The Newsletter of the New Hampshire Chapter of the American Academy of Pediatrics!

The Granite State Pediatrician

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Pediatrics in New Hampshire
A View from the GSP Editor

This year I will have been editor of the Granite State Pediatrician (GSP) for ***twenty years.*** During this time, I've remained, for the most part, in the shadows, rarely contributing articles, mostly content to put the newsletter together every 2 months. Rarely, news has been scarce. Most years we had at least 5 newsletters per year. That means over that past twenty years pediatricians in New Hampshire have received well over 100 GSP newsletters. It is a good solid number and one that I am very proud of.

In case you were wondering, I began Londonderry Pediatrics in 1986, a practice affiliated with Parkland Hospital, and then started my own independent practice, Hampshire Pediatrics, in Manchester in 1988. I worked at Hampshire Pediatrics for 19 years. It was a great experience and I learned a lot about running a business and how to take good care of patients and parents. After a brief stint at the Elliot for a year I joined Dartmouth Hitchcock in 2008, and was involved in developing the NICU at Catholic Medical Center as well the West Side Clinic in Manchester. I now work at the Dartmouth Clinic in Nashua with a wonderful bunch of pediatric providers and staff. I continue to write for Contemporary Pediatrics about medical practice and office technology as I have for the past 28 years.

The New Hampshire Chapter of the American Academy of Pediatrics (aka the New Hampshire Pediatric Society, NHPS) continues to champion for the well-being of children in our state. Although the presidents of the NHPS have changed the overall goals of the NHPS - keeping our patients, safe and healthy -has not. Year after year New Hampshire ranks at the top of most lists as among the best states in which to raise a child.

I'd like to thank the individuals who are regular contributors to the GSP, especially Dr. Gladstone (thanks Wendy), without whose help this newsletter would not be possible. Thanks also to Catrina Watson for her invaluable assistance over the years. And thanks to you readers for what you do.

Can't wait to see what happens over the next 20 years.

- ***Andy Schuman MD***
Editor, GSP

Each year an estimated 1,000 New Hampshire children under the age of six test positive for elevated blood lead levels greater than 5 micrograms per deciliter (mcg/dL), the threshold set by the Center for Disease Control and Prevention indicating a child has lead exposure and the need for case management. According to the Division of Health and Human Services, New Hampshire's pediatric elevated blood lead level (EBLL) rates are 2.5 times the national average. Currently, 37% children currently enrolled in New Hampshire's public schools, who have been tested for lead exposure, have had an EBLL greater than 5mcg/dL at some point in their lives. In New Hampshire during 2014, of the 10,281 5 year-olds who were tested for lead at some point in their lives, 15% had an EBLL greater than or equal to 5 mcg/dL. Most of these children will be entering kindergarten within the next year. It is quite possible that these numbers are actually much higher.

According to the Department of Health and Human Services, testing rates for one and two year olds in New Hampshire have remained flat and in some communities have declined over recent years. In 2014, blood lead testing rates for New Hampshire 2 year olds were only 37%. The successful passing of Senate Bill 135 in July 2015 includes requirements intended to improve New Hampshire's testing rates, especially for children in high-risk communities, including an 85% testing rate milestone for one- and two-year olds living in universal testing communities, receiving Medicaid or WIC (Woman, Infant, Children supplemental nutrition program) benefits or enrolled in Head Start.

Why is childhood lead poisoning still a health issue in our State?

New Hampshire has some of the oldest housing stock in the country with more than half of the housing built before lead paint was banned in 1978. Children living in homes built prior to 1978 are at increased risk for lead exposure. Near trace amounts of lead dust generated from friction, impact or chipping lead paint surfaces is the primary source of nearly every EBLL in New Hampshire. Children are exposed to lead from crawling on floors and touching surfaces where lead dust collects and then placing hands or objects in mouths. Home renovations and repairs completed by either uninformed DIY homeowners or contractors not certified by the EPA in lead-safe work practices are another common source of lead exposure. 1 in 3 children who have an EBLL were exposed to lead during home renovations.

Lead Exposure's Negative Impact on Children's Brain Development

Study after study demonstrates that even low blood lead levels negatively impact a child's development. The Center for Disease Control and Prevention (CDC) released a paper Educational Interventions for Children Affected by Lead (April 2015) which identifies lead's 'Neurobehavioral Signature," and the negative impact that lead exposure has on children's cognitive abilities, speech and language, hearing, visual-spatial skills, attention, impulse control, social behavior, emotional regulation, and motor skills. The CDC paper outlines the importance of early intervention, education and nutrition support services for children with an EBLL.

