WELCOME to the

Rural Health Equity ECHO:
Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 1- Addressing Rural Health Equity: Contextual Considerations
September 13, 2023

Please let us know you are here: Type your name, email, organization into CHAT

Rural Health Equity: Tackling the Social Drivers of Health

1 - Addressing Rural Health Equity: Contextual Considerations	9/13/20232
2 - Housing	9/27/2023
3 - Food and nutrition	10/11/2023
4 - Transportation	10/25/2023
5 - Childcare	11/8/2023
6 - Access to healthcare	11/29/2023
7 - Special barriers to well-being and care	12/6/2023
8 - Cross cutting solutions	12/20/2023

Series Learning Objectives

After participating in the Rural Health Equity ECHO participants will be able to:

- Explain rural health equity and the complex issues that come together to produce unfair health outcomes in northern New England (NNE).
- Apply key equity principles to working with others in order to overcome barriers to health equity in NNE.
- Engage in actions that promote greater health equity in NNE.

Project ECHO (Extension for Community Healthcare Outcomes)

- ECHO is a telementoring model that uses virtual technology to support case-based learning and provide medical education.
- Highly Interactive. All teach, all learn.

Components of ECHO:

Today's Program

- Brief housekeeping
- Didactic: Addressing Rural Health Equity, Beth Wilson
- Panel of perspectives – Rudi Fedrizzi, Angela, Sally Kraft
- Case presentation: Kris van Bergen-Buteau
- Case discussion
- Summary
- Up Next

Notes

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CME

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- Track participation via DH ECHO Connect site
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ECHO Participant Demographics
Total Registrants: # 134

Public Health	33
Medical Professional	21
Administrative	18
Educator	18
Community Based Health Worker	11
Policy Maker/Advocate	3
Researcher	2
Student	2
Community Service Organization	2
Other	12

Core Panel

- Elisabeth Wilson, MD, MPH, MS-HPEd - Chair and Professor, Department of Community and Family Medicine, Dartmouth Health and Geisel School of Medicine
- Kris van Bergen-Buteau, CPHQ- Director, Workforce Development & Public Health Programs, North Country Health Consortium
- Rudy Fedrizzi, MD- Public Health Services District Director, Vermont Department of Health
- Andrew Loehrer, MD, MPH- Staff Physician, Dartmouth Health
- Andy Lowe- Executive Director, New England Rural Health Association
- Angela Zhang, MSW - Program Services Director, LISTEN community services
- Chelsey Canavan, MSPH - Manager, Center for Advancing Rural Health Equity

Rural Health Equity ECHO

Tackling the Social Drivers of Health

Health Equity

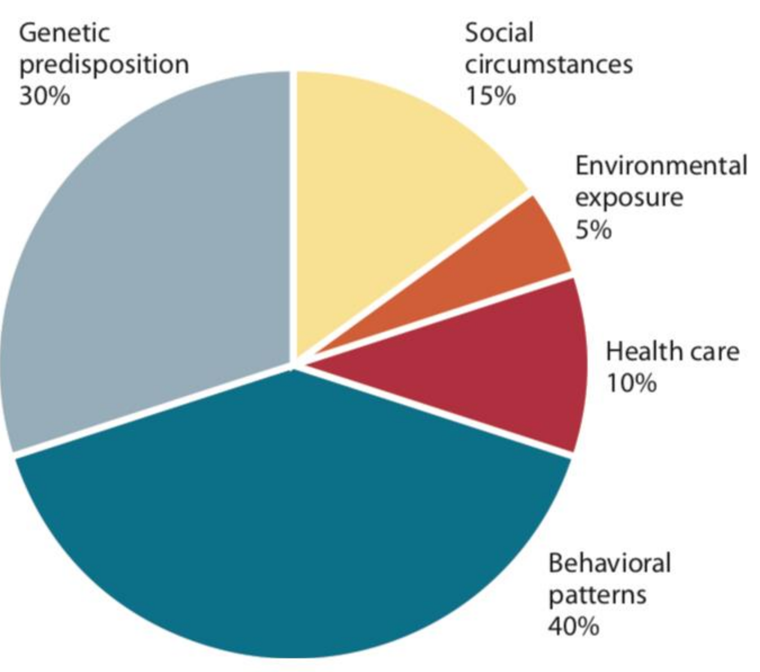
Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Braveman, P. *A New Definition Of Health Equity To Guide Future Efforts And Measure Progress*, Health Affairs, June 22, 2017

https://www.healthaffairs.org/content/forefront/new-definition-health-equity-guide-future-efforts-and-measure-progress

What Drives Health?



Health Outcomes
- Mortality (length of life): 50%
- Morbidity (quality of life): 50%

Health Factors
- Health behaviors (30%)
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex
- Clinical care (20%)
  - Access to care
  - Quality of care
- Social & economic factors (40%)
  - Education
  - Employment
  - Income
  - Family & social support
  - Community safety
- Physical environment (10%)
  - Environmental quality
  - Built environment

Programs and Policies

https://www.countyhealthrankings.org/

Social Drivers of Health

The social determinants [drivers] of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Rural Health

Despite the many positive attributes and assets associated with working and living in rural communities, many rural American population groups experience significant health disparities.

Health disparities are differences in health status when compared to the population overall, often characterized by indicators such as higher incidence of disease and/or disability, higher mortality rates, lower life expectancies, and higher rates of chronic pain.

Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid.

Rural Health Information Hub, supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS

https://www.ruralhealthinfo.org/topics/rural-health-disparities

New Hampshire Premature Death

Montpelier
CO
GR
CA
BE
SU
Concord
ME
ST
Manchester
RG
CH
HR
Nashua
Lowell
Albany

BEST WORST MISSING

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

County Health Rankings & Roadmaps (CHR&R) is a program of the University of Wisconsin Population Health Institute.

https://www.countyhealthrankings.org/

Your zip code matters more than your genetic code

HANOVER, NH

86.7 yrs.

life expectancy

$137,344

median household income

LEBANON, NH

80.7 yrs.

life expectancy

$67,698

median household income

GRAFTON, NH

78.9 yrs.

life expectancy

$61,429

median household income

NEWPORT, NH

77.5 yrs.

life expectancy

$54,816

median household income

Courtesy of Sally Kraft,
Sources: NH Wisdom (life expectancy 2016-20); D-H, NLH, MAHHC 2021-22 CHNAs (household income)

Rural Health

August 2023

CMS (Centers for Medicare & Medicare Services) recognizes that more than 61 million Americans live in rural areas including rural, Tribal, frontier, and geographically isolated territories. These Americans face several unique challenges in health care that can differ dramatically among the different kinds of rural areas across the country. Rural residents tend to be older and in poorer health than their urban counterparts, and rural communities often face challenges with access to care, financial viability, and the

CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

Rural Health Overview

Rural communities comprise vast and varied landscapes that encompass micropolitan, frontier, and tribal lands, as well as U.S. territories and other island communities. These communities are increasingly diverse; nearly a quarter of people living in rural areas are from racial or ethnic minority groups. CMS is working to advance health equity across the nation's health system to enable people living and working in rural, tribal, and geographically isolated communities to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

https://www.cms.gov/priorities/health-equity/rural-health

Health

Population

Safety
&
Security

Social
Supports

Economics

Social

Economic

Environment

Community
Processes

Education

Recreation
Heritage
Arts

Community
Infrastructure

Environment

Being

Belonging

Becoming

©Rural Development Institute, Brandon University.

The purpose of the framework is to assist residents of rural communities in self-assessing quality-of-life measures that are listed under the framework as “Being,” “Belonging,” and “Becoming.”

Being involves understanding the current state of the community; *belonging* denotes how the community fits within the broader context; and *becoming* encompasses all the purposeful activities that are carried out to achieve the community's goals.

Annis R, Racher F, Beattie M. Rural community health and well-being: A guide to action. Brandon, Manitoba: Rural Development Institute; 2004. [September 22, 2016].

Up Next

- Next session: Housing on September 27th
- Please submit your cases/questions, track your attendance for CME/CNE and view course resources at the: DH ECHO Connect site
- Recordings will be posted on the D-H ECHO website https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials

Connect with this learning community

- ECHO Connect site: https://connect.echodartmouth-hitchcock.org/
- Navigate to My ECHOs page
- Click Resources
- Click View Cohort Roster
  - Name
  - Organization
  - Location
  - Email

SCIENCE AND PRACTICES TO KEEP PEOPLE SAFE AND BUSINESSES PRODUCTIVE AS COVID-19 CONTINUES

SUMMARY OF THIS ECHO

OF SESSIONS

12

WHAT THIS ECHO WILL FOCUS ON

As the COVID-19 pandemic continues, understanding of the virus and strategies to keep people safely engaged in productive work and business encounters is evolving. This second DH ECHO series on COVID-19 for employers and organizational leaders will examine advances in scientific understanding of COVID-19 and its prevention and management. It will explore timely new topics of importance such as strategic distribution of COVID vaccines, emerging perspectives on aerosols and ventilation, business travel considerations, and operationalization of pods to safely maximize social and work interactions. It will update more familiar topics such as PPE, surface and facility hygiene, regulatory changes, and emotional health during COVID with the latest information. Critical new topics will be integrated as they emerge. Sessions include a brief didactic and robust discussion.

WHEN IT STARTS	WHEN IT ENDS	LINK TO PARTICIPATE	LINK TO COHORTS
1/27/2021	6/30/2021	Navigate to ECHO	View Cohort Roster

SUMMARY OF EACH SESSION

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Session 2- Housing
September 27, 2023

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Today’s Program

- Brief housekeeping
- Didactic:
  - Intro: Housing, health & equity, *Rudi Fedrizzi*
  - Overview of NH Housing , *Rob Dapice*
- Case presentation: *Andy Lowe*
- Case discussion:
- A story of success: *Andrew Winter*
- Summary
- Up Next

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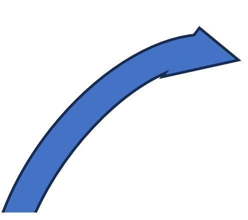
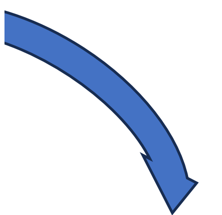
Guest Panelists

- Michael Redman – Executive Director, Upper Valley Haven
- Andrew Winter – Executive Director, Twin Pines Housing

Insecure Housing



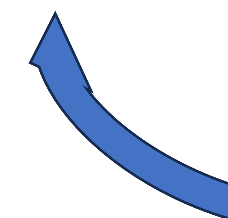


Life impacts

- Reduced activity, mobility, self-efficacy
- Social disruption
- Limited or unemployment
- Financial burdens or bankruptcy due to health costs

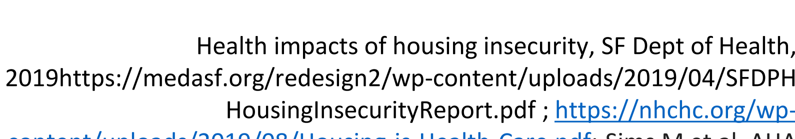
Challenges to health

- Chronic toxic stress, hypervigilance
- Limited hygiene resources
- Risk of violence & injury
- Medication access, storage, admin
- Wound & acute care management
- Chronic illness management
- Less access to health care



Poor Health

- Mental health challenges
- Wounds, injuries, infections
- Increased ER visits
- Developmental challenges in kids
- Pre-term birth
- Cardiovascular conditions
- Shorter life expectancy



Health impacts of housing insecurity, SF Dept of Health, 2019https://medasf.org/redesign2/wp-content/uploads/2019/04/SFDPHHousingInsecurityReport.pdf ; https://nhchc.org/wp-content/uploads/2019/08/Housing-is-Health-Care.pdf; Sims M et al, AHA Council on Epidemiology and Prevention and Council on Quality of Care and Outcomes Research. Importance of Housing and Cardiovascular Health and Well-Being: A Scientific Statement From the American Heart Association. Circ Cardiovasc Qual Outcomes 2020; Amato S, Nobay F, Amato DP, Abar B, Adler D. Sick and unsheltered: Homelessness as a major risk factor for emergency care utilization. Am J Emerg Med. 2019 Mar;37(3):415-420 2020 *Stookey J, CHPH birth statistic master file*

Picture courtesy of Change Lab Solutions, https://www.changelabsolutions.org/healthy-neighborhoods/housing

Housing equity

Stability	Affordability	Quality & Safety	Neighborhood Opportunity

Fair Housing Act (1968) prohibits discrimination in rental, sales, financing of housing based on
- Race, color, national origin, religion, sex (including gender identity and sexual orientation), disability, family status

Equal Credit Opportunity Act (1974) prohibits creditor discrimination based on
- The above
- Plus marital status, age, or receipt of public assistance

Despite prohibitions, some populations remain more vulnerable to
- Discriminatory rental or sales by landlords/realtor/sellers
- Reduced access to credit
- Appraisal biases (due to make up of neighborhoods)

Hernández D, Swope CB. Housing as a Platform for Health and Equity: Evidence and Future Directions. Am J Public Health. 2019 Oct;109(10):1363-1366. doi: 10.2105/AJPH.2019.305210. Epub 2019 Aug 15. PMID: 31415202; PMCID: PMC6727307; Swope CB, Hernández D. Housing as a determinant of health equity: A conceptual model. Soc Sci Med. 2019 Dec;243:112571.

OVERVIEW OF NEW HAMPSHIRE HOUSING

for Dartmouth Health Project ECHO

ROB DAPICE
Executive Director
September 2023

WE PROMOTE, FINANCE, AND SUPPORT HOUSING SOLUTIONS FOR THE PEOPLE OF NH

- Established in 1981 by state legislature as a self-sustaining public corporation
- Not a state agency – no state operating funds
- Governed by a 9-member Board of Directors that is appointed by Governor and Council

HOUSING SOLUTIONS FOR THE PEOPLE OF NH

NEW HAMPSHIRE HOUSING HAS...

- Helped more than 55,000 families purchase their own homes
- Provided financing to create 16,000+ multifamily units
- Provided direct assistance to tens of thousands of households

LAST YEAR NEW HAMPSHIRE HOUSING...

