The Political Determinants of Health
Policies to Advance the Health & Economic Prosperity of New Hampshire Communities

Sponsored by the Dartmouth Hitchcock Office of Government Relations
In Partnership with
Today’s Program

• Brief housekeeping, Seddon Savage
• Didactic: *Infrastructures that Support Health* Health care workforce & health impacts of inadequate housing
  – Carolyn Isabelle, MA and Terri Lewinson, PhD, MSW
• Synopsis of Bills, Courtney Tanner
• Discussion of Bills, All
• Summary
• Up Next, Seddon Savage
Notes

• Please let us know you are here. Enter name, email, organization in Chat
• Enter comments or questions in chat at any time. Or raise virtual hand and we will call on you when it works. Please mute otherwise.
• Didactics are recorded audio-visually for educational & quality improvement purposes and posted to D-H ECHO site https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials
  
  Participating in this session is understood as consent to be recorded. Thank you.
• Please protect privacy in discussion of clinical scenarios.
• Questions to ECHO Tech Support thru personal CHAT or ECHO@hitchcock.org
ECHO Participant Demographics
Total Registrants: # 239

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<tr>
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ECHO Core Panel

- Courtney Tanner, JD, MSW  
  Director, D-H Government Relations, Course Director
- Matthew Houde, JD  
  Vice President of D-H Government Relations
- Sally Kraft, MD, MPH  
  Vice President, Population Health, DHMC
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  Vice President, State Government Relations, NH Hospital
- Jonathan Thyng, MD  
  Family Medicine Specialist, D-H Nashua
- Rebecca Woitkowski, JD  
  Kids Count Policy Director, New Futures
- Michael Padmore  
  Director of Advocacy, NH Medical Society
- Pamela Dinapoli, RN, PhD  
  Executive Director of the NH Nurses Association
- Jennifer Alford-Teaster, MA, MPH  
  Board Member, NH Public Health Association
Key Trends impacting our regional labor pools

1. **Aging Population.** New Hampshire and Vermont have the 3rd and 4th oldest populations in the country with a median age of 43.

2. **Slow Growth.** New Hampshire and Vermont population growth is approximately 1%, compared to 4+% nationally.

3. **Increasing Competition** amongst healthcare providers as well as from other industries.

4. **Low Unemployment Rate.** The unemployment rate in New Hampshire and Vermont is 2.5 - 2.7% respectively.

5. **Cost of living comparable to urban areas:** high cost of living pushes our workforce to more rural parts of the state. Even with significant investment in compensation it is not possible to keep up with rising inflation.

* Bureau of Labor Statistics and U.S. Census Bureau, National Hospital Association
Housing Challenge:

**Critical Inventory Shortage:**
- Current inventory does not meet current or future needs
- There is a 98% occupancy rate in the Upper Valley

**Affordability:**
- The inventory that is available is not affordable for the majority of the positions for which Dartmouth Health hires
  - Affordable housing costs (rent/mortgage, interest, taxes, utilities) are typically defined as no more than 30% of gross income, for example:
    - $70k annual salary: 30% on housing costs is $2,100/month
    - $50k annual salary: 30% on housing costs is $1,500/month
  - Current available inventory in the Upper Valley is typically priced between $1,900 - $2,600/month not including utilities
Workforce Needs:
- Currently 1900+ openings at Dartmouth Health
- Small regional talent pool means more people needs to relocate to fill open position.
- Demand for healthcare services continues to increase resulting in planned increases to facilities and services. This further increases the demand for workforce housing and childcare.

Impact to Recruitment:
- Candidates are declining offers or withdrawing their acceptance of an offer once they research housing options and can't find reasonable options
- New hires secure affordable housing but have a 30-60minute commute each way
- Candidates who are joining us are doing under high stress conditions related to housing and childcare
- When childcare can't be found it becomes impossible to return to the workforce
- Short term housing needed for travelers (average length of service 13-26 weeks)
Example 1:
Newly graduated, medical or nurse resident earning $60,000/year*. They are excited to start their career and want to rent their own apartment close to work. They do not want to share with a roommate and are considering getting a pet.

Student loans and their car payment is also a factor when considering how much they can spend on rent.

Monthly Budget:

<table>
<thead>
<tr>
<th>Monthly income after taxes</th>
<th>$3,950</th>
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<tr>
<td>Budget for rent &amp; utilities (est. 30% of income)</td>
<td>$2,200</td>
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<tr>
<td>Car Payment, Insurance &amp; Gas</td>
<td>$500</td>
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<tr>
<td>Healthcare Premiums</td>
<td>$100</td>
</tr>
<tr>
<td>Student Loans</td>
<td>$250</td>
</tr>
<tr>
<td>Groceries</td>
<td>$300</td>
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<tr>
<td><strong>Total</strong>:</td>
<td><strong>$3,350</strong></td>
</tr>
<tr>
<td>Disposable Income</td>
<td>$600 or 15%</td>
</tr>
</tbody>
</table>

*Salary quoted for illustrative purposes. Actual salaries vary by role, organization and region.*
Example 2:
The median family income in New Hampshire is just under $78,000. Let’s imagine a family of 4, with one school age child and one child in fulltime daycare.

