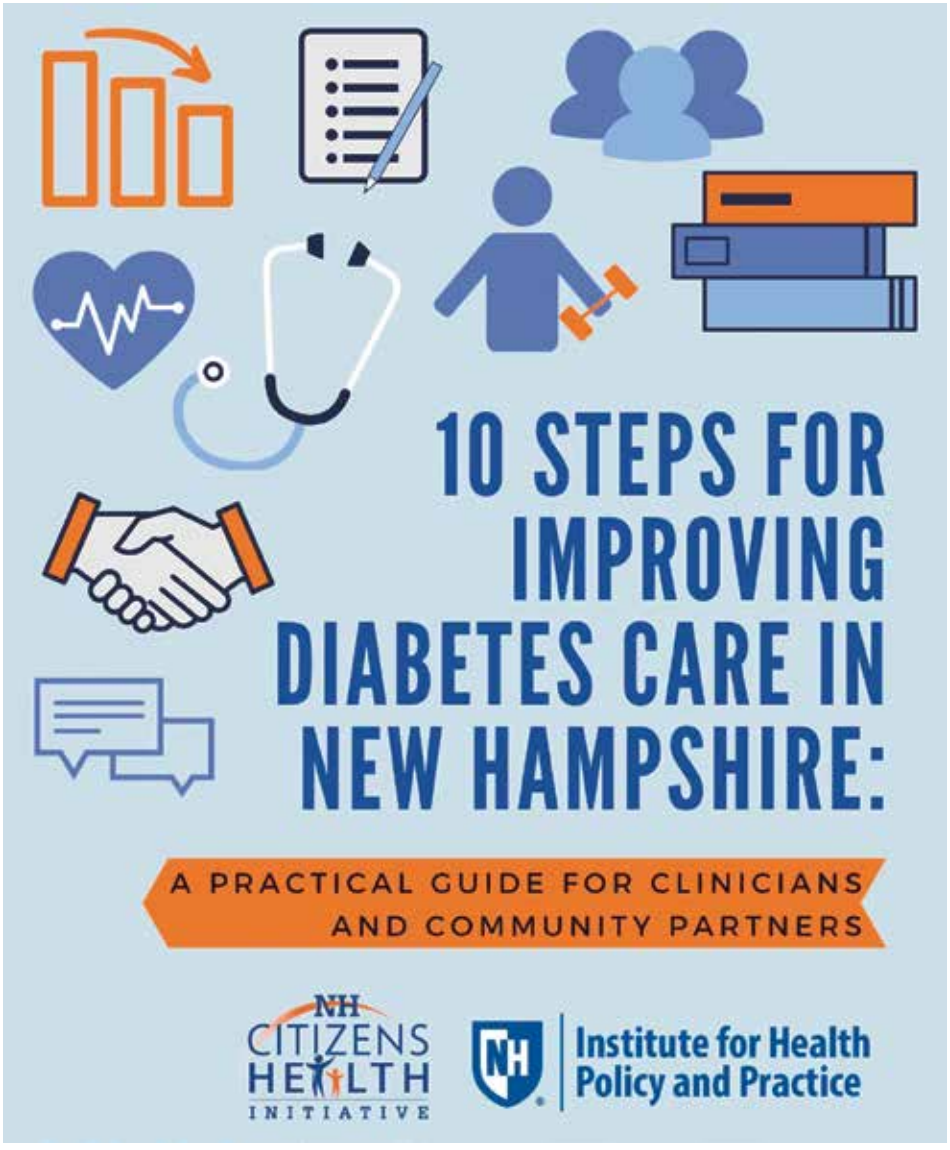
Marcy Doyle, DNP, MHS, MS, RN, CNL
Clinical and Quality Improvement Director
Department of Nursing
Institute for Health Policy and Practice
New Hampshire Citizens Health Initiative
University of New Hampshire

Using quality improvement processes to improve health care can be difficult...

The Institute for Health Policy and Practice, NH Citizens Health Initiative Publishes Resource to Improve Diabetes Care

The 10 Steps for Improving Diabetes Care in New Hampshire grew out of a belief that a similar, comprehensive approach to health improvement that worked for improving high blood pressure control was translatable to diabetes care. The original *10 Steps for Improving Blood Pressure Control in New Hampshire* demonstrated measurable improvements in clinical outcomes at the practice level across New England and beyond. In this new guide, you will find an easy to follow stepwise format of practical, best-practice strategies that are feasible to implement in any primary care setting. Strategies are equally applicable to planning for prediabetes.