- Financed 1,800 units of multifamily rental housing
- Monitored operations of thousands of units of rental housing we financed
- Administered federally funded rental assistance for 9,000 households statewide
- Helped 1,300+ families purchase a home

HOMEOWNERSHIP PROGRAMS

- **Mortgage Programs:** Downpayment assistance + flexible underwriting; government-insured single-family mortgages using a pipeline of 70 lenders partners
- **Unique Products:** HomeFirst program downpayment assistance program; 1stGenHomeNH; Purchase-Rehab; Manufactured Housing in ROCs
- **Homebuyer Tax Credit Program** (Mortgage Credit Certificate): tax savings of up to $2,000/year for life of loan
- **Homebuyer Education:**
  Grants to HOMEteam, AHEAD, The Housing Partnership
- **Special Grants:**
  Granite State Independent Living, Habitat for Humanity
- **NH Homeowner Assistance Fund Program**

MULTIFAMILY HOUSING DIVISION

WE FINANCE

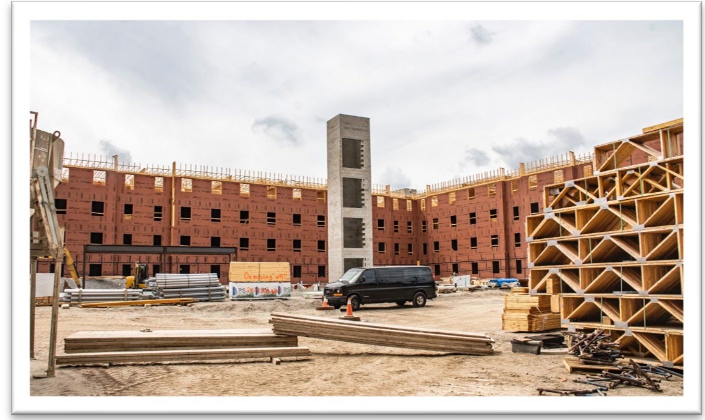
construction, acquisition & preservation of affordable rental housing for families, individuals of all ages, and people who need supportive housing services (substance use disorders, veterans, transitional)

FUNDING SOURCES

include private investments through bonds and tax credits, federal grants and guarantees, state Affordable Housing Fund, and other NH Housing resources

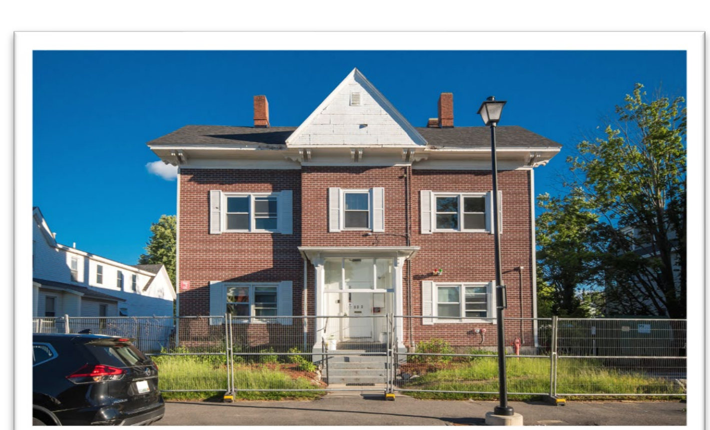
NH HOUSING MULTIFAMILY FUNDED PROJECTS

PORTSMOUTH - Griffin Place



NASHUA - Monahan Manor

LEBANON - Tracy Community Housing



MANCHESTER - 323 Manchester St.

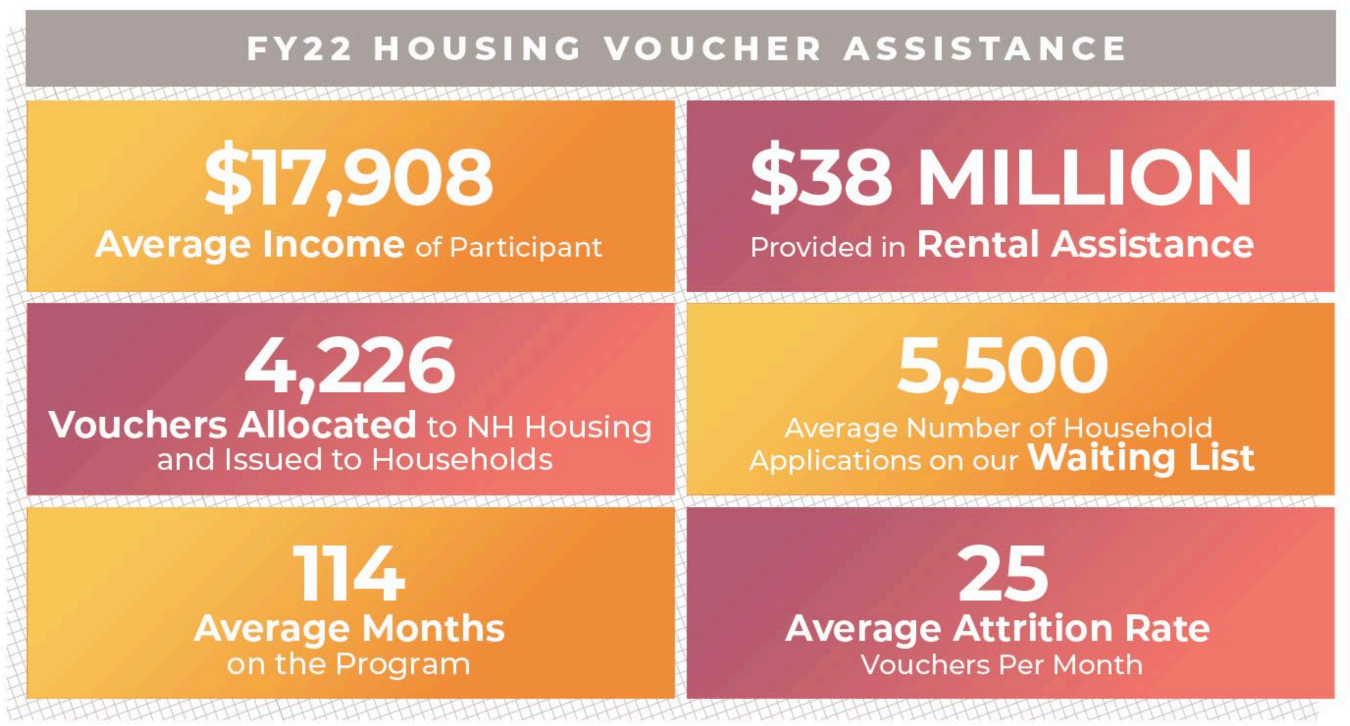
PLYMOUTH – Boulder Point Vet. Housing

BRISTOL - Newfound River Apts.

ASSISTED HOUSING DIVISION

- **Housing Choice Vouchers**
  (Section 8 vouchers)
  Direct assistance to low-income households through HUD program

- **Other Assistance Programs**
  - Family Self-Sufficiency financial & employment coaching
  - Voucher Assisted Mortgage Option
  - Veterans Affairs Supportive Housing Vouchers
  - Moving to Work Grants
  - Landlord Incentives

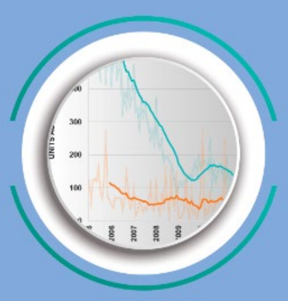


RESEARCH • ENGAGEMENT • POLICY

- Housing Studies and Reports
- Annual Residential Rental Cost Survey
- Housing Advocacy/Technical Assistance and grants
- Housing Planning Reports (state & federal)
- Conferences focused on housing issues and policies
- InvestNH Municipal Planning & Zoning Grants

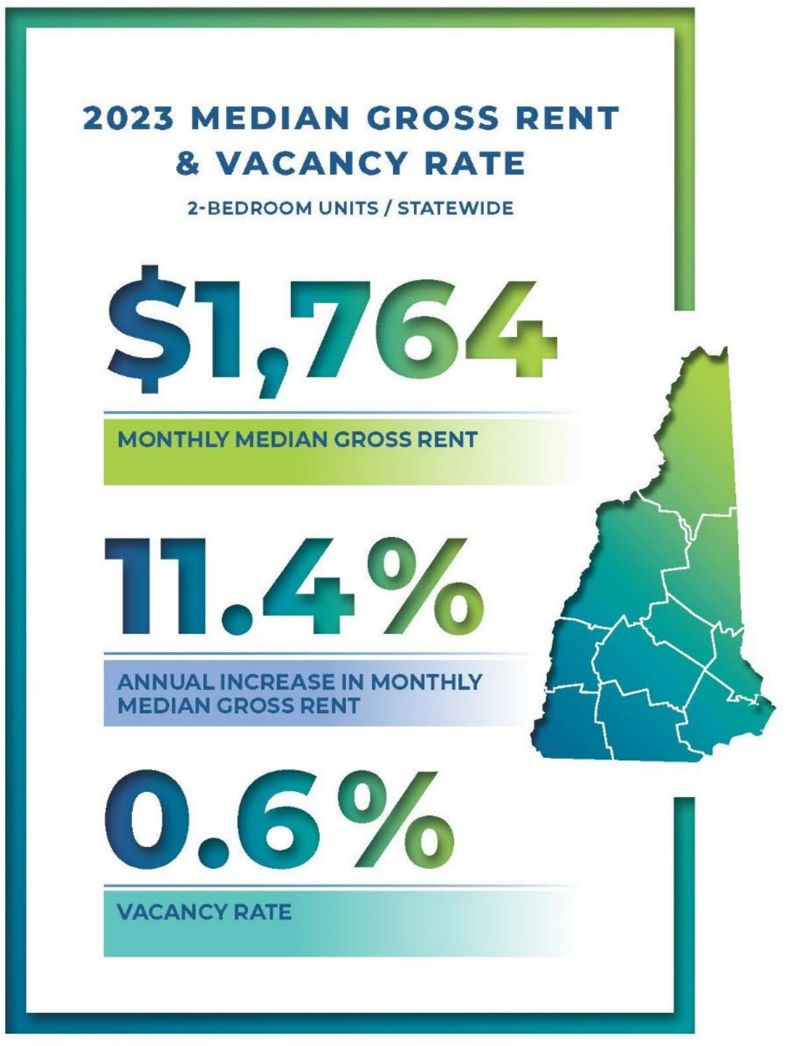
HOUSING MARKET

SNAPSHOT



- **Rental Market**
- **Purchase Market**
- **Market Trends**
- **How Much Housing Does NH Need?**

2023 RESIDENTIAL RENTAL COST SURVEY



MEDIAN GROSS RENTAL COST

$1,900
$1,800
$1,700
$1,600
$1,500
$1,400
$1,300
$1,200
$1,100
$1,000
$900
$800
$700