Monthly Budget:

<table>
<thead>
<tr>
<th>Monthly Budget</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Monthly income after taxes</td>
<td>$5,375</td>
</tr>
<tr>
<td>Budget for rent &amp; utilities (est. 30% of income)</td>
<td>$1,700</td>
</tr>
<tr>
<td>Daycare</td>
<td>$1,000</td>
</tr>
<tr>
<td>Car Payment, Insurance &amp; Gas (1 vehicle)</td>
<td>$500</td>
</tr>
<tr>
<td>Healthcare Premiums</td>
<td>$250</td>
</tr>
<tr>
<td>Student Loans</td>
<td>$250</td>
</tr>
<tr>
<td>Groceries &amp; Household Supplies</td>
<td>$800</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$4,498</strong></td>
</tr>
<tr>
<td>Disposable Income</td>
<td>$875 or 16%</td>
</tr>
</tbody>
</table>

*Salary quoted for illustrative purposes. Actual salaries vary by role, organization and region.*
Community & Workforce Needs

- Investment in housing that is affordable to our workforce:
  - Young professionals and families earning between $40-75K
  - Additional supply so that more people can relocate to this region

- Investment in different types of housing so that when young professionals are ready to grow out of their apartment they have a place to move (and stay in our region/workforce)

- Thoughtful placement of housing to ensure our critical services such as hospitals can continue to operate and provide care to our people in our communities (reduce commute).

- Commitment to statewide expansion and stabilization of childcare services (both early childhood and after-school programs) so parents can reenter our workforce.
Housing as a Determinant of Health

April 20, 2022
Political Determinants of Health
Project ECHO

Terri Lewinson, PhD, MSW
Health and Aging Policy Fellow
Associate Professor
Dartmouth College
Terri.d.Lewinson@Dartmouth.edu
Focus: Housing Precarity

Housing is Unaffordable / Inaccessible

- Over 38 million Americans live in poverty;
- Most low-income people experience severe housing cost burden and spend over 50% of their income on housing costs;
- Over 4 million people “double up” with others due to financial hardship;
- Nearly 600,000 people experience homelessness per year in U.S.;
- In 2016, an average of nearly 4 million evictions were filed annually.

Housing and Health are Interconnected

- Housing precarity restricts access to preventive health care, healthy food options, social engagement, etc.;
- Deficient housing and instability are associated with many physical and mental health conditions
  - Poor air conditions, toxin exposure, structural deficiencies, violence/crime create risks for chronic and acute health challenges (COPD, depression, injuries, cognitive decline, etc.);
- Housing oppression led to health disparities.

(Benfer et al., 2020; NAEH, 2020; Swope & Hernandez, 2019)
Swope and Hernandez (2019)
Housing and Health Disparities Conceptual Model

Structures
- Structural inequality in race and class
- Exclusionary policies and practices, both historical and contemporary

Mechanisms Through Which Structure Impacts Housing
- Limited available housing stock
- Concentration of marginalized and unequal distribution of resources by neighborhood
- Limited ability to develop financial resources through housing equity

Housing Pillars
- Neighborhood factors
- Housing conditions and quality
- Housing affordability
- Residential stability

Mediators/Moderators
- Differential vulnerability due to chronic stress
- Ability to acquire resources that promote health
- Differential vulnerability across the life course
- Health behaviors such as smoking and physical activity

Health outcome
- General/overall (self-rated health, mortality)
- Chronic disease
- Infectious disease
- Maternal, reproductive, infant, and sexual health
- Injury
- Mental health

This Cause: | Can Become this Illness or Condition: | How to Prevent this Illness or Condition:
--- | --- | ---
In homes built before 1978:  
- Peeling paint  
- Sloppy repair/paint work | Lead poisoning – causes lower IQ and other learning and behavior problems in children | • Fix lead hazards  
• Work safely and check for dust  
• Clean up the site after any work is finished
Smoking, secondhand smoke | Asthma, respiratory problems, sudden infant death syndrome (SIDS), lung cancer, and deaths from fires | • Don’t smoke in the home  
• Don’t let anyone else smoke in the home
Radon | Lung cancer | • Install fan systems that can remove radon or vapor barriers that can block radon
Lack of a working smoke alarm | Fire injuries and deaths | • Install smoke alarms on every floor of the home  
• Use long-life smoke alarms with lithium-powered batteries  
• Test all smoke alarms every month
Moisture and mold | Asthma and respiratory problems | • Fix water leaks  
• Keep house well ventilated
Pesticide use | Acute poisonings and possible chronic conditions such as cancer, low birth weight and prematurity | • Keep pests out by cutting off their water, food, and access  
• Use pesticides wisely  
• Store pesticides properly

| Stats |
--- |
Many homes have unhealthy conditions:  
1 in 16 have high radon levels  
1 in 10 have water leaks  
1 in 6 have structural problems  
1 in 4 have lead-based paint  
1 in 4 do not have a working smoke alarm
The housing problems that can make us sick are interconnected:  
• Lack of ventilation (airflow) keeps poisons in and builds up moisture.  
• Moisture causes deteriorated paint, attracts and sustains pests, and leads to mold.  
• Pests make holes that become leaks and make people use poisonous pesticides.