The impact of childhood lead poisoning on New Hampshire's children, families, classrooms and communities is significant. Yet this environmental public health issue has often been ignored up until recent changes to the State's Lead law, RSA 130-A. Recent legislation has brought much needed attention to childhood lead poisoning, low testing rates, and prevention.

New Legislation – Childhood Lead Poisoning BLL Testing Rates

Changes to New Hampshire's current childhood lead poisoning statues were made with the passing of Senate Bill 135 that was signed by Governor Hassan in July 2015. All Granite State pediatricians are impacted by these changes. Here are the key points of the new legislation:

- Improve Pediatric Blood Lead Testing Rates To prevent children from being missed and to provide children the treatment and protection they need, this new law establishes a 85% testing rate milestone for one- and two-year olds living in universal testing communities, receiving Medicaid or WIC benefits or enrolled in Head Start. The new law also requires, should this BLL testing target not be reached by 2017, that the NH Division Public Health Services (DPHS) change current rules and move to compliance enforcement.
- Establishes the Childhood Lead Poisoning & Screen-

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ing Commission This Commission with its two working subcommittees on 1) screening and 2) prevention will explore new initiatives to both improve detection through increased BLL testing rates and to reduce exposure through prevention. Dr. William Storo, pediatrician at Dartmouth-Hitchcock Concord and President of New Hampshire Pediatric Society has been appointed a member of this new commission.

 Getting information to parents of children with EBBL greater than 5mcg/dl. New Hampshire's statute has not been amended to reflect CDC's lowering of the blood lead reference value in 2013 to 5 mcg/dL with strong statement of "no safe level of lead exposure". The new legislation attempts to address this gap by ensuring that DPHS notifies each and every parent of a child with an EBLL >5mcg/dL with information to ensure they understand the consequences of lead poisoning and the steps that can be taken to avoid lead hazards. Information is also will be provided to landlords, to enable them to take action to eliminate lead hazards when a tenant's child has been found to be poisoned.

 New Lead Fact Sheet for Providers conducting capillary testing. Any medical provider conducting capillary blood lead testing shall provide their patients with Lead and Children factsheet prepared by DPHS to any parent or guardian of a child whose test indicates any presence of lead. This new Lead and Children fact sheet describes the health effects of childhood lead poisoning, the advisability of obtaining a venous blood test, and the benefits of identifying and addressing lead hazards. The Lead and Children factsheet also includes a statement that, in the case of rental properties, it is advisable to inform the property owner of the EBLL and that the family cannot be evicted based on the child's EBLL.

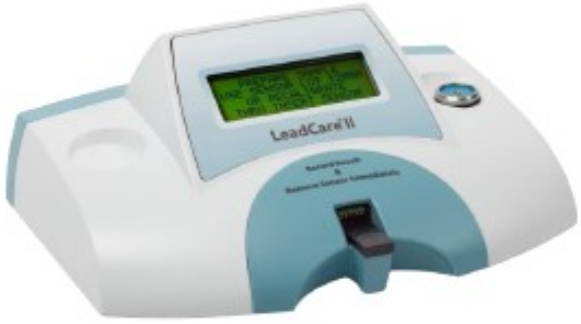
NH Childhood Lead Poisoning Medical Testing Guidelines

The American Academy of Pediatrics (AAP), in absence of a state guideline, recommends that all children be tested for lead exposure at 1 and 2 years old. Many other New England states, follow the AAP guideline and have what is known at "Universal Testing" where all children are tested for lead exposure at age 1 and age 2.

New Hampshire uses a "risk-based approach "to recommend which children be tested for lead. Individual towns and their demographics are evaluated and are designated either a Universal or a Target community. In New Hampshire, 52% of our communities are classified as high risk, or Universal (U) testing communities. Children living in Universal communities, along with all children receiving Medicaid or WIC benefits or enrolled in Head Start and Early Head Start, are to be tested for elevated lead levels at ages 1 and 2; no questions asked.

Children residing in communities thought to have less risk or Target (T) communities and are not receiving Medicaid or WIC benefits or enrolled in a Head Start program are tested using a targeted approach. The NH Childhood Lead Poisoning Screening and Management Guidelines have a Risk Questioner for Pediatricians that includes five simple questions to assess the child's risk: If answer is yes, or 'unknown' to any of the questions, the child should be tested.