2014
2017
2020
2023

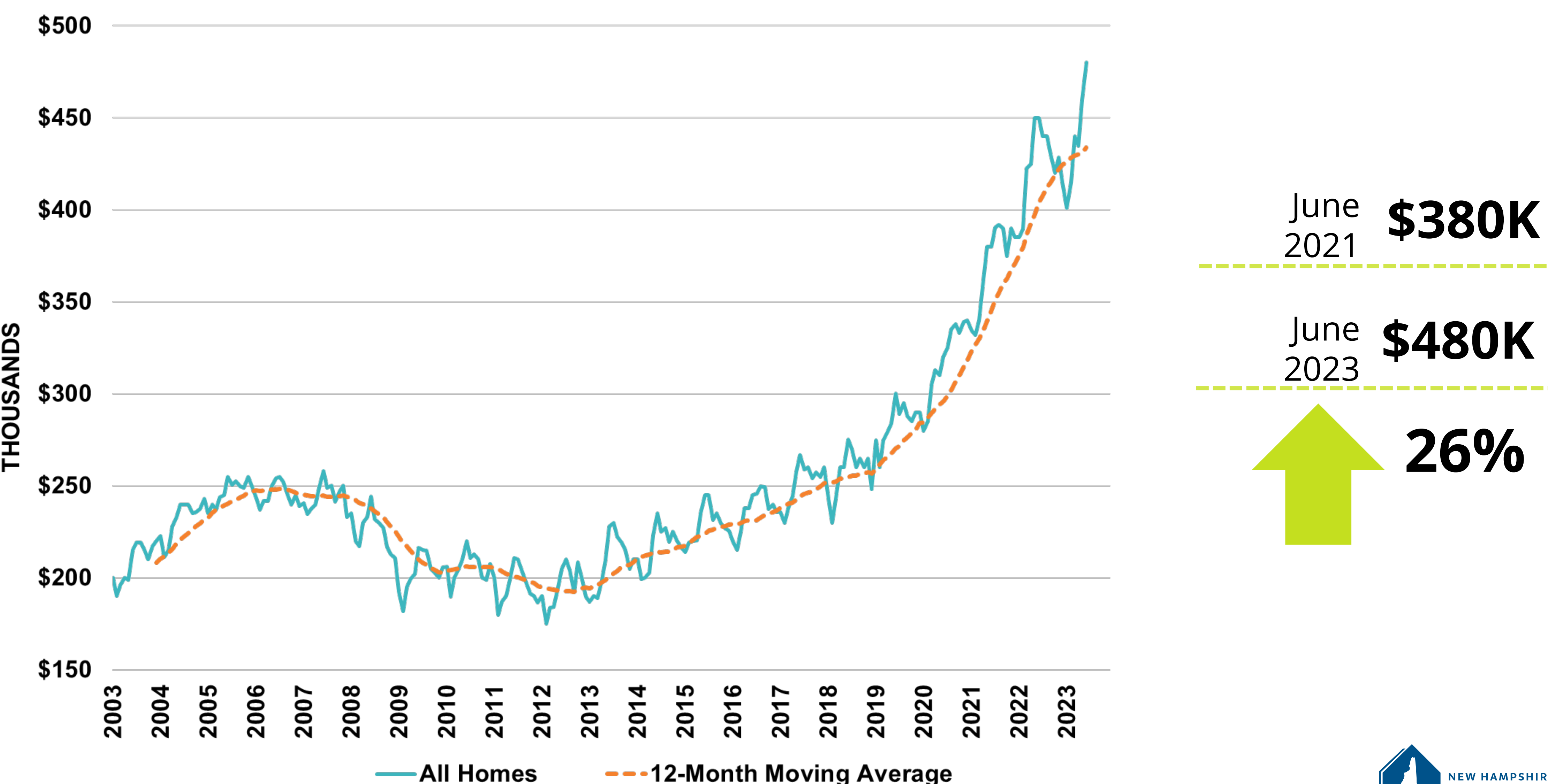
$1,764
$1,644
$1,296
$1,177

2-Bedroom Median Gross Rent
All Units Median Gross Rent

+36%
+40%
2018-2023
Percent Change

Residential Purchase Market Trends

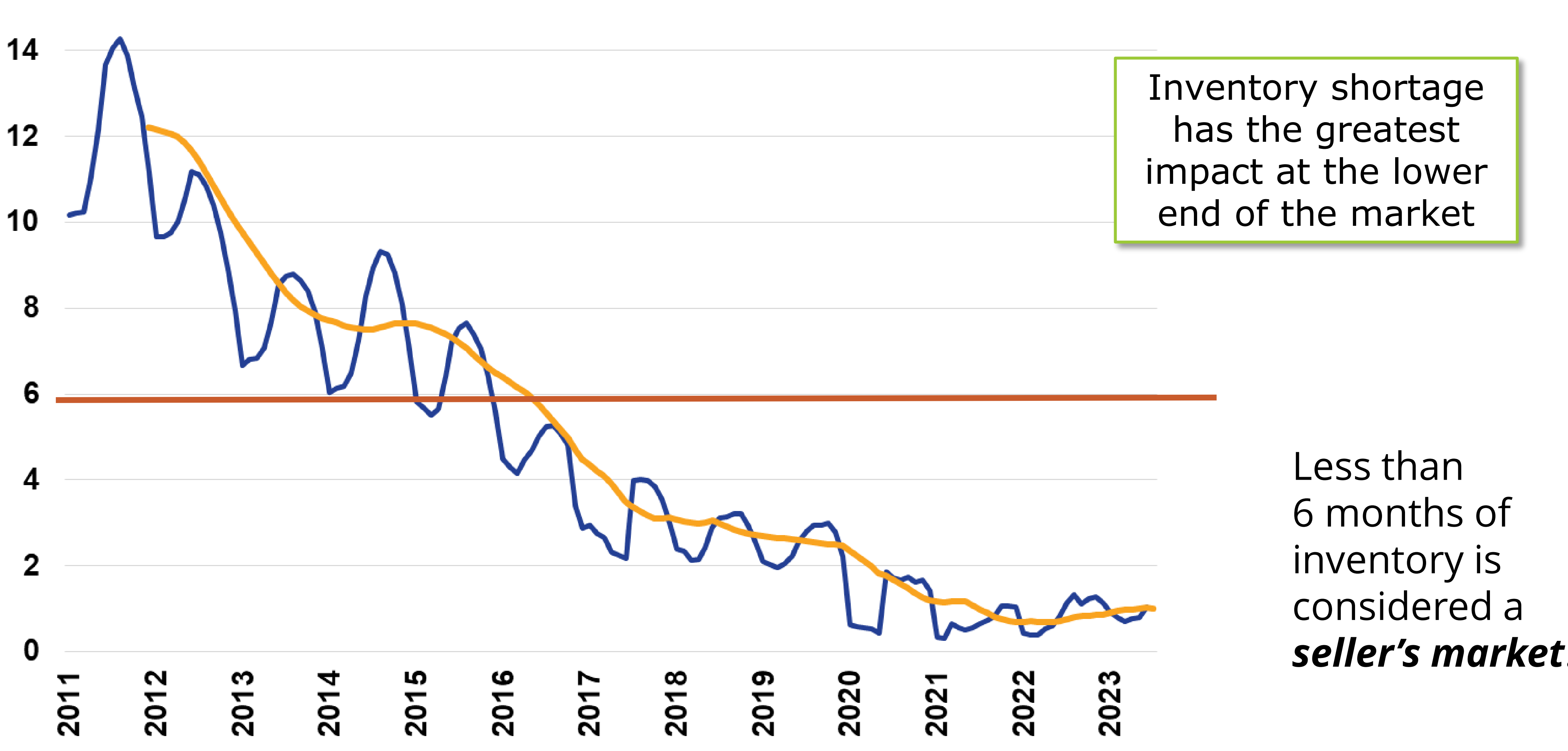
SINGLE-FAMILY MEDIAN SALES PRICE



Source: PrimeMLS

SINGLE-FAMILY HOUSING INVENTORY

Months to absorb active listings at prior 12 months' sales pace



Source: PrimeMLS

INTEREST RATES

PERCENT

9
8
7
6
5
4
3
2
1
0

2003 2005 2007 2009 2011 2013 2015 2017 2019 2021 2023

6.71%

Source: Freddie Mac Primary National Mortgage Market Survey, Average 30-Year Fixed Rate

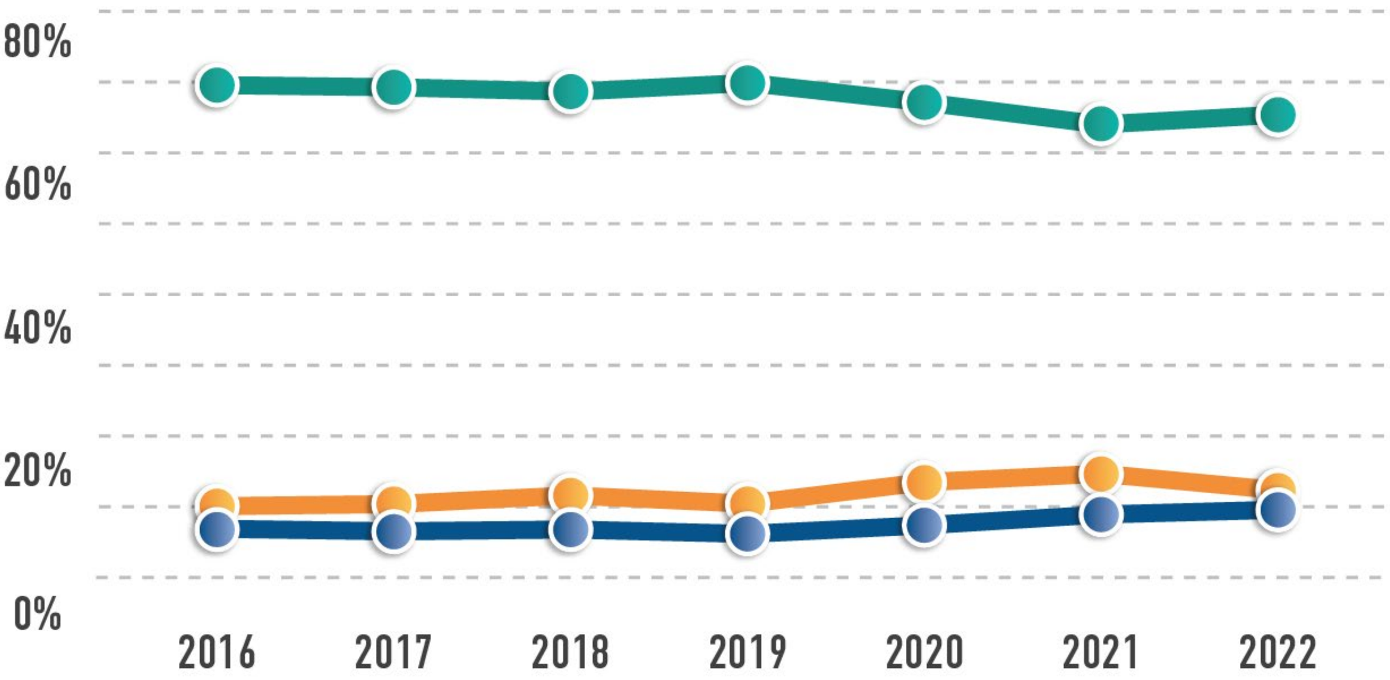
IMPACT OF INTEREST RATES

3.0% INTEREST RATE	4.0% INTEREST RATE	5.0% INTEREST RATE	6.0% INTEREST RATE	7.0% INTEREST RATE
$1,602 PER MONTH	$1,814 PER MONTH	$2,040 PER MONTH	$2,278 PER MONTH	$2,528 PER MONTH

Interest rate and payments calculated based on $400,000 home with 5% down payment, 30-year mortgage.
Per-month cost reflects principal and interest only, excludes estimated insurance and taxes.

WHERE DO NH HOMEBUYERS COME FROM?

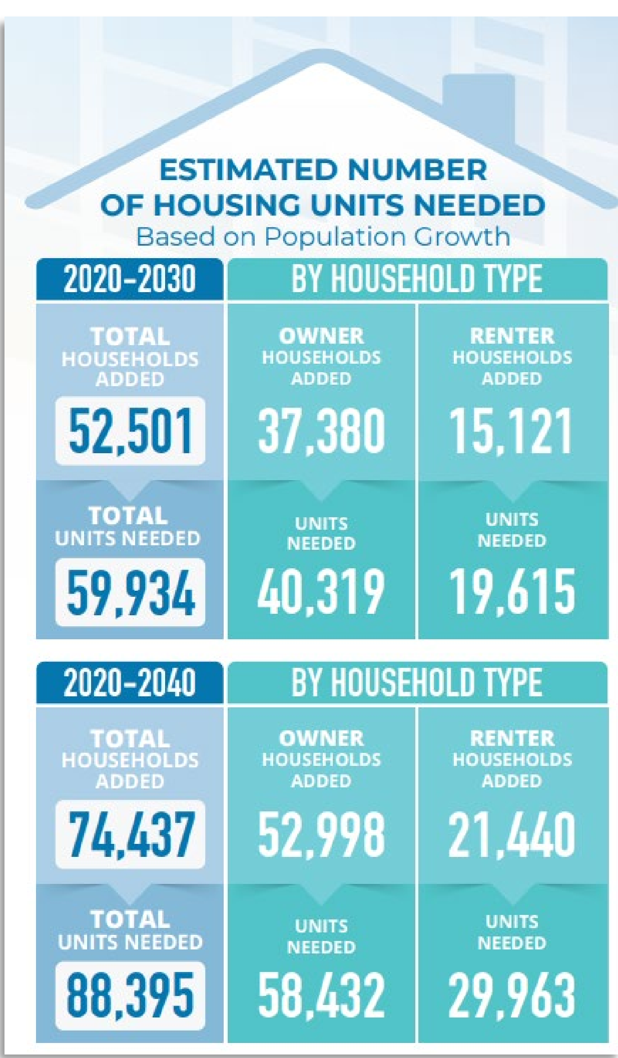
	2016	2017	2018	2019	2020	2020	2022
NH	74.7%	74.6%	73.7%	74.8%	71.5%	68.4%	69.8%
MA	14.7%	14.9%	15.7%	14.9%	17.8%	19.0%	16.4%
Other	10.6%	10.5%	10.6%	10.3%	10.7%	12.6%	13.8%



- Percentage of overall NH home sales
- Modest increase in buyers from “away”

Source: Warren Group; NH Housing

HOW MUCH HOUSING DOES NH NEED?



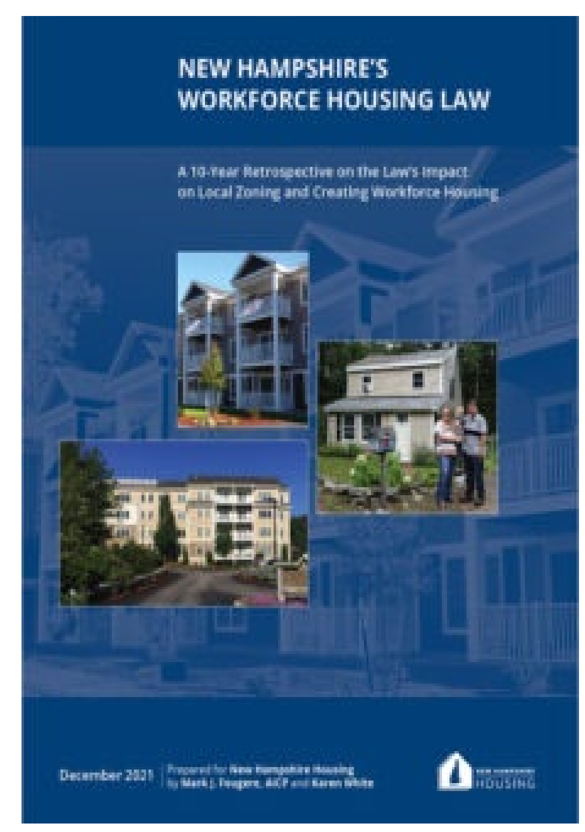
BASED ON ESTIMATED POPULATION GROWTH:

Almost 60,000 Units Between 2020 and 2030
Nearly 90,000 Units Between 2020 And 2040

- **A total of 23,670 housing units is needed today:** This is New Hampshire's current housing shortage.
- **Additional funding & financing tools to support development of single-family & multifamily housing are key.** More state and federal funding sources have been allocated in recent years, but more is needed.
- **Through planning and zoning changes in our communities,** we will be able to add different types of housing to meet the needs of NH's people, regardless of their income or age or where they live in the state.

WHAT HAS THE STATE DONE?

- Workforce Housing Law, 2008
  - All municipalities must allow a “reasonable and realistic opportunity” for the development of workforce housing
- Accessory Dwelling Unit Law, 2016
  - Municipalities required to allow attached ADUs
- Housing Appeals Board, 2020
  - Alternative to trial court providing accelerated and less expensive appeals of local decisions on housing development
- Community Toolbox, 2022
  - Variety of measures to improve local development process



WHAT IS THE STATE DOING?