Policies and Practices Contributing to Housing Disparities

**Policy**
- Native American displacement to reservations: Forced removal from their lands and restriction to reservations to facilitate expanding White settlement.
- Urban renewal and subsidization of suburbanization: Government funding for highways and other facilitators of suburbs open only to Whites, while "blighted" urban neighborhoods were demolished.
- Redlining: Government-run or sponsored ratings of neighborhood-level home mortgage loan security, which discriminated against minority neighborhoods.
- Public housing transformation: Shift towards neoliberal policies of individual vouchers and public housing demolition.

**Practice**
- Housing discrimination: Differential treatment of marginalized groups during the process of searching and applying for housing.
  - 1900: Racial residential covenants: Provisions in private property deeds specifying that the property could not be sold or rented to Blacks and sometimes other non-White groups.
  - 1950:
  - 2000: Predatory lending: Disproportionate targeting of poor and non-White neighborhoods and individuals for unfavorable loans, even if they qualified for better terms.
- Gentrification: Movement of higher-income, usually White residents into lower-income urban neighborhoods, often causing displacement.

[Source: https://www.sciencedirect.com/science/article/pii/S0277953619305659]
# Potential Housing Strategies

<table>
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<th>Description</th>
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<tbody>
<tr>
<td>Zoning regulation for land use policy</td>
<td>Use zoning regulations to address aesthetics and safety of the physical environment, street continuity and connectivity, residential density and proximity to businesses, schools, and recreation, etc.</td>
</tr>
<tr>
<td>Inclusionary zoning and housing policies</td>
<td>Require developers to reserve a proportion of housing units for residents with low incomes via mandatory requirements or incentives such as density bonuses</td>
</tr>
<tr>
<td>Rent regulation policies</td>
<td>Establish tenant protections via regulations to the housing rental market such as limits on rent increases and eviction protections for tenants with low incomes; typically via rent stabilization</td>
</tr>
<tr>
<td>Housing reparations</td>
<td>Apologize for discriminatory housing policies; increase subsidies, financing, and paths to homeownership for people of color; and invest in systematically disadvantaged neighborhoods</td>
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<td>Housing choice voucher program (Section 8)</td>
<td>Provide eligible families with low and very low incomes with vouchers to help cover the costs of rental housing; also called Section 8</td>
</tr>
<tr>
<td>Housing first</td>
<td>Provides rapid access to permanent housing and support (e.g., crisis intervention, needs assessment, case management), usually for chronically homeless individuals with persistent mental illness or substance abuse issues</td>
</tr>
<tr>
<td>Housing rehabilitation loan &amp; grant programs</td>
<td>Provide funding, primarily to families with low or median incomes, to repair, improve, or modernize dwellings and remove health or safety hazards</td>
</tr>
<tr>
<td>Rapid re-housing programs</td>
<td>Transition families and individuals experiencing homelessness into permanent housing quickly, often with supports such as short-term financial assistance, case management, landlord negotiations, etc.</td>
</tr>
</tbody>
</table>

http://whatworksforhealth.wisc.edu/factor.php?id=126
https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies
Thank you!
2022 NH Legislation: Public Health Overview

Childcare legislation

- **SB 446** – Child care workforce fund and grant program
- **SB 326** – Office of Early Childhood

Housing legislation

- **SB 329** – establishing a commission to study barrier to housing development in NH, including workforce and middle-income housing
- **SB 400** – zoning and planning board training and investments and incentives for affordable housing development
- **SB 210** – relative to the sale of manufactured housing parks
Reminders

• Next session on May 4, Access to Health: Geography and Workforce

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The Political Determinants of Health
Policies to Advance the Health & Economic Prosperity of New Hampshire Communities: Session 3

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In Partnership with

New Hampshire Medical Society
New Hampshire Public Health Association
New Futures
New Hampshire Hospital Association
Dartmouth-Hitchcock
Today’s Program

• Brief housekeeping, Seddon Savage
• Didactic: Focus on Postpartum Medicaid Expansion, Julia Frew & Daisy Goodman
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[Map showing geographical distribution of registrants]
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Political Determinants of Health
Focus on Postpartum Medicaid Expansion

Daisy Goodman, CNM, DNP, MPH,
Julia Frew, MD
Importance of Postpartum Health Care

- Recovery from childbirth
- Follow up on pregnancy complications
- Management of chronic health conditions
- Preventive health care
- Access to family planning
- Screening, diagnosis, and treatment for maternal mental health

Relationship with an obstetric care provider is often the only point of contact with the health care system for reproductive-aged women.
Maternal Mortality Occurring After 6 Weeks Postpartum In The United States

![Bar graph showing maternal mortality causes and percentages.](https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf)
Redefining Postpartum Care

ACOG Committee Opinion 736- Optimizing Postpartum Care

✓ Engagement across Fourth Trimester
  • Short interval follow up (1-2 weeks)
  • Pregnancy spacing/reproductive life plan
  • Emphasis on screening for social determinants and linkage to services

✓ Multidisciplinary
  • Lactation support
  • Mental health evaluation/treatment
  • Substance use screening/treatment

✓ Personalized transition to a primary medical home
Postpartum Medicaid Coverage: Nationally and in NH