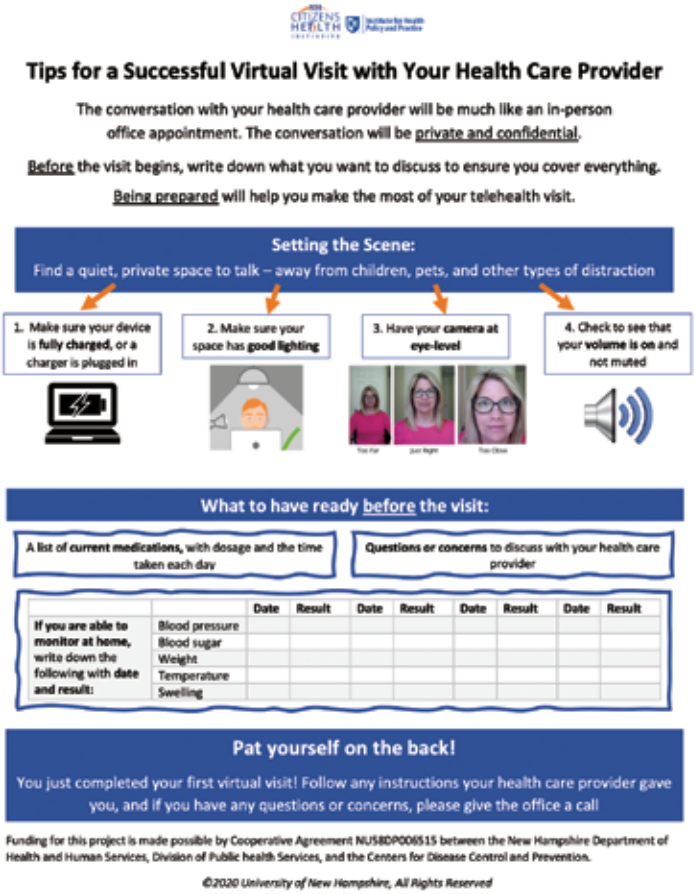
While working with the Rural Health Clinic Action Learning Collaborative (2015-2018), practices across New Hampshire documented success in the



use of quality improvement strategies to improve clinical care for patients with diabetes, including documentation of increased patient engagement and decreased hemoglobin A1c (HbA1c) values.

Using quality improvement processes to improve health care can be difficult, especially with so many competing priorities vying for clinician and staff time. Yet, every health care professional wants to deliver the best care, in the best ways, to ensure the best outcomes for their patients. We believe that you will find *10 Steps for Improving Diabetes Care in New Hampshire* to be a sensible and rewarding road map to success for you and your patients.

Implementing *10 Steps for Improving Diabetes Care in New Hampshire*, in coordination with other efforts by care teams, public health entities, health systems, advocacy groups, patients, and their families, moves New Hampshire toward reducing the burden of diabetes and preventing complications. This is especially important during the COVID-19 Pandemic. The strategies outlined within the guide have been tested in primary care practices around the state and have demonstrated practice-based improvements. Additional resources your practice may find useful while providing patient care via telehealth include: *Taking an Accurate Blood Pressure at Home and Tips for a Successful Telehealth Visit*. These can be found at https://www.citizenshealthinitiative.org/reports-presentations. ■



Tips for a Successful Virtual Visit with Your Health Care Provider

The conversation with your health care provider will be much like an in-person office appointment. The conversation will be private and confidential.

Before the visit begins, write down what you want to discuss to ensure you cover everything.

Being prepared will help you make the most of your telehealth visit.

Setting the Scene:
Find a quiet, private space to talk – away from children, pets, and other types of distraction

1. Make sure your device is **fully charged**, or a charger is plugged in
2. Make sure your space has **good lighting**
3. Have your **camera at eye-level**
4. Check to see that your **volume is on** and not muted

What to have ready before the visit:

A list of **current medications**, with dosage and the time taken each day

Questions or concerns to discuss with your health care provider

		Date	Result	Date	Result	Date	Result	Date	Result
If you are able to monitor at home, write down the following with **date and result:**	Blood pressure								
	Blood sugar								
	Weight								
	Temperature								
	Swelling								

Pat yourself on the back!
You just completed your first virtual visit! Follow any instructions your health care provider gave you, and if you have any questions or concerns, please give the office a call

Funding for this project is made possible by Cooperative Agreement NU58DP006515 between the New Hampshire Department of Health and Human Services, Division of Public health Services, and the Centers for Disease Control and Prevention.