- Biennial State Budget (HB 2)
  - $25M for Affordable Housing Fund (plus $5M annual dedication from RETT)
  - $10M for InvestNH
  - $5M for "Housing Champions" Program
    - *3 municipal grant programs established*
- House Special Committee on Housing
- Next year: ADUs, manufactured housing, permit processes

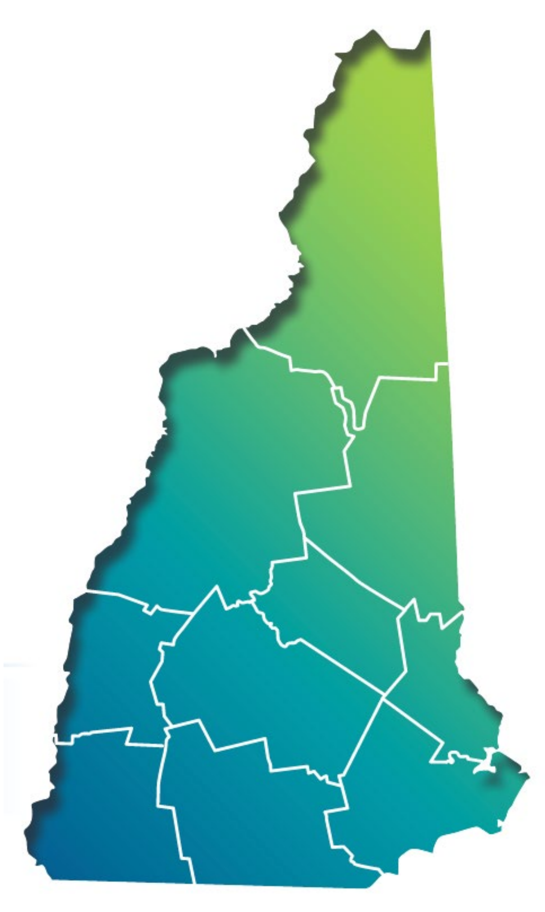
INVEST NH INITIATIVE

- InvestNH is a $100 million fund to accelerate the approval and construction of affordable workforce housing in NH (NHBEA & NH Housing)
- Funded through the Governor's Office for Emergency Relief and Recovery using the state's allocation of Fiscal Recovery Funds
- Capital subsidy to provide financing to eligible developers

InvestNH Municipal Planning & Zoning Grant ($5 million)

- Grant funding and community engagement training to support municipalities as they take steps toward regulatory change
- $4.3 million granted to 64 unique communities
- NHHOPgrants.org

HOUSING CHALLENGES IN NH



- **Rising home prices, increasing rents – very low inventory of homes for sale and apartments to rent**
- **Mismatch of housing stock for a changing demographic & economy**
  - Demand for similar types of housing (older & younger)
  - What are the housing options we have now?
  - What do current and future residents of the region need?
  - What do we allow?
- **Local resistance to housing development**
- **Economic conditions & influences**
  - Supply, demand, interest rates, insufficient inventory
  - The need
- **A range of solutions is needed**

ROB DAPICE

Executive Director / CEO

603-472-8623

NHHousing.org

info@nhhfa.org

Richie's Story

- Richie was homeless and addicted to alcohol, begging for money and sleeping under a bridge.
- He ended up in the hospital due to his deteriorating health, with doctors doubting he would survive detox.
- Richie was put into a coma, waking up sober but with nerve damage that affected his ability to walk.
- He eventually moved into The Upper Valley Haven’s Hixon House Shelter allowing him to continue medical treatment in the Upper Valley.

Parkhurst Housing
Lebanon, NH

- Twin Pines' Parkhurst House provides housing for chronically homeless individuals, like Richie.
- When Richie moved into his one-bedroom apartment in Parkhurst Community Housing, it was his first home in eight years.
- He received support from an on-site case manager, had easy access to physical therapy, and was able to utilize a free bus for medical appointments.
- Richie developed strong friendships through his church and AA.

Richie Today

- Regained mobility through hospitalizations and surgeries
- Achieved sobriety through residential treatment programs
- Continued receiving assistance from Haven's case worker and TPH supportive services staff
- Transitioned from Parkhurst Apartments to Tracy Street Apartments in West Lebanon
- Embraced art as a crucial part of maintaining sobriety
- His move out of Parkhurst created a fresh start for another homeless individual

Up Next

- Next session: Food and Nutrition on October 11
- Please submit your cases/questions, track your attendance for CME/CNE and view course resources at the: DH ECHO Connect site
- Recordings will be posted on the D-H ECHO website https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials

Connect with this learning community

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  - Organization
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  - Email

SCIENCE AND PRACTICES TO KEEP PEOPLE SAFE AND BUSINESSES PRODUCTIVE AS COVID-19 CONTINUES

SUMMARY OF THIS ECHO

OF SESSIONS

12

WHAT THIS ECHO WILL FOCUS ON

As the COVID-19 pandemic continues, understanding of the virus and strategies to keep people safely engaged in productive work and business encounters is evolving. This second DH ECHO series on COVID-19 for employers and organizational leaders will examine advances in scientific understanding of COVID-19 and its prevention and management. It will explore timely new topics of importance such as strategic distribution of COVID vaccines, emerging perspectives on aerosols and ventilation, business travel considerations, and operationalization of pods to safely maximize social and work interactions. It will update more familiar topics such as PPE, surface and facility hygiene, regulatory changes, and emotional health during COVID with the latest information. Critical new topics will be integrated as they emerge. Sessions include a brief didactic and robust discussion.

WHEN IT STARTS	WHEN IT ENDS	LINK TO PARTICIPATE	LINK TO COHORTS
1/27/2021	6/30/2021	Navigate to ECHO	View Cohort Roster

SUMMARY OF EACH SESSION

WELCOME to the

Rural Health Equity ECHO:
Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 3- Food and Nutrition
October, 11 2023

Please let us know you are here: Type your name, email, organization into CHAT

Series Learning Objectives

After participating in the Rural Health Equity ECHO participants will be able to:

- Explain rural health equity and the complex issues that come together to produce unfair health outcomes in northern New England (NNE).
- Apply key equity principles to working with others in order to overcome barriers to health equity in NNE.
- Engage in actions that promote greater health equity in NNE.

Today's Program

- Brief housekeeping
- Didactic: *Food and Nutrition, Chelsey Canavan*
- Case presentation: *Hanna Flanders*
- Case discussion
- Summary
- Up Next

Notes

- Please let us know you are here. Enter name, email, organization, questions in Chat
- Pre course survey: https://redcap.hitchcock.org/redcap/surveys/?s=949FNFW3APN34KKA
- Raise virtual hand or enter comments in chat at any time. We will call on you when it works. Please mute otherwise.
- To protect individual privacy, please use non-identifying information when discussing cases.
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CME

- One hour of free CME is available for every session attended, up to 8 sessions.
- Track participation via DH ECHO Connect site
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ECHO Participant Demographics
Total Registrants: # 182

Medical Professional	21
Researcher	2
Student	2
Community Service Organization	2
Community Based Health Worker	11
Policy Maker/Advocate	3
Administrative	18
Public Health	33
Educator	18
Other	12

Core Panel

- Elisabeth Wilson, MD, MPH, MS-HPEd - Chair and Professor, Department of Community and Family Medicine, Dartmouth Health and Geisel School of Medicine
- Kris van Bergen-Buteau, CPHQ- Director, Workforce Development & Public Health Programs, North Country Health Consortium
- Rudy Fedrizzi, MD- Public Health Services District Director, Vermont Department of Health
- Andrew Loehrer, MD, MPH- Staff Physician, Dartmouth Health
- Andy Lowe- Executive Director, New England Rural Health Association
- Angela Zhang, MSW - Program Services Director, LISTEN community services
- Chelsey Canavan, MSPH - Manager, Center for Advancing Rural Health Equity

Food and nutrition security

Rural Health Equity ECHO
Oct 11, 2023

Chelsey Canavan, MSPH

Food security means access by all people at all times to enough food for an active, healthy life.

Nutrition security means consistent access to and availability and affordability of foods and beverages that promote well-being, while preventing—and, if needed, treating—disease.

Mozaffarian D, Fleischhacker S, Andrés JR. Prioritizing Nutrition Security in the US. *JAMA.* 2021;325(16):1605–1606. doi:10.1001/jama.2021.1915.
Coleman-Jensen, Alisha, Matthew P. Rabbitt, Christian A. Gregory, Anita Singh, September 2022. Household Food Security in the United States in 2021, ERR-309, U.S. Department of Agriculture, Economic Research Service

Food insecurity is associated with:

Children

- Adverse birth outcomes
- Overweight & obesity
- Anemia
- Asthma
- Depression
- Suicidal ideation
- Cognitive development
- Academic performance

Adolescents

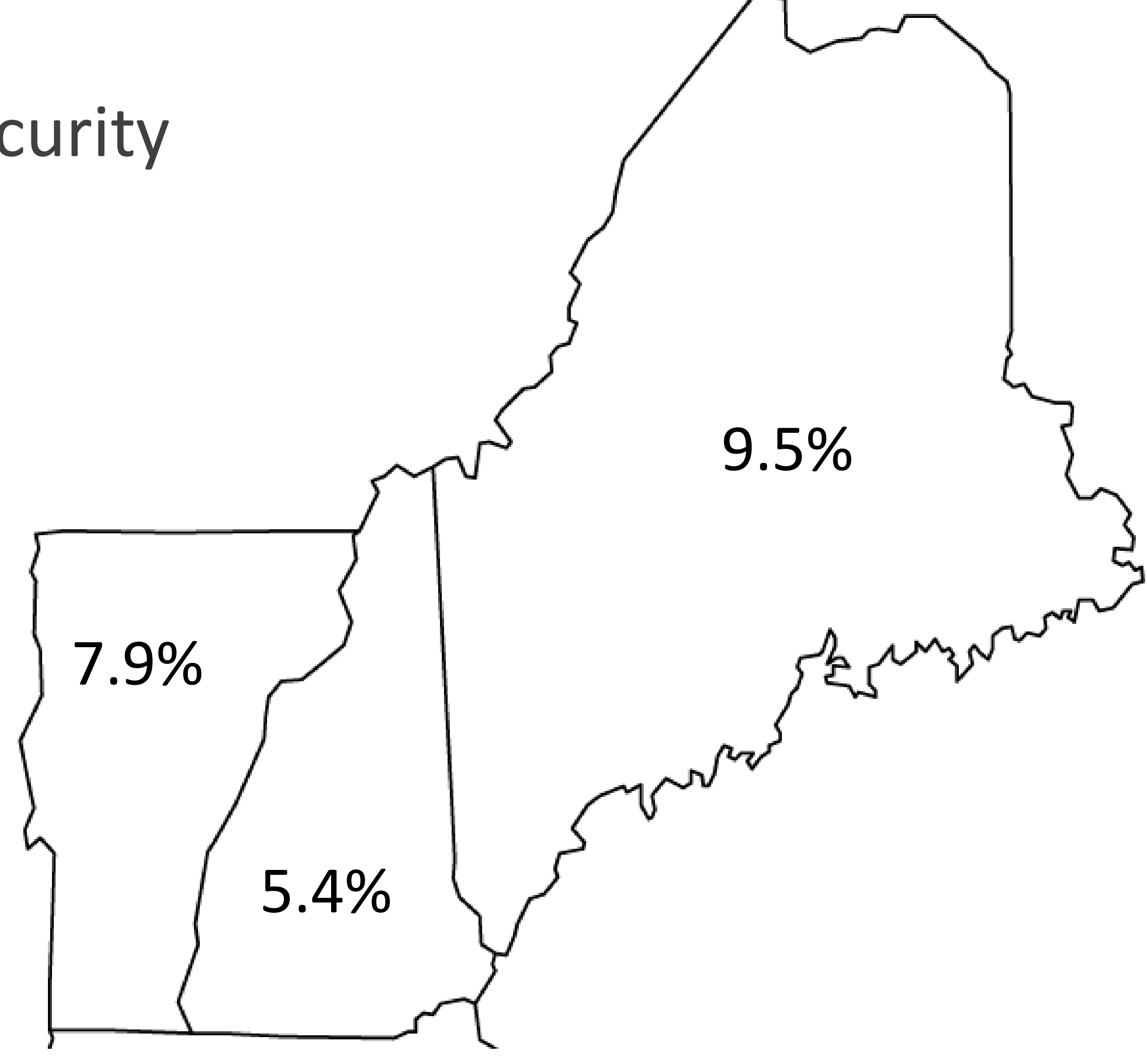
- Sexually transmitted infections
- Substance use
- Anxiety, mental heath
- Nutrient deficiencies
- Anemia
- Academic performance

Adults

- Overweight & obesity
- Diabetes
- Hypertension
- Heart disease
- Cancer
- Depression
- Anxiety
- Sleep disorders

Gundersen C, 2015; Simonovich SD 2020; Shankar P 2017; Nagata JM 2021; Arenas D 2019; Gregory CA 2021