- Medicaid covers 4 in 10 births in the US, and 3 in 10 in NH
- Eligibility is capped at higher levels than for non-pregnant people
- Outside of the context of public health emergency, pregnancy-related Medicaid eligibility ends for many women at 42-60 days postpartum
- This leads to a gap in eligibility for postpartum people
- This gap is most significant in states which have not expanded Medicaid - but is still significant in NH

NH

Postpartum Rates of Medicaid Coverage Are Higher Than Pre-Pregnancy Rates

In Expansion States, Higher Rates of Medicaid Coverage and Fewer Uninsured Among Postpartum Women

Coverage status of women who have given birth in prior year

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<tr>
<td>Pre-Pregnancy</td>
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<td>61%</td>
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<tr>
<td></td>
<td>11%</td>
<td>23%</td>
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<td>58%</td>
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<tr>
<td></td>
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<td></td>
<td>41%</td>
<td>44%</td>
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<tr>
<td></td>
<td>61%</td>
<td>58%</td>
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<tr>
<td></td>
<td>7%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>32%</td>
<td>21%</td>
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NOTE: Percent may not add up to 100% due to rounding.


Improving Care and Coverage

• NH Healthy Moms, Healthy Babies Act of 2022
  • Based on Federal legislation (“Improving Care and Coverage for Mothers Act”)
  • Upcoming hearing April 12
  • Will maintain postpartum Medicaid coverage for 12 months for women with incomes up to 196% of the federal poverty level (FPL)
  • Women with incomes below 138% of the Federal Poverty Limit will continue to be covered under the Granite Advantage Program

“The purpose of the program shall be, through ensuring continuous coverage for a 12-month postpartum period, to increase identification and mitigation of preventable pregnancy related and pregnancy associated morbidity and mortality, including those related to substance use disorder and mental illness.”
Can legislation make a difference?

Four Postpartum Cases
Perinatal Mental Health

Mental health and substance use disorders are the leading cause of maternal mortality during pregnancy and up to 1 year postpartum.

Without insurance coverage, many women cannot afford to continue receiving mental health or SUD treatment or fill needed prescriptions.
Cristina

24 year old woman, currently 8 months postpartum, with history of depression, anxiety, and PTSD. Her partner was employed, so she was not eligible for Medicaid due to household income over the eligibility cap.

Cristina was started on antidepressant medication for her postpartum depression at her 6 week postpartum visit, but then stopped her medication because she could no longer afford to fill the prescriptions. She also stopped seeing her counselor for the same reason.

Feeling more depressed with suicidal ideation, she called a crisis hotline and was advised to go to the emergency department. There, she was evaluated and assessed to need inpatient psychiatric admission.
Pregnancy Intention

According to 2020 NH Pregnancy Risk Monitoring System (PRAMS) Data, only 69.9% of mothers wanted to be pregnant at the time they became pregnant.

Kelli

A 28 year old woman, currently 4 months postpartum, Kelli did not attend her 6 week postpartum visit as her infant was sick. She was unable to reschedule due to loss of insurance coverage.

Kelli started working part time as an in-home childcare provider, which made her ineligible for Medicaid coverage. Her employer could not offer her health insurance, so she was uninsured.

Although she planned to start oral contraceptives at her postpartum visit, she discovered she was pregnant again at 4 months postpartum.
Maternal Cardiac Disease

Nationally, 23% of late postpartum deaths are caused by cardiomyopathy

According to the American College of Obstetricians and Gynecologists, 88% of the women who died would have been identified as high risk and referred if they had been appropriately evaluated.

Mia

A 38 year old woman with history of pre-eclampsia, currently 6 months postpartum. She was diagnosed with chronic hypertension during her pregnancy, having not received much medical care prior to that time, and during her pregnancy also developed pre-eclampsia. She was advised to have her blood pressure evaluated, but missed her 6 week appointment and then lost Medicaid coverage as she started working again part time.

Over the past few months she experienced increasing shortness of breath at rest, swelling in her legs and feet, and sometimes heart palpitations, which she attributed to being overtired after work. She presented to her local emergency department due to difficulty breathing, and was diagnosed with cardiomyopathy.
Overdose
Population-based study of treatment engagement and overdose among perinatal women

- Overdose risk was lowest during pregnancy and highest at 7-12 months postpartum
- Only 64% received pharmacotherapy for OUD during the prenatal year
- Pharmacotherapy reduced overdose risk > 50%
- Factors associated with overdose included anxiety, depression, homelessness
Diana

Diana was 3 months postpartum when she died of an accidental overdose, leaving behind her 4 year old son and 3 month old infant.

During her last pregnancy, she had been stable in recovery from opioid use disorder, treated with buprenorphine/naloxone. When she lost insurance coverage postpartum, she tried to stop this medication on her own because she was unable to afford treatment visits or prescriptions.