Tips for Taking an Accurate Blood Pressure at Home

Your health care provider uses your blood pressure measurements to help make decisions about medications and treatments

Here are some tips for taking your blood pressure to ensure you are giving your provider the **most accurate** measurement:

Step 1:
Relax for 5 minutes before taking your blood pressure. It is **best not to talk** while taking your measurement.

Breathe

Step 2:
Sit with **your back supported** by a chair and both **feet on the floor.**

Step 3:
Place the cuff **directly on the skin.** Do not put it over clothing.

Step 4 - with Wrist Cuff:
Place the cuff on your wrist. With your **elbow on the table,** place your **hand over your heart.** Relax your arm and rest your hand while the device is measuring.

Step 4 - with Arm Cuff:
Place the cuff on your arm above your elbow. Ensure that your **arm is supported** by a hard surface, like the arm of a chair or a table.

Step 5:
Once you have completed taking your blood pressure, be sure to **write down the date, time, and result.**

Keep the list of your blood pressure results and any questions you have for your health care provider in a safe place so you can share it during your telehealth visit.

Funding for this project is made possible by Cooperative Agreement NU58DP006515 between the New Hampshire Department of Health and Human Services, Division of Public health Services, and the Centers for Disease Control and Prevention.

Oge Young, MD
NHMS Past President

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
Grace

Names and identifying details have been changed to protect the privacy of the individuals.

Grace was her name. She presented to my office as a new patient having bleeding well past menopause. She never saw doctors and only came to see me when her flow turned heavy. As suspected, her postmenopausal bleeding was a sign of uterine cancer. Fortunately, her cancer proved a low grade tumor. A simple hysterectomy provided sufficient treatment for her malignancy.

Surprisingly, Grace returned for follow up, and eventually, she decided to visit me for annual exams. Since graduating from high school, she had worked in housekeeping at a health care facility. She met her husband, John, there 40 years before. His job was in maintenance. They loved their work. They loved their life and each other. Their only disappointment was a barren marriage for many years. Her past menstrual history suggested that she had rarely ovulated. To her astonishment, one day at age forty, Grace experienced the "miracle" of pregnancy. Her antepartum course, labor and delivery were uncomplicated, bringing them a daughter, they named Madeline. She laughed at how much Madeline changed their lives, but added, "Never had they known such joy."

Grace remembered Madeline's first smile, her first words, her first steps- all those "firsts" to which we, as parents, hold on. She described those moments to me with the delight she knew at each of those milestones. She told me about the first birthday card Madeline made for her announcing, "For your birthday, I give you Me!" A birthday present to her mom at age 10 was simply, "My love for you," her words written with a drawing on bright yellow paper. Grace had saved those gifts and much more.

Tragically, Madeline was killed shortly following her 12th birthday. Emile and Grace had set aside money all year to buy her a new bicycle. She had learned to ride on a neighbor's hand me down. The new bike, shining pink and white with streamers at the ends of the handle bars, even had a bell to liven her ride. Usually quiet natured, she had jumped and jumped, and then screamed, when Emile opened the garage door revealing her birthday surprise.

Only a few days later, a car collided with the beautiful bicycle on which she rode. Madeline died instantly. Ironically, the dirt road in front of their home was rarely traveled. Coming around a bend near their yard, a young driver had not seen her. Knowing this final story, I struggled to understand how Grace could share so much about her daughter with laughter, her face aglow. As I held her chart each year before stepping into her room, it was hard for me to swallow.

Grace would be smiling, seemingly excited to see me for her exam. My habit was to ask patients about their children, many of whom I had delivered. Grace would be waiting for me to ask about Madeline. And, she would tell another wonderful memory, sounding as though she had saved it for just me. One year, at the end of a story, I finally asked, how was she able to talk with such glee about Madeline, knowing that she was gone.

She grabbed my cheeks, lifted my sunken head and looked into my moist eyes; "Don't be sad, Dr. Young. We had her for twelve glorious years, when we thought she would never come. I love her now as much as I loved her then, and nothing will ever take her from me." Grace admitted she would never forget the sight of Madeline's crumpled bicycle and her small broken body. Yet, over the years, her sadness had been replaced slowly by all the joy Madeline had brought her.