Prevalence of food insecurity in our states



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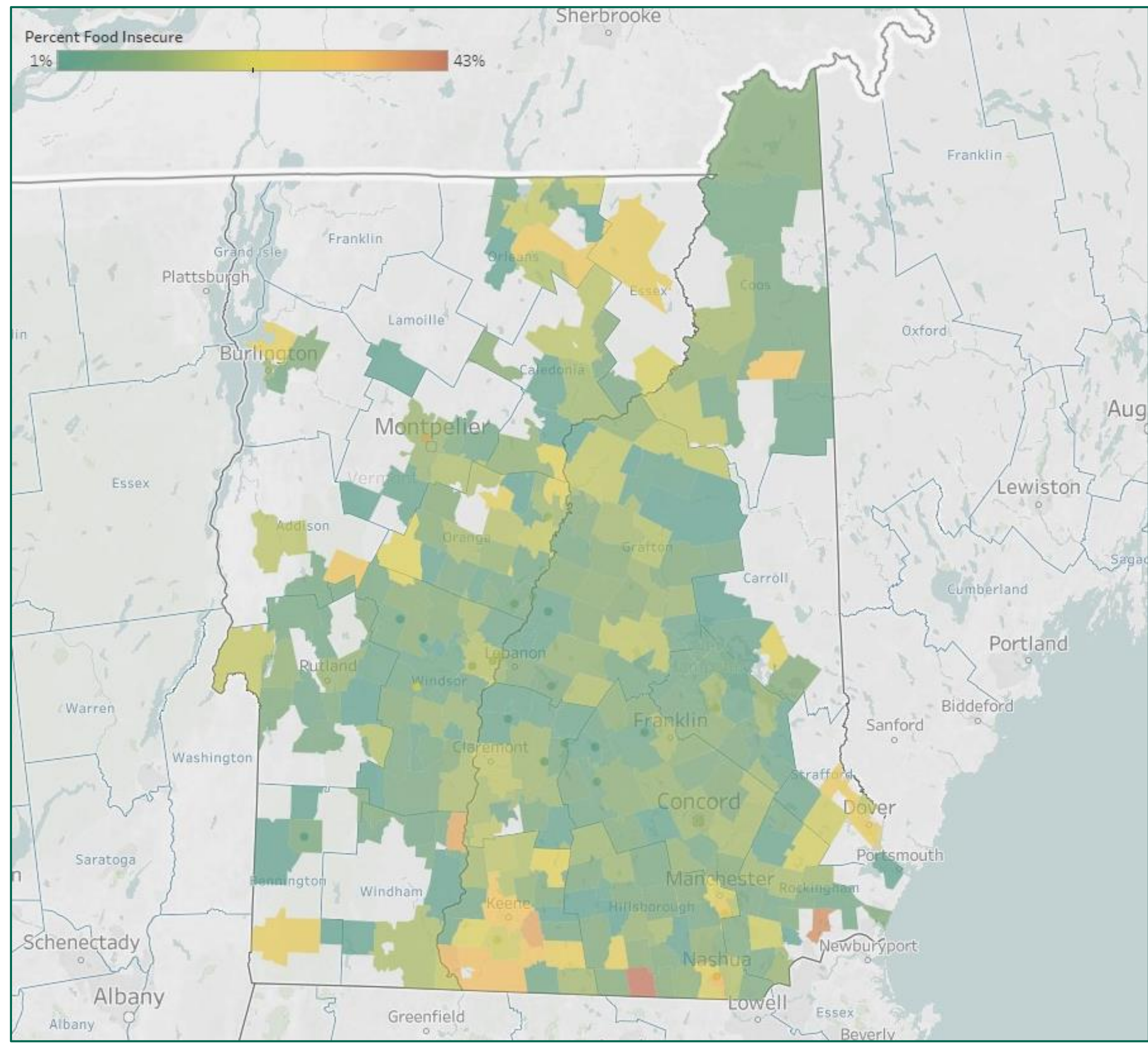


Food insecurity among DH primary care patients by zip code (2022)

Average ~10-11%

It’s not just about calories

Red meat consumption associated with higher mortality; risk of type 2 diabetes, cardiovascular disease, certain types of cancer.

Ultra processed food consumption associated with higher mortality, obesity, cancer, depression.

Plant-foods such as whole grains, vegetables, fruits, nuts and legumes are protective factors for heart disease, diabetes, and overall mortality.

Willett, W., Rockström, J., et al. (2019). Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems. The Lancet (British Edition), 393(10170), 447–492. https://doi.org/10.1016/S0140-6736(18)31788-4;
Srour, B., & Touvier, M. (2021). Ultra-processed foods and human health: What do we already know and what will further research tell us? EClinicalMedicine, 32, 100747–100747. https://doi.org/10.1016/j.eclinm.2021.100747
Zheng Y, Li Y, Satija A, Pan A, Sotos-Prieto M, Rimm E, Willett WC, Hu FB. Association of changes in red meat consumption with total and cause specific mortality among US women and men: two prospective cohort studies. BMJ. 2019 Jun 12;365:l2110. doi: 10.1136/bmj.l2110. PMID: 31189526; PMCID: PMC6559336.

What would an equitable and sustainable food system look like?

"Food production is the largest cause of global environmental change.

Agriculture occupies about **40% of global land**, and food production is responsible for up to **30% of global greenhouse-gas emissions** and **70% of freshwater use**."

Willett, W., Rockström, J., et al. (2019). Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems. *The Lancet (British Edition)*, *393*(10170), 447–492. https://doi.org/10.1016/S0140-6736(18)31788-4

Greenhouse gas emissions per 1000 kilocalories

Greenhouse gas emissions[1] are measured in carbon dioxide-equivalents (CO_2eq)[2] .

Food	Emissions
Beef (beef herd)	36.44 kg
Prawns (farmed)	26.09 kg
Lamb & Mutton	12.53 kg
Beef (dairy herd)	12.2 kg
Tomatoes	11 kg
Fish (farmed)	7.61 kg
Cheese	6.17 kg
Poultry Meat	5.34 kg
Milk	5.25 kg
Pig Meat	5.15 kg
Eggs	3.24 kg
Brassicas	3 kg
Bananas	1.43 kg
Cassava	1.36 kg
Citrus Fruit	1.22 kg
Rice	1.21 kg
Root Vegetables	1.16 kg
Oatmeal	0.95 kg
Apples	0.9 kg
Palm Oil	0.83 kg
Potatoes	0.63 kg
Wheat & Rye	0.59 kg
Groundnuts	0.56 kg
Other Pulses	0.52 kg
Maize	0.38 kg
Peas	0.28 kg
Nuts	0.07 kg

J Poore, T Nemecek. Reducing food’s environmental impacts through producers and consumers. *Science* **360**, 987-992 (2018). DOI: 10.1126/science.aaq0216

FOOD SYSTEM

PRODUCTION, STORAGE, TRANSFORMATION, TRANSPORTATION

FOOD ENVIRONMENT

External Domain **Personal domain**

External Domain

AVAILABILITY

Presence of food sources or products

PRICES

Monetary value of food products

VENDOR AND PRODUCT PROPERTIES

Vendor properties (typology, opening hours, services) and product properties (food quality, composition, safety, level of processing, shelf-life, packaging)

MARKETING AND REGULATION

Promotional information, branding, advertising, sponsorship, labelling, policies

Personal domain

ACCESSIBILITY

Physical distance, time, space and place, individual activity spaces, daily mobility, mode of transport

AFFORDABILITY

Purchasing power

CONVENIENCE

Relative time and effort of preparing, cooking and consuming food product, time allocation

DESIRABILITY

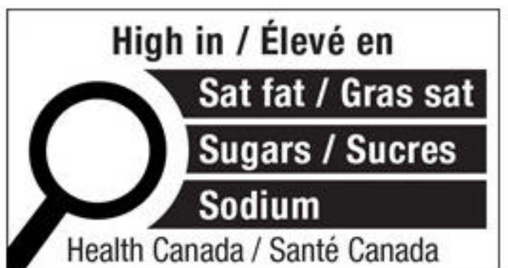
Preferences, acceptability, tastes, desires, attitudes, culture, knowledge and skills

ACQUISITION AND CONSUMPTION

HEALTH AND NUTRITION OUTCOMES

Turner, C., et al. (2018). Concepts and critical perspectives for food environment research: A global framework with implications for action in low- and middle-income countries. *Global Food Security*, *18*, 93–101. https://doi.org/10.1016/j.gfs.2018.08.003

What works?



Sat fat / Gras sat
High in
Sugars / Sucres

tes
in

considering similar changes and congressional
d free meals to all kids nationwide.

Questions?

Comments?

Ideas?

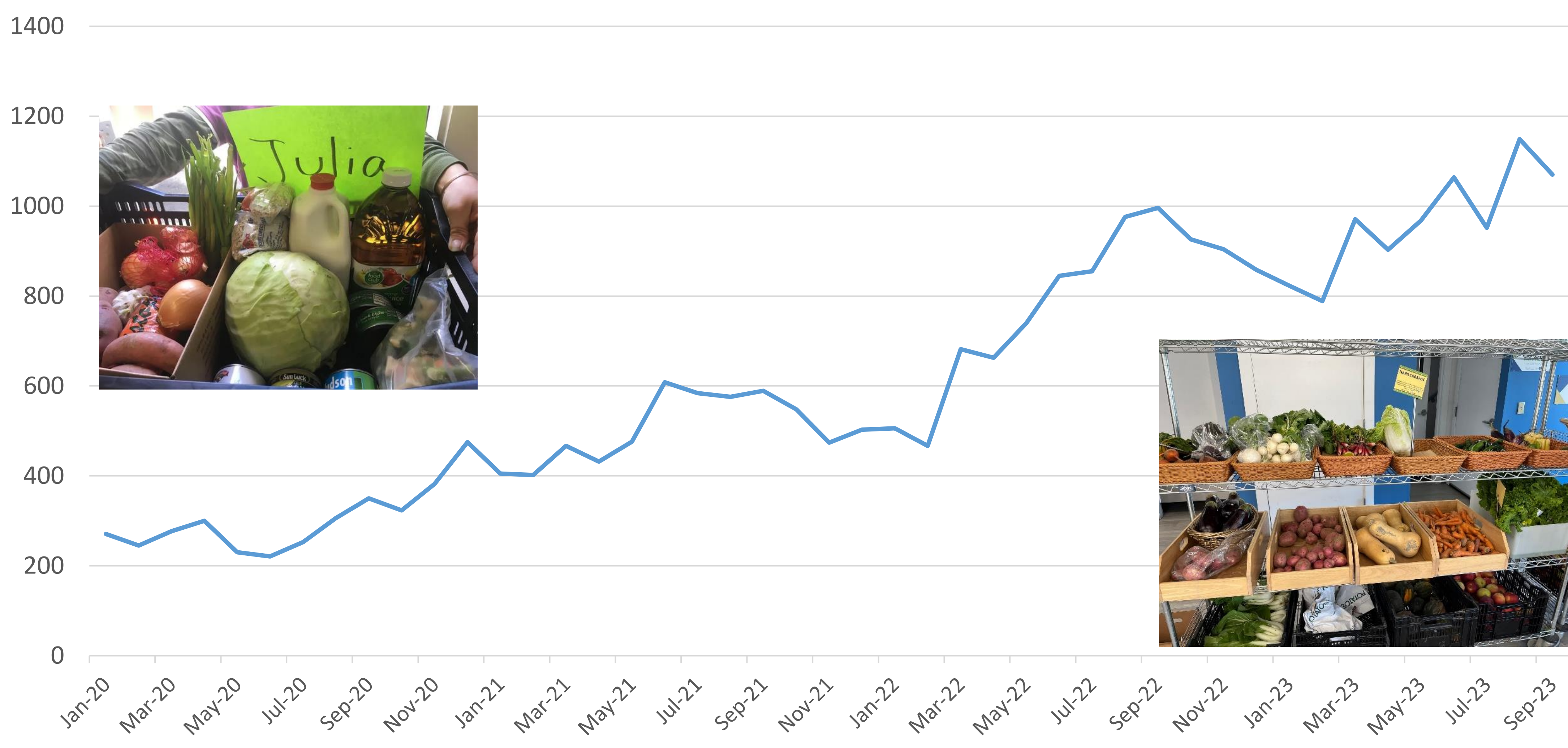
LISTEN Community Services

Food Pantry Demand & Growth

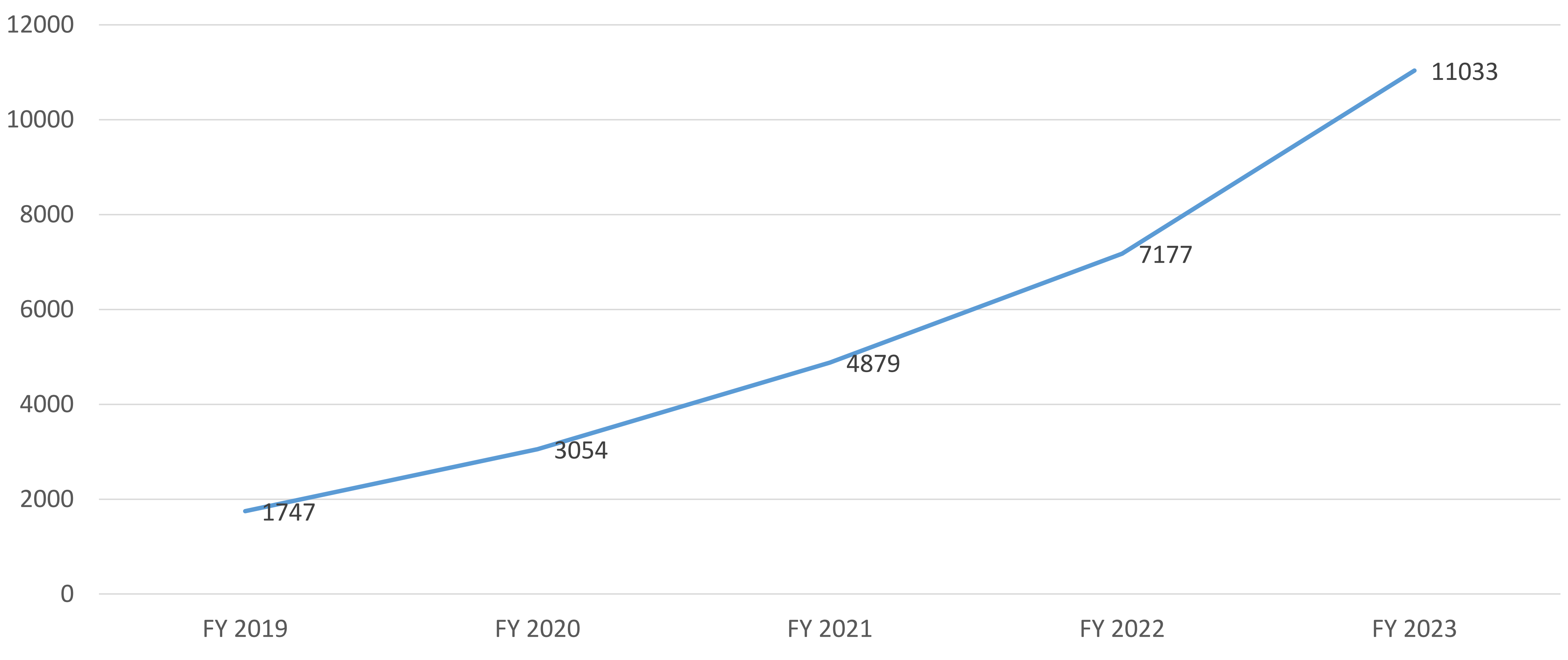
LISTEN Food Pantry

- Based in Lebanon, NH
- Open 5 days a week (Mon 12-4, Tu-Fri 10-4)
- Offer fresh produce, frozen meat, and other nonperishable goods
- 1 F/T Food Pantry Manager, 3 P/T Food Pantry Assistants (2 FTE total)
- 200 volunteers

LISTEN Food Pantry Visits



Food Pantry Visits by Year



Wheat BRAN FLAKES
RAISIN BRAN
RAISIN BRAN
FROSTED FLAKES
The Sound of Breakfast
SPAGHETTI SAUCE
Campbell's
premium diapers

Up Next

- Next session: Transportation on October 25
- Please submit your cases/questions, track your attendance for CME/CNE and view course resources at the: DH ECHO Connect site
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SCIENCE AND PRACTICES TO KEEP PEOPLE SAFE AND BUSINESSES PRODUCTIVE AS COVID-19 CONTINUES

SUMMARY OF THIS ECHO

OF SESSIONS

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SUMMARY OF EACH SESSION

WELCOME to the

Rural Health Equity ECHO:
Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 4- Transportation
October 25, 2023

Please let us know you are here: Type your name, email, organization into CHAT

Series Learning Objectives

After participating in the Rural Health Equity ECHO participants will be able to:

- Explain rural health equity and the complex issues that come together to produce unfair health outcomes in northern New England (NNE).
- Apply key equity principles to working with others in order to overcome barriers to health equity in NNE.
- Engage in actions that promote greater health equity in NNE.