Diana was able to manage her withdrawal symptoms and cravings for a few weeks, but then was offered medication by a friend to help with her withdrawal. This medication turned out to be counterfeit, containing fentanyl, causing her to overdose. When EMS arrived, they were unable to resuscitate her.
States Expanding Postpartum Medicaid Coverage

Postpartum Coverage Tracker Map

- Approved 1115 waiver (5 states)
- Enacted legislation to seek federal approval through SPA or 1115 waiver (15 states & DC)
- Pending legislation to seek federal approval through SPA or 1115 waiver (6 states)
- Planning to submit a SPA or 1115 waiver (4 states)
- Proposed/pending 1115 waiver (1 state)

NOTE: Pending legislation includes legislation that has passed one or both chambers. * State limits the eligible population, provides a limited benefit package, and/or limits the coverage period (>12 months). DC has enacted legislation to seek federal approval through SPA or 1115 waiver.

SOURCE: KFF analysis of approved and pending 1115 waivers, state plan amendments, and state legislation.

https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/#
2022 NH Legislation: Public Health Overview

Social safety net bills – SNAP, Medicaid

**SB 407/HB 1536** – extending Medicaid for postpartum women

**SB 403** – re-establishing the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Farmers Market Nutrition Program

**SB 404** – establishing a supplemental nutrition assistance program

Behavioral Health

**HB 503** – access to MAT (SUD treatment)

**SB 444** – relative to childhood adverse experiences treatment and prevention
Reminders

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The Political Determinants of Health

Policies to Advance the Health & Economic Prosperity of New Hampshire Communities: Session 2

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• Didactic: Immunization & Registries, Susanne Tanski, MD
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Poll: Balancing Personal Choice & Public Health

When the important values of personal choice and public health conflict in policy situations what do you tend to value more in formulating your position?

(Choose one)

• Strongly favor personal choice over public health
• Somewhat favor personal choice over public health
• Somewhat favor the public health over personal choice
• Strongly favor the public health over personal choice
Notes

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- Questions to ECHO Tech Support thru personal CHAT or [ECHO@hitchcock.org](mailto:ECHO@hitchcock.org)
### ECHO Participant Demographics

Total Registrants: # 220

<table>
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<td>Other</td>
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</tbody>
</table>
ECHO Core Panel

- Courtney Tanner, JD, MSW  
  Director, D-H Government Relations, Course Director
- Matthew Houde, JD  
  Vice President of D-H Government Relations
- Sally Kraft, MD, MPH  
  Vice President, Population Health, DHMC
- Paula Minnehan, MS  
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- Jonathan Thyng, MD  
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  Executive Director of the NH Nurses Association
- Jennifer Alford-Teaster, MA, MPH  
  Board Member, NH Public Health Association
Vaccines, Vaccine Registries and Public Health

Susanne Tanski, MD MPH
Section Chief and Vice Chair of Pediatrics
Children’s Hospital at Dartmouth-Hitchcock
What’s a Vaccine? Why do we vaccinate?

• A training exercise for the immune system

• Vaccines contain a dead or weak form or fragment of the virus or bacteria to train the body to fight of an infection, or to not get sick from the infection

• Bacteria: diptheria, tentanus, whooping cough, some causes of meningitis, typhoid, tuberculosis, bubonic plague, anthrax and cholera

• Viruses: influenza, measles, mumps, rubella, chicken pox, yellow fever, rotavirus, smallpox (now eradicated), and Covid-19
WEAKEN THE VIRUS

Viruses are weakened so they reproduce poorly inside the body.

INACTIVATE THE VIRUS

Viruses are completely inactivated (killed) with a chemical.

TYPES OF VACCINES

USE PART OF THE PATHOGEN

USE PART OF THE PATHOGEN

Part of the virus or bacteria is used as the vaccine.

INACTIVATE THE TOXIN

A harmful protein made by the bacteria (toxin) is inactivated (killed) with a chemical. The inactivated toxin is called a toxoid.

USE PART OF THE GENETIC CODE

VECTOR VIRUS

The gene from the pathogen is put into a virus that can't reproduce itself but can still enter cells and deliver the gene.

mRNA

mRNA that is the blueprint for a protein from the pathogen is used as the vaccine.

DNA

DNA, the genetic code from which mRNA is made, is used as the vaccine.

GO TO VACCINE.CHOP.EDU/TYPES-OF-VACCINES FOR MORE INFORMATION.
The Role of Vaccines in Public Health: INDIVIDUAL benefits

Reduces serious disease and death
Prevents long-term sequelae

Polio example:

*Acute polio*: asymptomatic to mild flu-like illness “non-paralytic polio”

*Paralytic polio*: Progressed to loss of reflexes and temporary or permanent paralysis and death

*Post-polio syndrome* – 15 to 40 years later – progressive muscle weakness leading to disability that affects up to 40% of polio survivors

![Polio cases and deaths in the US since 1943](Chart: The Conversation, CC-BY-ND • Source: Our World in Data, derived from US Public Health Service and the Centers for Disease Control and Prevention • GettheData)
Prior to vaccines, childhood and parenthood was marked by quarantines and illnesses:

Quarantine for measles after exposure: 21 days (contagious for 4 days before and after the rash... incubation ~8-12 days)

Quarantine for chicken pox: Infectious before rash, home until all spots have scabbed over – 7-10 days

Quarantine/isolation for Covid-19: 10 days

*Missed school, Missed work (and often Misery)*

Source: Vaccinate Your Family, 2018 State of the Immunion Report
The Role of Vaccines in Public Health: INDIVIDUAL, FAMILY and COMMUNITY benefits

HOW HERD IMMUNITY WORKS

- When no one has immunity, contagion has many opportunities to spread quickly.
- The more immunity we have in the system, the less often contagion comes into contact with the susceptible.
- Spread of contagious disease is contained.