In New Hampshire, BLL testing rates are very low for 1 and 2 year olds, with only 37% of 2 year olds being tested in 2014. All pediatric health providers need to put attention on improving BLL testing rates to identify lead exposure and support protective and early interventions for healthier outcomes. In-office, blood lead testing is gaining the attention of more New Hampshire pediatricians as a means of improving BLL testing rates and supporting better health outcomes.



In-Office Capillary BLL Testing: Proven Effective in Improving Testing Rates

The implementation and use of in-office, capillary BLL equipment, is an effective, highly accurate, and proven means of increasing testing rates. These small analyzers are designed for efficient, in-office BLL testing, using a capillary sample drawn during work flow of the 1 and 2 year old Well Child Check. The LeadCare II analyzers are easy to use and provide accurate results within minutes before a child leaves the office.

In the 1990's the CDC had recommended venous blood for blood lead testing because of capillary samples presented a risk of false positives due to skin contaminated with lead dust. However, the CDC discovered that venous blood draws were a significant deterrent to pediatric blood testing because venous collection meant a second, additional trip to a lab and a significant percentage of children did not go for the test. In addition, the CDC discovered that the venous

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blood draw on a very young child was perceived as more traumatic to child and parent, leading more parents to refuse the blood draw at their child's 2 year old Well Child Check appointment. In the early 2000's, response to these deterrents, the CDC investigated capillary collection for BLL testing. The CDC determined that, with proper sampling technique, the benefits of capillary blood lead testing (increased testing rates) significantly outweighed the very low incidence (~2%) of contaminated samples. In 2004, the CDC, armed with information from recent research, made two significant contributions to help pediatric providers improve BLL screening rates. First, the CDC provided grant funding for the development of LeadCare II system that requires just two drops (50 µL) of blood, and provides results within three minutes. Second, the CDC produced an Instructional Video describing how to collect capillary (finger stick) samples for blood lead testing. The CDC's goal in supporting the development of a point-of-care, capillary BLL testing system was to improve compliance with AAP BLL testing guidelines by making lead testing available in more locations, especially high risk communities where compliance is low.

The CDC's goal in developing the LeadCare II was to improve compliance with AAP BLL testing guidelines by offering an easier, less traumatic sample collection technique. In-office, capillary BLL testing LeadCare II analyzers are proven effective to increase screening rates and allow pediatric providers to share the results and important preventative education with families before the Well Child Check visits ends and the child leaves the exam room. Learn more about LeadCare II analyzers.

Guidelines and Resources Available for Pediatricians

In early 2015, the Division of Public Health Services (DPHS), Healthy Homes and Lead Poisoning Prevention Program sent by US mail to all pediatric practices the new NH Childhood Lead Poisoning Screening and Management Guidelines booklet with current childhood lead poisoning testing, treatment, clinical evaluation and management information. Lists in this booklet identify all New Hampshire communities with the Universal 'U' or Target 'T'. It also contains the five (5) screening questions for Target communities and many other resources for pediatricians to share with patient families to support lead poisoning awareness and education.

In addition, new childhood lead testing and medical management quick guides are now available for pediatricians to use in exam rooms. The laminated medical management quick guides include 1) Child Lead Testing and Treatment, Clinical Evaluation and Management 2) Lead Testing Designation by Community and 3) Lead Testing With LeadCare II Analyzers.

New Hampshire DPHS Health Homes and Lead Poisoning and Prevention Program has new parent information fact sheets on Childhood Lead Poisoning, Lead Hazards, Lead and Pregnancy, Lead and Nutrition, Lead in the Environment, and Take Home Lead. These are available printed or electronically for pediatricians to distribute to parents.