Today’s Program

- Brief housekeeping
- Didactic: Rural Transit Challenges & Opportunities, Ezekiel Baskin
- Case presentation: Andy Lowe
- Case discussion
- Summary
- Up Next: Childcare

Notes

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ECHO Participant Demographics
Total Registrants: # 184

Medical Professional	74
Public Health	33
Administrative	18
Educator	18
Community Based Health Worker	11
Policy Maker/Advocate	3
Researcher	2
Student	2
Community Service Organization	2
Other	12

Core Panel

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- Chelsey Canavan, MSPH - Manager, Center for Advancing Rural Health Equity

Rural Transit: Challenges & Opportunities

If you live or work rurally:
How many days per week, on average, do you spend time in the car (as driver or passenger)?

If you live or work rurally:
How much time per day, on average, do you spend in the car (as driver or passenger)?

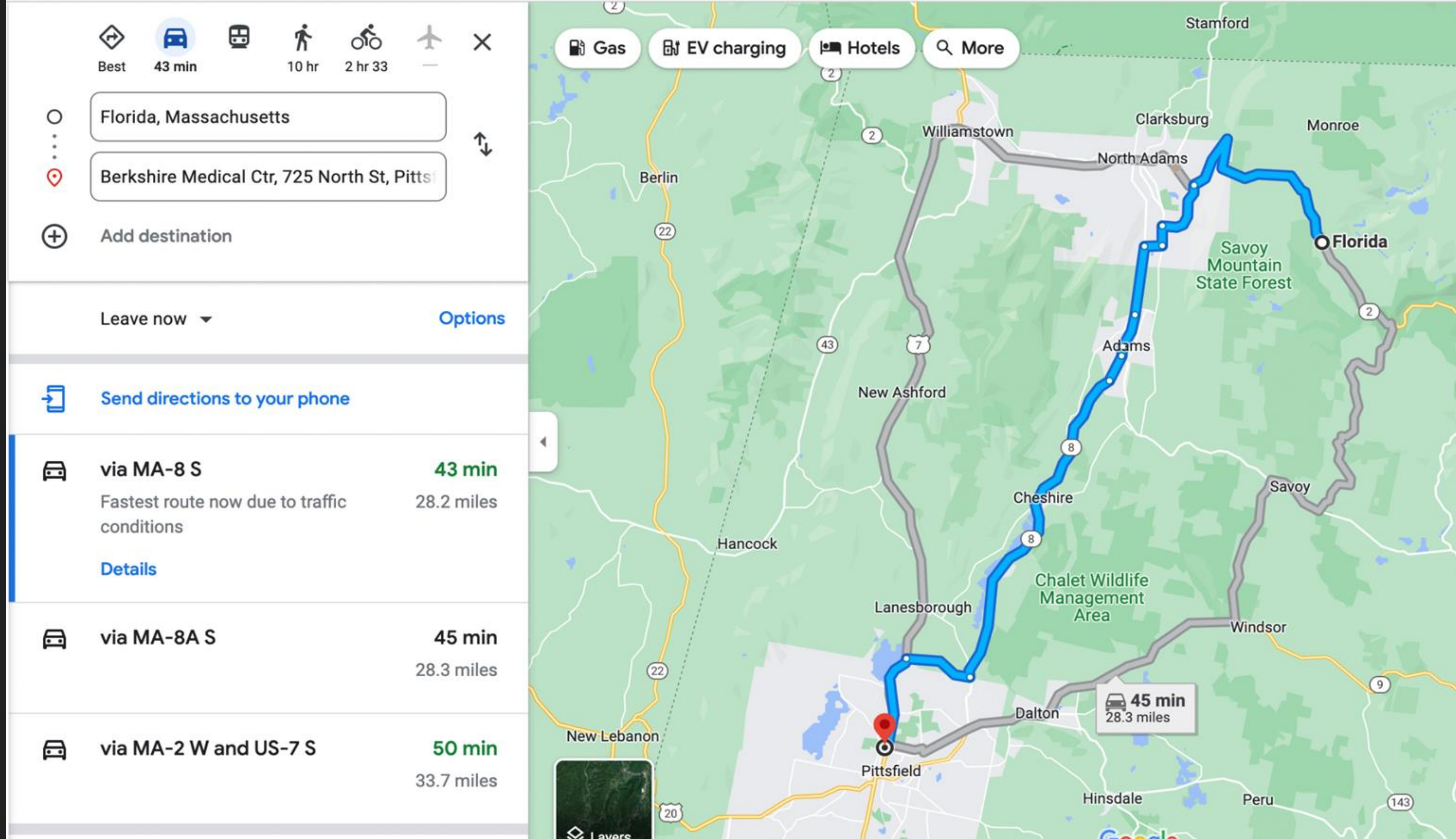
If you live or work rurally:
How many days per week, on average, do you spend time on public transit (e.g. buses, trains, publicly-funded microtransit)?

“Transportation decisions affect everyone, by influencing where they live, how they can get to work and school, whether they can easily access health and other essential services, how they socialize with family members and friends, and ultimately if they can thrive in a physical environment that supports healthy outcomes.”

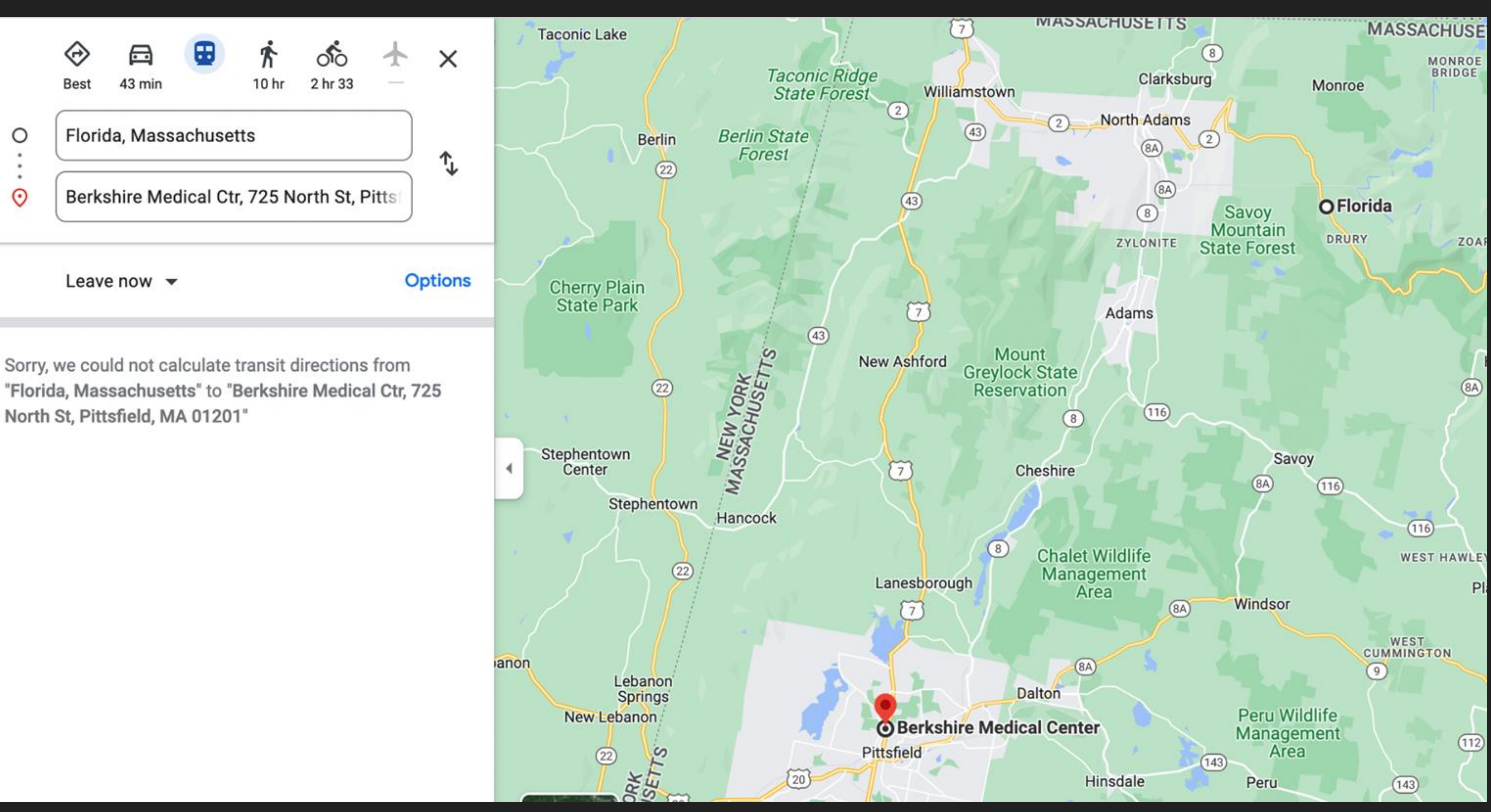
From *Transportation: A Community Driver of Health* (2021)

Transportation is a critical social determinant of health

- Access to healthcare (primary care, emergency, specialty care, preventative care)
- Employment
- Education
- Housing
- Social isolation
- Domestic violence / intimate partner violence
- Walkability & chronic disease



Best
43 min
10 hr
2 hr 33
Florida, Massachusetts
Berkshire Medical Ctr, 725 North St, Pitts
Add destination
Leave now
Options
Send directions to your phone
via MA-8 S
43 min
Fastest route now due to traffic conditions
28.2 miles
Details
via MA-8A S
45 min
28.3 miles
via MA-2 W and US-7 S
50 min
33.7 miles
Gas
EV charging
Hotels
More
Stamford
Clarksburg
Monroe
Williamstown
North Adams
Berlin
Florida
Savoy Mountain State Forest
Adams
New Ashford
Cheshire
Savoy
Hancock
Chalet Wildlife Management Area
Lanesborough
Windsor
45 min
28.3 miles
Dalton
New Lebanon
Pittsfield
Hinsdale
Peru
Layers