Source: Historyofvaccines.org
Vaccines are COST SAVING for INDIVIDUALS, FAMILIES and COMMUNITIES

The Vaccines for Children (VFC) program helps ensure that all children have a better chance of getting their recommended vaccines. VFC has helped prevent disease and save lives.

CDC estimates that vaccination of children born between 1994 and 2018 will:

- prevent **419 million** illnesses
- help avoid **936,000** deaths
- save nearly **$1.9 trillion** in total societal costs (that's more than the population of the U.S.A)

**WHOOPING COUGH OUTBREAK IN A SINGLE SCHOOL:**

$52,000

**MEASLES OUTBREAK IN A STATE:**

$1.3 Million

**AVERAGE FLU SEASON:**

$87 Billion

The Economic Burden of Vaccine-Preventable Diseases

While vaccines save money, treating vaccine-preventable diseases can be expensive for local, state and national authorities.

Source: CDC.gov

Source: Vaccinate Your Family, 2018 State of the Immunization Report
Measles is another example of vaccine success ("eliminated" in 2000), with a cautionary tale...
NH leads the nation in vaccinations for measles, mumps and rubella

By PAUL FEELY
New Hampshire Union Leader

CONCORD - At 96.3 percent, New Hampshire has the highest measles, mumps and rubella (MMR) vaccination rate for infants in the country, according to a study released last week. The state's department of Health and Human Services reports over 97 percent of all school-aged children have received immunizations.
Vaccine Registries – Proposed in 1997, enacted in NH in 2021. What are they?

What? An electronic database of consolidated and CONFIDENTIAL listing of a population’s immunization records, available to healthcare providers, schools, public health agencies and the patient/parent

Why? By 2 years of age >20% of kids in the US have seen more than one medical providers, resulting in scattered records

Why? Vaccines save lives, reduce disease and disability, and preserve our economic engines. It’s important to identify populations at risk
People receive vaccinations from a variety of places:
- Hospital
- OB/GYN
- Workplace
- Doctor's office
- Public health department
- Urgent care
- Pharmacy

These sources send vaccination records to state or city IIS:
- Vaccination record
- Vaccination record
- Vaccination record
- Vaccination record
- Vaccination record
- Vaccination record

IISs provide records to patients and authorized professionals:
- Parents and general public use the information to enroll children in schools and day care and to determine if they need vaccinations.
- Doctors and health care providers use IISs to determine which vaccinations are needed and to care for patients.
- Public health uses the information to develop programs that increase vaccination coverage and decrease the harm caused by vaccine-preventable diseases.
**Parent/Person:** Vaccine Registries are a SECURE and TRUSTED SOURCE for vaccine records

- No need to call/log on to multiple offices or wait for a copy
- For School
- For Camp
- For Travel: Many countries require proof of vaccine status
Healthcare Providers: Vaccine Registry Provides a TRUSTED SOURCE for vaccine information

- Provides needed information including formulation, dates, manufacturer
  - This information is NEEDED to determine if up-to-date for series
    - For example: Injected Polio Vaccine vs. Oral Polio Vaccine
  - Decreases over-vaccination due to incomplete information
  - Facilitates identification of patients if there are changes to the vaccine schedule
Community: Vaccine Registries allow identification of populations at risk for targeted outreach to improve vaccination rates and reduce disease.

In 2013, in response to an epidemic in Vermont, NH health officials called schools throughout NH to determine if kids were vaccinated against whooping cough.

A vaccine registry would have eliminated this manpower need.
Vaccine Registries: Opt-Out far superior to Opt-In in terms of paperwork/manpower

• BOTH allow choice and convenience for parent/patient
• Current state: Opt-Out requires a signature to not include in registry, followed by scanning to chart
• Opt-In would require a signature which is a BARRIER to participation, requires paperwork for more patients (since most want to participate)
• Only Texas and Montana are Opt-In, remainder are Opt-Out
• ALWAYS have the option to remove from database with signature
In Sum:
Vaccines are good for Individual, Family and Community Health

Vaccine *registries* are good for Individual, Family and Community Health (and opt-out is better!)
2022 NH Legislation: Public Health Overview

**Public Health Infrastructure**
- **HB 1606** – opt-in immunization registry

**Pediatric Policy**
- **HB 1241** – prohibit a school district from mandating a COVID-19 vaccination
- **HB 1379** – DHHS rulemaking authority re immunizations
- **HB 1633** – requiring COVID-19 vaccination for school attendance
- **SB 288** – prohibiting requiring COVID-19 vaccination for school/care enrollment

**Healthy Communities**
- **HB 1604** – conscientious exemption
- **HB 1210** – exemption from vaccine mandates
- **HB 1455** – state enforcement of federal vaccination mandates
HB 1606 – opt-in immunization registry
House HHS recommended OTP (pass) as amended
Will be voted on by the full House before 3/31
2022 NH Legislation: Public Health Status