Grace has since died, but her grace is not forgotten. ■

James G. Potter
NHMS Executive Vice President

Part One of their findings... ...focuses on how the coronavirus has affected physicians' practices and their patients.

Physician Perspectives on the Impact of the COVID-19 Pandemic

Thank you to the New Hampshire physicians who participated in The Physicians Foundation's 2020 Physician Survey in late July. Part One of their findings, entitled ***Survey of America's Physicians: COVID-19 Impact Edition*** focuses on how the coronavirus has affected physicians' practices and their patients.

Many of these findings are similar to an earlier survey fielded by the Medical Society in early May. However, due to the limited response, we were not able to draw a representative sample of Granite State physicians.

Key findings of the public health COVID-19 impacts of the survey include:

- **Nearly 50% of physicians believe the coronavirus pandemic will not be under control until sometime after June 1, 2021.**
- 96% of physicians believe the pandemic will not be under control until after January 1, 2021.
- **Close to three quarters (72%) of physicians indicated that COVID-19 will have serious consequences for patient health in their communities because many patients delayed getting care they needed during the pandemic.**
- A primary cause of harm to patients presented by COVID-19, cited by 76% of physicians, is employment changes that may result in patients losing health insurance.
- **The majority of physicians (59%) believe opening businesses, schools and public places presents a greater health risk to patients than prolonging social isolation.**
- 88% of physicians believe a potential spike in COVID-19 cases poses the risk of moderate to great harm to patients.

COVID-19's impact on physician practices included the following findings:

- **8% of physicians have closed their practices as a result of COVID-19.**
- The great majority of physicians (96%) will not leave medicine due to COVID-19 health risks.

- 43% of physicians have reduced staff due to COVID-19.
- 72% of physicians have experienced a reduction in income due to COVID-19. Of these, 55% have experienced income losses of 26% or more.
- By contrast, 41% saw volume decreases of 26% or more, which may be difficult or impossible for most physician practices to sustain for more than a few months.
- **Of those physicians who applied for Paycheck Protection Program support, 75% indicated they received the support and it was sufficient for them to stay open.**
- The majority of physicians (59%) agreed that COVID-19 will lead to a reduction in the number of independent physician practices in their communities.
- One-half (50%) said that hospitals will exert stronger influence over the organization and delivery of health care as a result of the pandemic.
- **12% of physicians have switched to a primarily telemedicine practice as a result of COVID-19. In 2018, only 6,000 physicians nationwide were in a primarily telemedicine practice, according to the Foundation's Physicians Survey.**
- 52% of physicians plan to increase use of telemedicine in their practices.
- **The majority of physicians (72%) believe the widespread use of telemedicine will not continue unless reimbursement rates for telemedicine visits remain comparable to in-person visits.**

We will also share the other two parts of The Physicians Foundation's 2020 Physician Study in the coming months. Physicians are encouraged to utilize these survey insights when speaking on the issues related to COVID-19's impact on the medical community.

The Physicians Foundation survey was conducted from July 15 - 26, 2020. Data is based on 3,513 responses. The full part-one report can be found at https://physiciansfoundation.org/research-insights/2020physiciansurvey/. Complete methodology is available on page 16.

The Physicians Foundation was founded in 2003, after a class-action lawsuit brought about by the New Hampshire Medical Society and 21 other medical societies against private third-party payers. The resulting monetary settlement has been used to provide $49 million in grants for the development of physician leadership training, physician moral injury/burnout, and identifying how policy can best adapt to the real needs of physicians and patients. Find out more at https://physiciansfoundation.org/. ■

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

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

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

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

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

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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Does your New Hampshire medical license expire June 30, 2021?

Due to the huge number of extension requests in recent years, the Board of Medicine has instituted a $100 late fee penalty for any physician who does not complete 100 credits within their two-year cycle or misses the Feb. 28 reporting deadline.

This year, we are pleased to offer an online reporting system for CME.
Please look for a letter in December detailing instructions for that new process.
You will not receive the traditional CME reporting form.

The CME requirements for the Jan. 1, 2019-Dec. 31, 2020 cycle have not changed.

- **100 total CME credits earned between Jan. 1, 2019 and Dec. 31, 2020**
- **Official transcripts or certificates documenting at least 40 Category 1 credits**
- **Documentation of 3 CME credits related to pain management/addiction disorder (if you hold a NH-DEA license)**
- **$40 CME processing fee**

Questions? Contact Mary West at mary.west@nhms.org