Additional Childhood Lead Poisoning Screening and Management Guideline booklets that include laminated quick guide reference sheets for exam rooms are available at no cost by request. Short educational sessions on NH childhood blood lead level testing requirements, medical management guidelines, NH DPHS public health nurse EBLL case management, and impact of recent legislation, can be scheduled at your practice or hospital affiliate. Convenient before clinic hours, lunchtime, or evening education sessions can easily be arranged. For more information about any of these resources, contact Gail Gettens, MS, child development specialist and Health Promotion Advisor, Division of Public Health Services, Healthy Homes and Lead Poisoning Prevention Program at 271-1393 or gail.gettens@dhhs.state.nh.us

- William Storo, MD, FAAP
President, New Hampshire Pediatric Society

Dartmouth-Hitchcock CHILDREN'S HOSPITAL AT DARTMOUTH

CHaD Welcomes New Provider

Frank Penna, MD
We are pleased to announce that Dr. Frank Penna has joined CHaD's Section of Pediatric Urology, and he will arrive this summer. He received his Doctor of Medicine from Rutgers University – Robert Wood Johnson Medical School in 2008 and completed his residency in Urology at Vattikuti Urology Institute in Detroit, MI, where he served as Chief Resident from 2013 -2014. He completed his fellowship in Urology at The Hospital for Sick Children, University of Toronto – Department of Surgery. We are delighted to welcome Dr. Penna to CHaD.

Dr. Penna will see patients in Lebanon and Manchester in the pediatric urology department of CHaD. Please call (603) 653-9882 for appointments and consultations. He welcomes your contact and referrals.

Save the Date!

Special Value Grand Rounds
Human Factors in Clinical Practice — A Hard Place for Soft Skills
Thursday, May 12
12 to 1 pm
Auditorium H, Williamson Translational Research Building, DHMC & via dhvideo

CHaD is building a collaborative partnership with the Royal Aberdeen Children's Hospital in Scotland, and we are excited to be hosting Dr. George Youngson and his team for an inaugural exchange visit this month. Dr. Youngson is an internationally recognized leader in patient safety.

Presenter: George G. Youngson CBE, MBChB, PhD, FRCSEd, FRCPEdin, Emeritus Professor of Paediatric Surgery, University of Aberdeen, Scotland, and Trustee, The ARCHIE Foundation.
Dr. Youngson's major interests are in surgical education, research into human factors related to surgical performance, and service configuration for children's specialist care. In June 2009, he was made Commander of the Or-

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AAP Annual Leadership Forum

As an early career pediatrician and an at large member of the NH Pediatric Society Executive Committee, I was lucky to attend this year's AAP Annual Leadership Forum (ALF) in place of Dr. Bill Storo, our chapter president, who was unable to attend. The ALF is a 4 day conference in Shaumburg, IL that pulls together the leadership of the AAP's chapters, councils, sections and committees. One goal of the ALF is to help AAP leaders develop leadership skills in many areas, including advocacy, quality improvement, disaster preparedness and engaging AAP members. It was inspiring to be around very involved pediatricians doing great work for children, including in our own District. The Maine chapter won the award for the best small chapter this year due in part to an very successful oral health project, their extremely high toddler vaccination rates, and great member involvement. I also learned many valuable tips to bring back to New Hampshire. For example, in order to facilitate collaboration, the New Jersey chapter creates a pocket-sized book called an Agenda For Children every year that they hand out to their state legislators to outline all of the issues that the pediatric society is interested in. That is something that we could easily put together in New Hampshire to improve our collaborations with our own legislators.
Another aim of the ALF is to determine the priorities of AAP members through a series of resolutions that are discussed in both small and large groups to determine what to ask the AAP to work on in this next year. This year there were 137 resolutions that were submitted. Some of the resolutions were very limited in their scope, including a resolution that the AAP should charge trainees a discounted price to attend the NCE on both Saturday and Sunday to help encourage involvement from trainees. Other resolutions were larger in their scope, including a resolution to ask the AAP to create a Center for Provider Resiliency at the AAP for providers suffering from burnout.
Several more controversial resolutions passed including a resolution asking the AAP to strongly support Planned Parenthood and other sexual health providers, and a resolution to support both pediatricians who choose to discharge families who do not vaccinate their children as well as pediatricians who agree to keep seeing children who are unvaccinated. As a Med-Peds provider, I spoke in favor of a resolution seeking payment parity for pediatri-

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Elliot Health Systems Pediatric Services

In light of recent changes at the Elliot Hospital, in particular, the closure of the Pediatric Intensive Care Unit (PICU), we would like to clarify the Pediatric services that continue to be available at the Elliot, and our commitment to the care of children in the southern NH Region.

Neonatal Intensive Care:

A 24 bed NICU, this 20-year old service provides tertiary level care to the southern region of New Hampshire. 4 Neonatologist and 5 nurse practitioners, a highly trained nursing staff, and ancillary services in respiratory care, nutrition and others provide care to over 400 admissions annually.