**HB 1241** – prohibit a school district from mandating a COVID-19 vaccination
House Education recommended OTP (pass) 10-8; full House will vote before 3/31

**HB 1379** – DHHS rulemaking authority re immunizations
House voted OTP (169-164) with amendment
Will be introduced to the Senate, likely Senate HHS

**HB 1633** – requiring COVID-19 vaccination for school attendance
*Failed in the House*

**SB 288** – prohibiting requiring COVID-19 vaccination for school/care enrollment
Senate Health and Human Services Committee to make a recommendation to the Senate;
Full Senate will note before 3/31
2022 NH Legislation: Public Health Status

HB 1604 – conscientious exemption
Passed House 176-174 and referred to House Finance

HB 1210 - exemption from vaccine mandates
House voted OTP (181-155) with amendment
Will be introduced to the Senate

HB 1455 – state enforcement of federal vaccination mandates
House voted OTP (174-159)
Will be introduced to the Senate
NH Legislative Resources

- **NH General Court website:** The General Court of New Hampshire
  - www.gencourt.state.nh.us

- **Find your Representative:** The New Hampshire House of Representatives
  - www.gencourt.state.nh.us/house/members

- **Find your Senator:** The New Hampshire State Senate
  - http://www.gencourt.state.nh.us/senate/members/wml.aspx
Reminders

• Next session on April 6th: Social Safety Net Bills
• Enter name, organization, and email into chat
• Didactic recordings and notes from the session will be posted on the D-H ECHO website:

https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials
The Political Determinants of Health
Policies to Advance the Health & Economic Prosperity of New Hampshire Communities: Session 1

Sponsored by the Dartmouth Hitchcock Office of Government Relations

In Partnership with

New Hampshire Medical Society
New Hampshire Public Health Association
newfutures
Project ECHO
Dartmouth-Hitchcock
The Series

Examining the potential health impact of proposed bills

• Overview of Social and Political Determinants of Health, 3/9
• Immunization & COVID Safety Bills, 3/23
• Social Safety Net Bills, 4/6
• Health Infrastructure Bills, 4/20
• Access to Healthcare - Geography and Workforce Bills, 5/4
• Influencing Macro Change – A Call to Action, 5/18
Today’s Program

• Brief housekeeping
• Didactic: Social & Political Determinants of Health, Sally Kraft
• Case & Policy Impact Discussion, Courtney Tanner
• Preview of health policy bills before NH Legislature, Courtney Tanner
• Summary, Jennifer Alford-Teaster
• Up Next
Project ECHO (Extension for Community Healthcare Outcomes)

• ECHO is a tele-mentoring model that uses virtual technology to support case-based learning and provide education about health
• Goal to elevate the health of our communities
• All Teach All Learn, gather collective wisdom
• Respectful listening essential to community of learning
Notes

• Please let us know you are here. Enter name, email, organization in Chat.
• Enter comments or questions in chat at any time. Or raise virtual hand and we will call on you when it works. Please mute otherwise.
• Didactics are recorded audio-visually for educational & quality improvement purposes and posted to D-H ECHO site https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials

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ECHO Participant Demographics
Total Registrants: # 183

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First 122 registrants
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- Jennifer Alford-Teaster, MA, MPH  Board Member, NH Public Health Association

Today's Presenter: Sally Kraft, MD, MPH  Vice President, Population Health, DHMC
Helen of Hanover NH

76 year old woman who retired 10 years ago from her position as a professor of mathematics from Dartmouth. She lives alone, but has an active social life attending church regularly, exercising 3 times a week at a local exercise facility and engaging in many lively family zoom sessions. She does have mild heart failure but this is well controlled with her medicines which she takes regularly.

COVID-19 has impacted her like it has all of us. She has been vaccinated and boosted (as has everyone in her immediate circle of friends).

Helen developed a cough in mid-February. When she first developed symptoms, she went on line, scheduled a COVID-19 test, got in her car and got the test. After receiving her positive results, she completed a video-telehealth visit with her PCP and her cardiologist. Her physicians recommended oral anti-viral treatment and she was able to ask a friend to pick up her medication and she started the therapy immediately. Her supportive friends delivered food and set up a system to check in on her twice a day. She was able to isolate at home without difficulty and, thankfully, she did well and has now recovered fully.
Jean of Newport NH

Jean is a 76 year old woman who worked for years as a checker at Hanafords and has struggled financially since leaving that job 10 years ago. She lives alone and doesn’t have a car so rarely leaves her home. She does not have any wifi in her home nor does she have a computer or a smart phone. She has a cell phone but service is unreliable at her home. She used to smoke (and she has a bad chronic cough with phlegm) and a couple of years ago she was told she had mild heart failure but she hasn’t been back to the physician for a while and when her prescriptions ran out last month, she didn’t get them refilled for many reasons including lack of transportation and co-pays for the meds.

COVID-19 has impacted her like it has all of us. She did get her first vaccine when the regional public health network hosted a clinic not too far from her home but she couldn’t get a ride to get her second vaccine and she didn’t get boosted. And honestly, she had heard that the vaccine had a microchip in it that allowed the government to track her whereabouts so she wasn’t sure she wanted to get another vaccine anyway.