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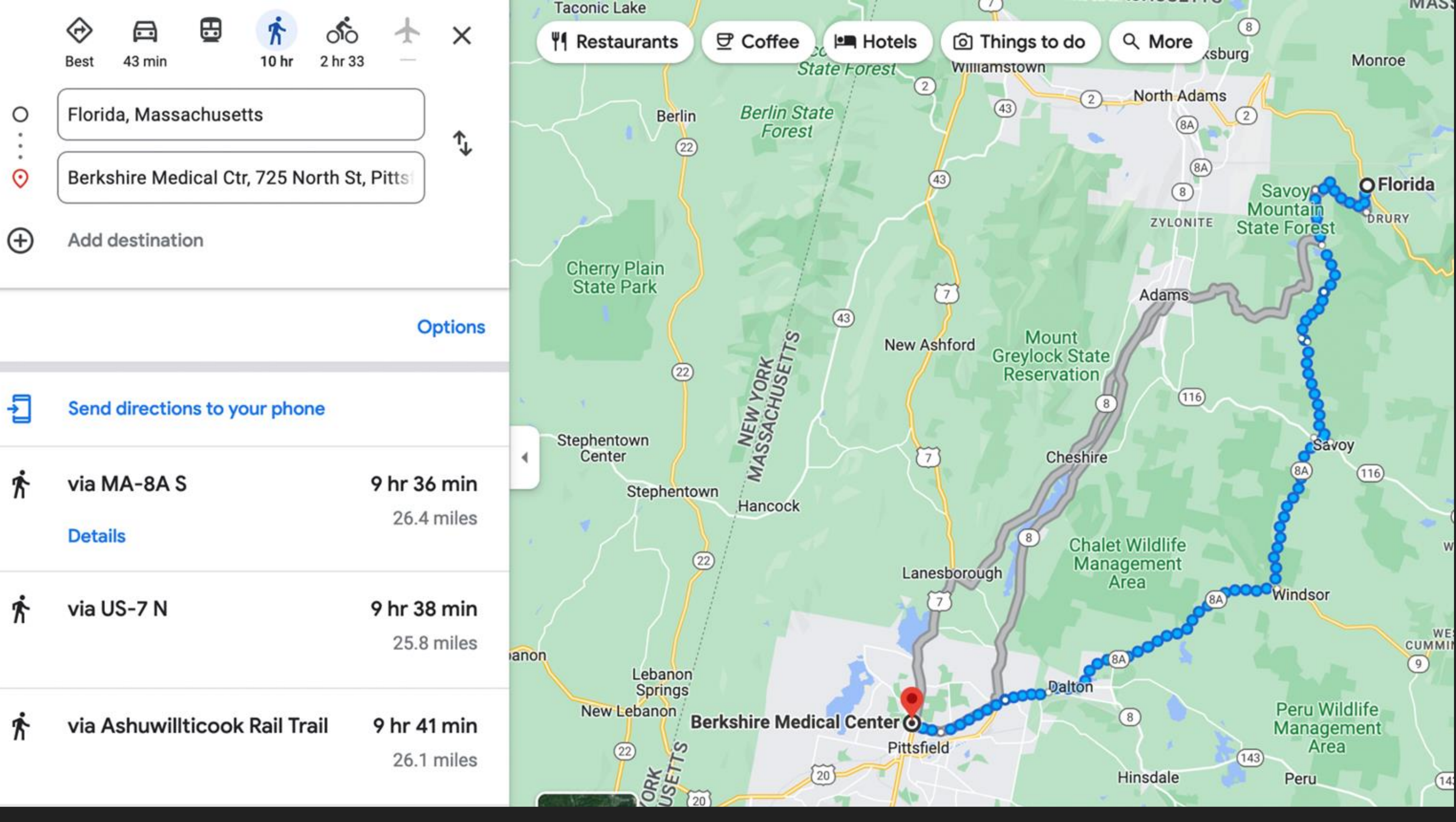
2 hr 33
Florida, Massachusetts
Berkshire Medical Ctr, 725 North St, Pitts
Leave now
Options
Sorry, we could not calculate transit directions from "Florida, Massachusetts" to "Berkshire Medical Ctr, 725 North St, Pittsfield, MA 01201"
Taconic Lake
Taconic Ridge State Forest
Williamstown
Clarksburg
Monroe
North Adams
Berlin
Berlin State Forest
Florida
Savoy Mountain State Forest
ZYLONITE
DRURY
Cherry Plain State Park
Adams
New Ashford
Mount Greylock State Reservation
NEW YORK
MASSACHUSETTS
Stephentown Center
Cheshire
Savoy
Stephentown
Hancock
Chalet Wildlife Management Area
WEST HAWLEY
Lanesborough
Windsor
WEST CUMMINGTON
Lebanon Springs
Dalton
New Lebanon
Berkshire Medical Center
Pittsfield
Peru Wildlife Management Area
Hinsdale
Peru



Best
43 min
10 hr
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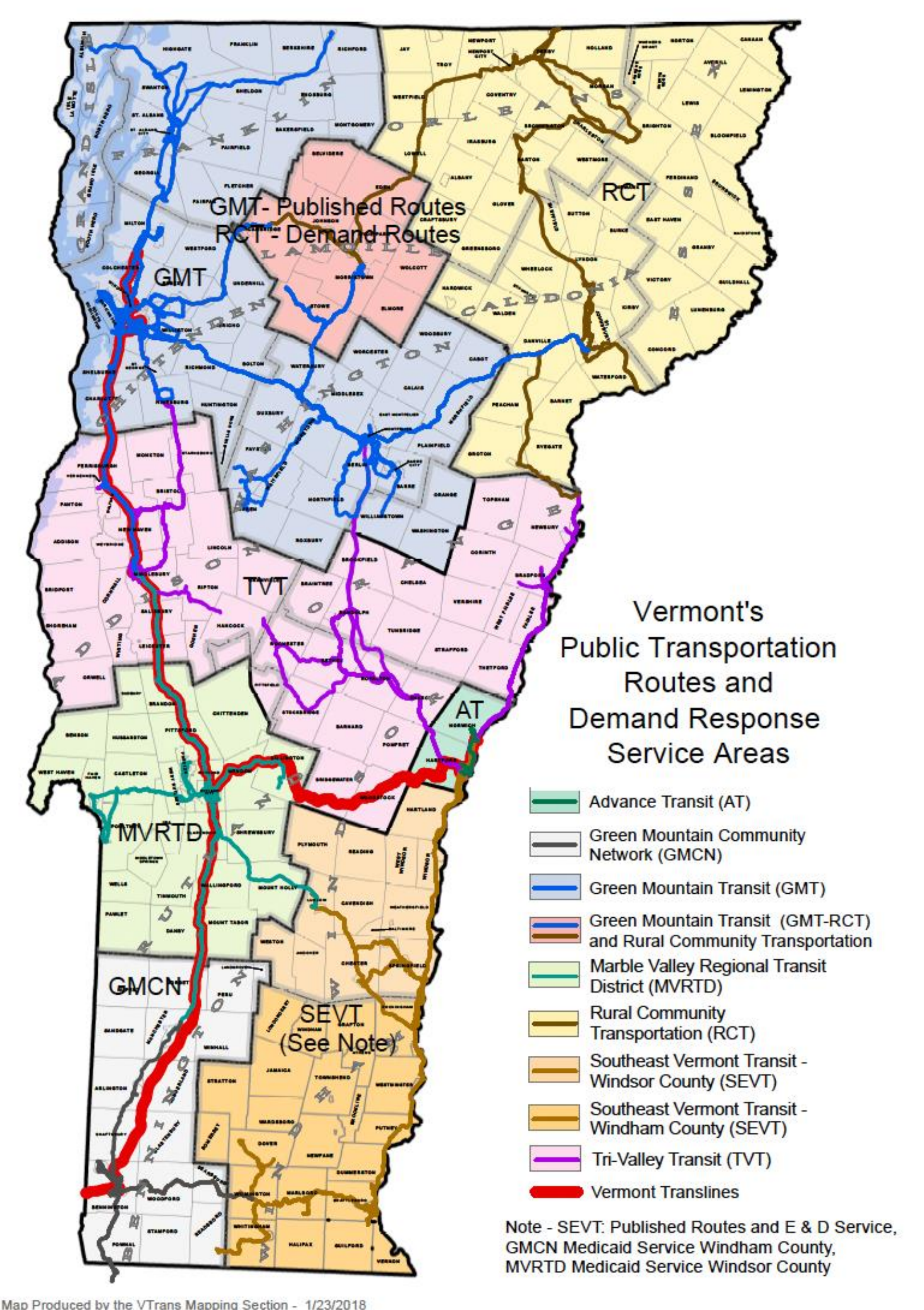
Florida, Massachusetts
Berkshire Medical Ctr, 725 North St, Pitts
Add destination
Options
Send directions to your phone
via MA-8A S
9 hr 36 min
26.4 miles
Details
via US-7 N
9 hr 38 min
25.8 miles
via Ashuwillticook Rail Trail
9 hr 41 min
26.1 miles
Restaurants
Coffee
Hotels
Things to do
More
Taconic Lake
Williamstown
North Adams
Monroe
Berlin
Berlin State Forest
Florida
Savoy Mountain State Forest
DRURY
ZYLONITE
Cherry Plain State Park
Adams
New Ashford
Mount Greylock State Reservation
NEW YORK
MASSACHUSETTS
Stephentown Center
Cheshire
Savoy
Stephentown
Hancock
Chalet Wildlife Management Area
Lanesborough
Windsor
Lebanon Springs
New Lebanon
Berkshire Medical Center
Dalton
Pittsfield
Peru Wildlife Management Area
Hinsdale
Peru

Core Challenges

- Customer Desirability
- Operational Feasibility
- Organizational Capacity
- Financial Viability

*Adapted from Rural Transit Dialogues facilitated by Central MA Regional Planning Commission

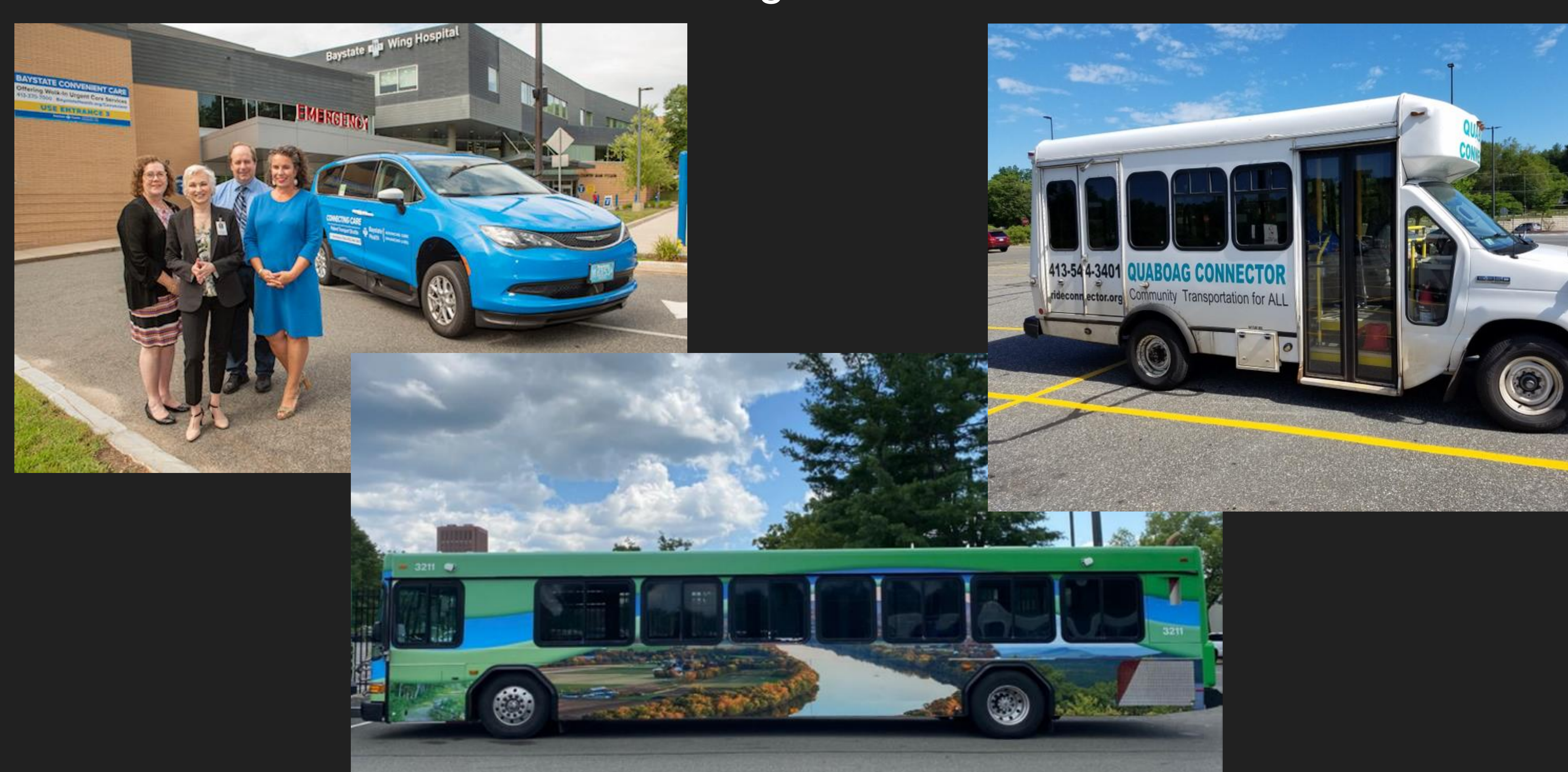


Vermont's
Public Transportation
Routes and
Demand Response
Service Areas
GMT- Published Routes
RCT - Demand Routes
GMT
RCT
TVT
AT
MVRTD
GMCN
SEVT
(See Note)
Advance Transit (AT)
Green Mountain Community Network (GMCN)
Green Mountain Transit (GMT)
Green Mountain Transit (GMT-RCT) and Rural Community Transportation
Marble Valley Regional Transit District (MVRTD)
Rural Community Transportation (RCT)
Southeast Vermont Transit - Windsor County (SEVT)
Southeast Vermont Transit - Windham County (SEVT)
Tri-Valley Transit (TVT)
Vermont Translines
Note - SEVT: Published Routes and E & D Service,
GMCN Medicaid Service Windham County,
MVRTD Medicaid Service Windsor County
Map Produced by the VTrans Mapping Section - 1/23/2018