In addition, Elliot Maternal-Fetal Medicine serves women with high risk pregnancies, providing ambulatory consultative and genetic services collaboratively with the women's primary OB provider. For women in-transported from hospitals the maternal fetal specialists provide both direct and consultative services in collaboration with neonatology.

Pediatric Specialty Services:

Ambulatory and in-patient services are provided by the following pediatric specialists:

Surgery
Gastroenterology
Pulmonology
Nephrology
Neurology
Integrative Medicine
Hospitalist Medicine
Emergency Medicine

Specialty services offer convenient local access to complex pediatric care. Pediatric Surgery and Gastroenterology offer procedural services at the Elliot at River's Edge Ambulatory Surgical Center, as well as the Elliot Hospital's main campus for more complex patients, as appropriate.

We are also expanding our Integrative Medicine program, with a dedicated Pediatric IM Clinic to be opening in early summer this year.

Our Pediatric and Adolescent Unit offers a breadth and depth of inpatient care not available elsewhere in the region, with care provided by experienced Pediatric Hospitalists 24/7 in collaboration with our pediatrics specialists.

Our transport line (663-KIDS) is dedicated to making referral efficient, with Hospitalists providing telephone consultation to referring MDs.

Our Pediatric ED is the second largest in New England, providing care to over 14,000 children annually.

We look forward to continuing to work with local primary care providers to advance the care of children in the region.

- Kevin Petit MD

Please read this if you have patients with complex medical care needs.

Cedarcrest Center for Children with Disabilities in Keene, NH is a specialized medical facility and school providing comprehensive services to children, birth to age 21. Cedarcrest provides long-term and short-term medical care, special education and therapy services. The Center has the capacity for 26 children in residence as well as 20 residential and day students in the school. While Cedarcrest Center is an Intermediate Care Facility for Individuals with Intellectual Disabilities, the range of children served include those with trachs, gastrostomy tubes, IV therapy, and those requiring oxygen and/or ventilator support or other intensive medical, educational and therapy services. Cedarcrest works closely with NH Medicaid, WellSense and NH Healthy Families in support of the children's needs.

Cedarcrest also provides short-term stays for children with disabilities. Examples include post-acute medical/surgical care; short term rehab, planned or emergency residential care when the in-home nurse plans a vacation and won't be available; or when the primary family caregiver is temporarily unable to provide the medical care for their child; for health reasons such as a back injury or surgery. A special focus short term stay can be created for a child in consultation with the family and school.

The therapy services at Cedarcrest are comprehensive with specializations in such areas as adapted equipment, orthotics, feeding assessments, and augmentative or alternative communications. An adaptive gym and playground and technology supports such as touch screen computers and iPads are available. Consultation services are also available.

There is more to Cedarcrest Center. If you care for a child with complex needs, encourage the family to visit Cedarcrest. If an emergency or planned short-term stay is needed, Cedarcrest may be an option for the family. Visit them at www.cedarcrest4kids.org or on www.Facebook.com/cedarcrestcenter

- Diana Dorsey, MD, FAAP

(This spring Cedarcrest has been requesting pediatrician input for strategic planning. It was clear to some that many pediatricians, advocates and families are not aware of Cedarcrest's availability to families as a resource.)

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cians. I see first hand that I am able to get paid at a higher rate than my straight pediatric colleagues, due to being an internist as well as a pediatrician, which isn't fair. I spoke up a few other times throughout the meeting, and every time, I felt proud and lucky to be representing the pediatrician's and children of New Hampshire.

Finally, the ALF was a wonderful opportunity for building relationships and seek mentoring. There were many events for District 1 leaders to get together, and my interactions with more experienced pediatrician leaders were respectful, enlightening and fun! For any of you interested in getting more involved in the NH Pediatric Society, please reach out. It has been a great way for me to learn about the resources of New Hampshire and seek local mentoring. Come help us work together to improve the health and lives of New Hampshire's children!

- Ashley Lamb MD MPH

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der of the British Empire (CBE) for services to Child Health in Scotland.