Jean developed a worsening cough in mid-February. She felt terrible but thought it was just a cold. She thought about getting a COVID-19 test but she couldn’t get to the testing site. Over the next couple of days she began to struggle to catch her breath and finally, she called 9-1-1. She arrived in the ED with a dangerously low oxygen level and had to be immediately intubated and placed on a ventilator. After 10 days in the ICU, she died.
Income and other social conditions are key drivers of health

HANOVER, NH
- 85.3 yrs. life expectancy
- $113,925 median household income
- 71.5% COVID vaccinated
- 9.5 Asthma ED visits rate per 10k

LEBANON, NH
- 80.6 yrs. life expectancy
- $56,488 median household income
- 77.3% COVID vaccinated
- 46.1 Asthma ED visits rate per 10k

CANAAN, NH
- 78.5 yrs. life expectancy
- $61,061 median household income
- 58.9% COVID vaccinated
- 43 Asthma ED visits rate per 10k

NEWPORT, NH
- 75.9 yrs. life expectancy
- $52,486 median household income
- 51.5% COVID vaccinated
- 80.3 Asthma ED visits rate per 10k

Sources: NH Wisdom, NH Hospital Discharge Data set, D-H, NH, MAHHC 2019 CHNAs, COVID 19 dashboard accessed 2/21/22
Today’s discussion

• Recognize that health outcomes are largely impacted by factors outside of the services delivered in the hospital and clinic

• Understand the health of our population deeply impacts our prosperity and economic vitality

• Demonstrate why we need to work “upstream” and address the social and political determinants of health
Social Drivers of Health

The circumstances in which people are born, grow up, live, work and age, as well as the systems put in place to deal with illness. These circumstances are, in turn, shaped by a wide set of forces: economics, social policies, and politics.
Five Most Pressing Social Determinants of Health

**Housing**
- Housing quality and instability
- Neighborhood violence

**Food**
- Inaccessible, unaffordable healthy food
- Disconnection from benefits (e.g., SNAP)

**Economics**
- Insufficient wages
- Lack of insurance coverage

**Interpersonal**
- Social isolation
- Discrimination
- Provider bias

**Education**
- Health illiteracy
- Lack of language skills
- Quality of public schools

**Impact**
- 26-36 years of reduced life expectancy for those experiencing homelessness
- 74% of food insecure households had to choose between paying for food and medicine
- 2x greater mortality risk for Medicaid beneficiaries vs. private insurance
- 26% increased risk of mortality resulting from loneliness
- 9 years gap in life expectancy for those without a high school diploma vs. college graduates
When it comes to health, your zip code matters more than your genetic code.
Age adjusted rates of COVID-19 deaths
US Health Disadvantage

• US has poor health outcomes compared to other wealthy countries
• US spends more money on health care than other wealthy countries
• We bear the economic burden of poor health
  • Employers pay more for health insurance.
  • Lost productivity in the workplace.
  • Taxes to care for uninsured, disabled,

Health and the economy are inextricably linked. Both must thrive if either is to be strong.
The US spends more on health care services but has worse health outcomes compared to other countries.
# Table 1.2 Indirect costs to U.S. employers due to diabetes

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<th>Productivity losses</th>
<th>Costs ($ billion)</th>
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<td>Reduced productivity days among persons not in labor force</td>
<td>14 million days</td>
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<tr>
<td>Work days absent</td>
<td>14 million days</td>
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<tr>
<td>Mortality</td>
<td>277,000 deaths</td>
<td>19.9</td>
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<tr>
<td>Reduced performance at work</td>
<td>114 million days</td>
<td>26.9</td>
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<tr>
<td>Reduced labor force participation due to disability</td>
<td>182 million days</td>
<td>37.5</td>
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<tr>
<td>Total</td>
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<td>89.9</td>
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</table>
Increase in the average deductibles in New Hampshire is one of the highest in the US (second only to VT).

Commonwealth Fund Dec 2018
**Upstream**
Improving the socioeconomic and environmental conditions, policies, payment systems that impact the health of our populations

**Midstream**
Assisting patients where they live

**Downstream**
Caring for patients in our hospitals, clinics
Manchester NH
Redlining
COVID-19 Cases Per 100k People By Race and Ethnicity In New Hampshire

![Bar chart showing COVID-19 cases per 100k people by race and ethnicity in New Hampshire.](https://healthequitytracker.org)
Political Determinants of Health

Three major aspects of the political determinants of health:

1. Voting
2. Government
3. Policy
To remember from today

• 80% of health is determined by socioeconomic, behavioral, environmental factors. Only 20% of health is determined by health care.

• The vitality and prosperity of our communities is deeply impacted by the health of the population.

• To improve health and health equity, we need to work “upstream” on the systems and forces that shape the conditions of our lives.
...we should be engaging in open and robust discussions of how politicians and politics affect and shape our patients’ lives, our communities, and the social determinants of health themselves.
Reminders

- Next session on March 23rd
  *Immunization & Immunization Registries*

- Enter name, organization, and email into chat

- Didactic recordings are posted on the D-H internet site: https://video.dartmouth-hitchcock.org/playlist/dedicated/1_hnxubuvk/