Description:
This presentation will review the component human factors in interventional clinical practice that affect patient outcomes, with particular emphasis on non-technical or "soft" skills:
the importance of communication and teamwork, leadership and cognitive performance, such as situation awareness and decision-making, particularly in urgent and crisis situations
the impact of performance shaping factors on the individual clinician and on the clinical team in a variety of settings
the classification and taxonomy that allows teaching and assessment of these skills

To watch a Value Grand Rounds presentation live online, go to: http://dhvideo.hitchcock.org/livetcs

The archive will be found at:
http://intranet.hitchcock.org/videoconferencing/valuegr/default.asp
Hosted by the Value Institute and sponsored by Children's Hospital at Dartmouth-Hitchcock (CHaD)

Help Promote National PrepareAthon Day

Pediatricians, including primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, have key roles to play in preparing and treating families in cases of disasters. During America's PrepareAthon! National PrepareAthon Day on April 30, 2016, take specific action to promote pediatric emergency readiness:
1. Encourage families to download a family communication plan for parents and kids. An Emergency Contact Card should be created for each family member. Review the Tips for Communicating during an Emergency, developed by the Federal Emergency Management Agency and the Federal Communication Commission, for additional information.
2. Check your state AAP Chapter and Department of Health Web site to make sure that information on children's preparedness is posted. Ask that a link be added from these sites to the AAP Children & Disasters Web site home page at www.aap.org/disasters.
3. Partner with your AAP state Chapter Contact for Disaster
Preparedness to write an article for your AAP Chapter newsletter. Focus on how members can get more involved!
4. Use Facebook, Twitter, YouTube, or a blog to send messages to your community about America's PrepareAthon! National PrepareAthon! Day or how to prepare for disasters.
For additional ideas, review the following AAP Disaster Preparedness Advisory Council disaster related policy statements and clinical reports:
· Providing Psychosocial Support to Children and Families in the
Aftermath of Disasters and Crises
· Ensuring the Health of Children in Disasters
· Medical Countermeasures for Children in Public Health
Emergencies, Disasters, or Terrorism

Thanks,
(Submitted to GSP by Diana Dorsey, MD, FAAP as AAP Disaster Preparedness NH
Chapter Contact)

Exposure to Domestic Violence Can Hurt Children
It Should be Reported to Child Protection Services

It's estimated that 30% of children in the US witness domestic violence each year. It's a very common problem. The effects on children are significant, long-lasting and harmful to their healthy development.

Known Adverse Effects:

- Witnessing violence against a caregiver results in chronic feelings of anxiety and helplessness.
- A child in such a situation develops a destroyed sense of security.
- The child often feels responsible for the violence and for the safety of siblings and pets.
- There is an impact on the nurturing relationship with the victimized adult who has unmet emotional needs.
- Children exposed to domestic violence are more likely to engage in violence as adults.
- Exposure to domestic violence in childhood is one of the Adverse Childhood Experiences that results in a host of health and social problems throughout life: http://www.acestudy.org/

Theoretical Risks:

- The incidence of child abuse or neglect approaches 60% in households where there is domestic violence.
- Even if there is no direct violence against a child, emotional maltreatment results in a child at risk for aggression, depression, anxiety, self-injury, suicidal behavior, alcohol and drug abuse.
- Many children exposed to domestic violence are taught not to cooperate with authorities
- Children can get caught in the "crossfire" when adults are physically violent with each other.
- An adult may intentionally injure a child in retaliation against another adult.

When you become aware of a child being exposed to domestic violence, you need to do something. Even if the child seems outwardly fine and denies any problems related to the DV, the child is being harmed. Actions for you to take:

- If you have access to a social worker, ask for their assistance.
- In an acute situation, call your local crisis center for advice: http://www.nhcadsv.org/crisis_centers.cfm
- Call for assistance from the Division for Children, Youth and Families: 1-800-894-5533. DCYF has domestic violence specialists who can help families and reduce the impact of domestic violence on children.

Everyone in New Hampshire is a mandated reporter when child maltreatment is suspected. This includes exposure to domestic violence. Calling DCYF can make things much better for a child. It's your moral and legal obligation to act. And it will help a child immeasurably.

Reference: "The emotional maltreatment of children in domestically violent homes: Identifying gaps in education and addressing common misconceptions. The risk of harm to children in domestically violent homes mandates a well-coordinated response," Campbell AM, Thompson SL, Child Abuse Negl. 2015 Oct;48:39-49.

The New Hampshire Child, Domestic Violence and Incapacitated Adult Fatality Committees, May 2016

- submitted by
Wendy Gladstone MD