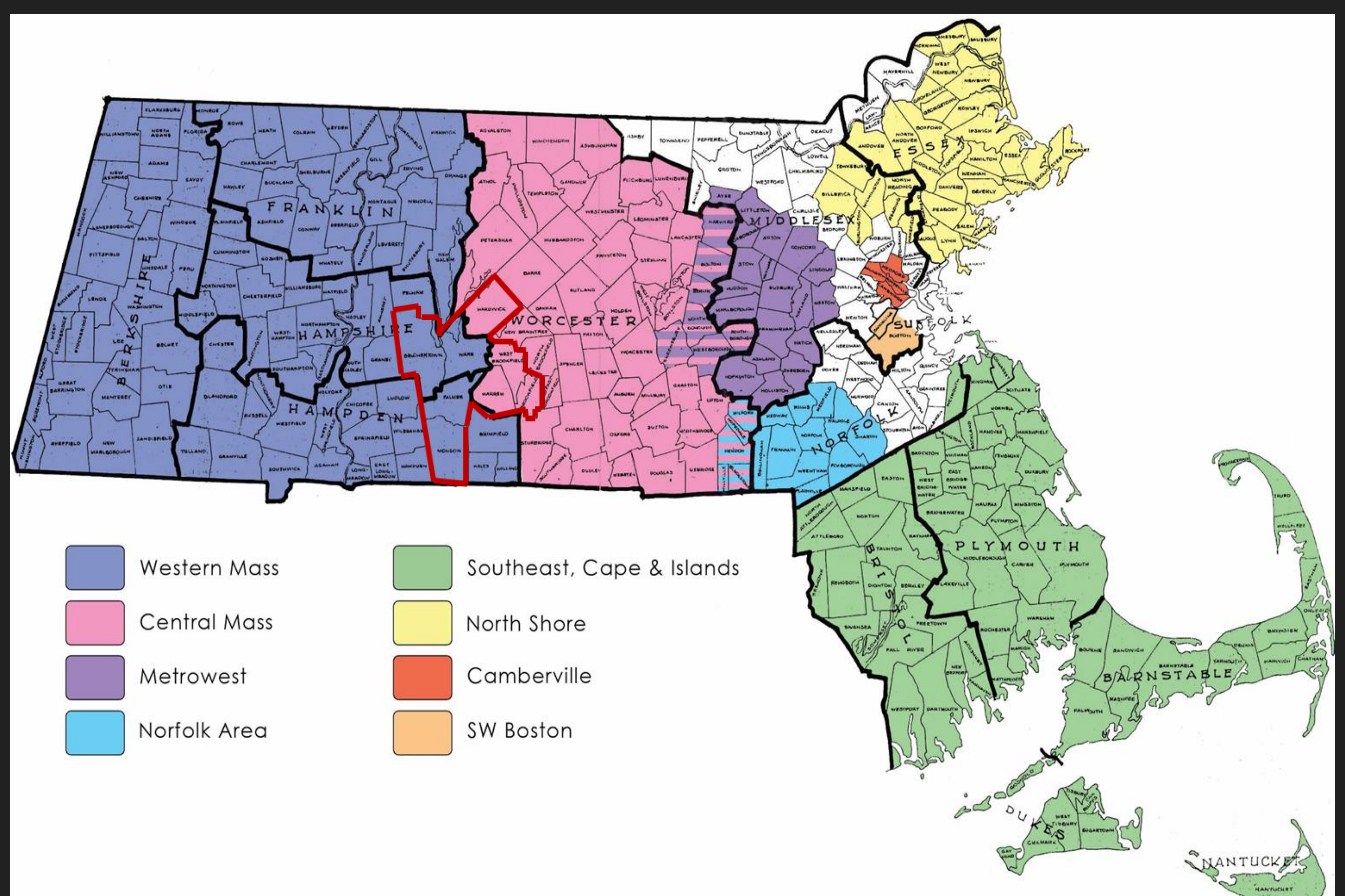
Opportunities

Innovative public transit models: Microtransit / demand response

Quaboag Connector



Quaboag Connector Service Area



Quaboag Connector Programs

Quaboag Connector

- Started in 2017. Demand-response transportation available to anyone in the service area. Rides are $2 each way.

B79 Amherst-Worcester Intercity Route

- Collaboration with PVTA since 2021. Provides fixed-route service from Amherst-Worcester along Route 9.

Palmer Rides to Work

- Launched in February 2022. Collaboration with Town of Palmer Community Development. Half-priced ($1) Quaboag Connector rides for low-income Palmer residents traveling for employment, employment-related training, job interviews, etc.

Baystate Health Connector

- Launched in 2022. Free medical rides to Baystate Health facilities, especially the Convenient Care center at Baystate Wing.

Senior Van

- Launched in 2022. Free, dedicated van for seniors in Ware.

Veterans Ride

- Veterans ride the Quaboag Connector free of charge as of summer 2022.

Yolobus BeeLine

- Based in rural Yolo County, CA
- Zone-based model that connects riders with existing traditional fixed route service
- Works to address first mile & last mile connectivity
- Fares are $1.50 - $2.00

Policy changes

- Increased funding for rural transit
- Change metrics to stop penalizing rural
- Funding equity for transit vs infrastructure

ACT NOW FOR EQUITABLE PUBLIC TRANSIT

S.2277/H.3272 Sen. Su Moran & Rep. Natalie Blais

Raise the Funding Floor for RTAs

Invest in Transit Statewide

Uplift Community Needs

Stop Equating Performance with Profit

Mindset changes

- Combat stigma
- Travel training
- Consider public transit options seriously / messaging

And there’s more!

- Walkability
- Bike collectives

Up Next

- Next session: Childcare on November 8th
- Please submit your cases/questions, track your attendance for CME/CNE and view course resources at the: DH ECHO Connect site
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OF SESSIONS

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Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 5- Childcare
November 8, 2023

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- Engage in actions that promote greater health equity in NNE.

Today's Program

- Brief housekeeping
- Didactic: Childcare, Courtney Hillhouse
- Case presentation: Amy Brooks
- Case discussion
- Summary
- Up Next: Access to healthcare

Notes

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ECHO Participant Demographics
Total Registrants: # 184

Medical Professional	74
Public Health	33
Administrative	18
Educator	18
Community Based Health Worker	11
Policy Maker/Advocate	3
Researcher	2
Student	2
Community Service Organization	2
Other	12

Core Panel

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Disclosure Statement

No Relationships to Disclose

Rural Health Equity
Tackling the Social Drivers of Health
CHILDCARE

Courtney Hillhouse, Regional Manager, Building Bright Futures

Importance of Equitable Childcare

- Accessible to ALL children and families
  - Workforce is strong = Spaces are available
  - Families feel welcomed
- Affordable for ALL families
  - More families can qualify for subsidy
  - Cost of childcare does not put a burden on families
- High Quality
  - Staff are trained and receive ongoing training
  - Services are available for Early Intervention
  - Children’s social and emotional needs are met

Dartmouth
Health
Project
ECHO

Dartmouth
Health

Rural Child Care Landscape:
Child Care Gap & Economic Impact

Child Care Gap	
Rural	35.1%
Urban	28.9%
National	31.2%

Economic Impact	
Rural Projected Economic Loss	$33 billion to $50 billion annually
National Projected Economic Loss	$142 billion to $217 billion annually

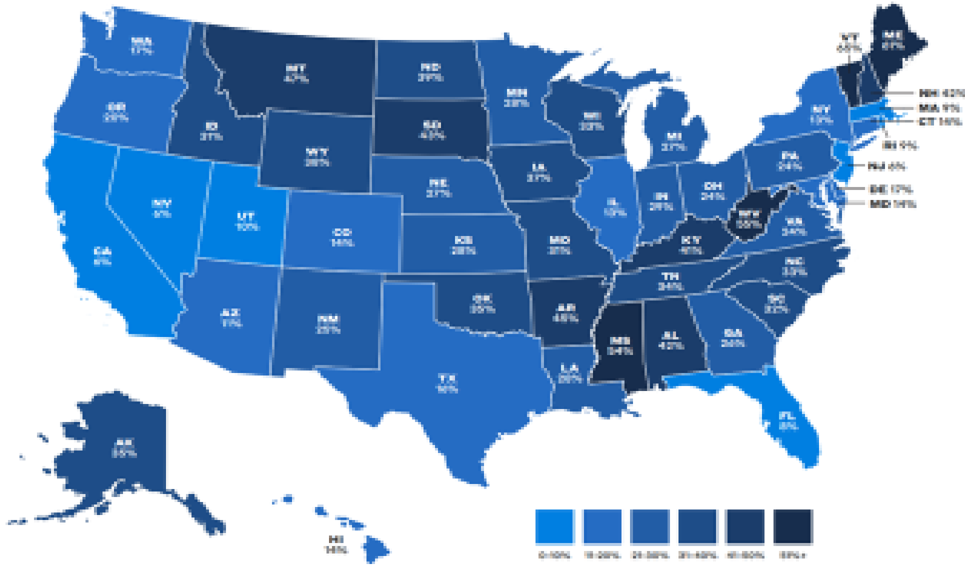
Data from Child Care in 35 States: What we know and don't know

Bipartisan Policy Center

Rural vs. Urban Child Care

- Families travel longer distances
- Workforce shortages felt more acutely
- Disproportionate access to resources
- Increased administrative burdens

Map 1. Percent of population living in rural areas, 2020 U.S. Census



Bipartisan Policy Center

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SCIENCE AND PRACTICES TO KEEP PEOPLE SAFE AND BUSINESSES PRODUCTIVE AS COVID-19 CONTINUES

SUMMARY OF THIS ECHO

OF SESSIONS

12

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WELCOME to the

Rural Health Equity ECHO:
Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 6- Access to healthcare
November 29, 2023

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Today's Program

- Brief housekeeping
- Didactic: Access to healthcare, Sally Kraft
- Case presentation: Andrew Loehrer
- Case discussion
- Summary
- Up Next: Special barriers to well-being and care

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Access to Health Care Services

Andrew Loehrer
Sally Kraft

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The ability to obtain health care services to achieve the best health outcomes.

5 A’s of Access

- Affordability
- Availability
- Accessibility
- Accommodation
- Acceptability

Penchansky R, Thomas JW. Med Care 1981

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He began to notice bright red blood in his stools but he otherwise felt good.

He is living paycheck-to-paycheck at this time and did not have any savings to cover his health plan deductible. He decided to skip going to the doctor and wait and see how things would go.

Affordability

- 25 million Americans do not have health insurance
- Having health insurance does not mean that you can afford health care
  - 50% working age US adults (19-64 years) report it is “hard” or “very hard” to pay for health care
  - 2 out of 5 working age US adults report delaying or skipping needed health care or a prescription in the past year because they could not afford it
  - NH has the second highest median annual spending on premiums and out-of-pocket health costs in the country ($5400/year)

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NEW HAMPSHIRE PUBLIC RADIO | BY [ANNMARIE TIMMINS - NEW HAMPSHIRE BULLETIN]
Published March 9, 2023 at 9:56 AM EST

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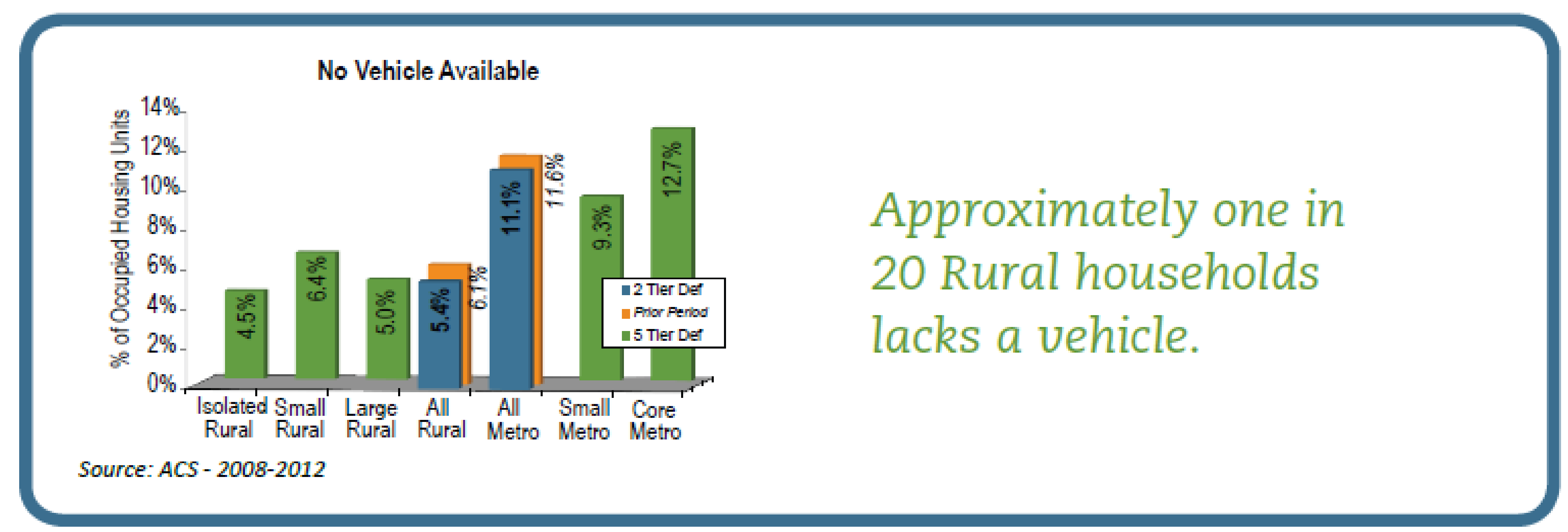

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- What about telehealth?
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  - However the cost of internet service can be prohibitive. Only 36.4% of NH residents and 1% of VT residents have access to a plan that costs less than $60/month.

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Acceptability

“Growing up as a person of color, particularly with the roots of, like immigrant parents and mixed status or undocumented. Like, we avoid the doctors unless we're dying. You’re not going to see us at a doctor's office….”

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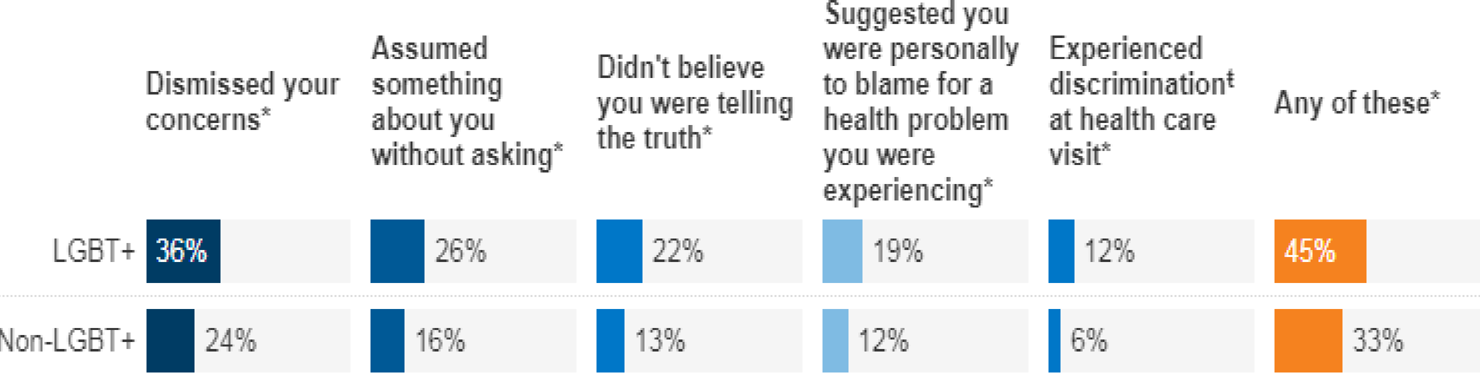

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Access to health care services is influenced by a number of different factors, including:

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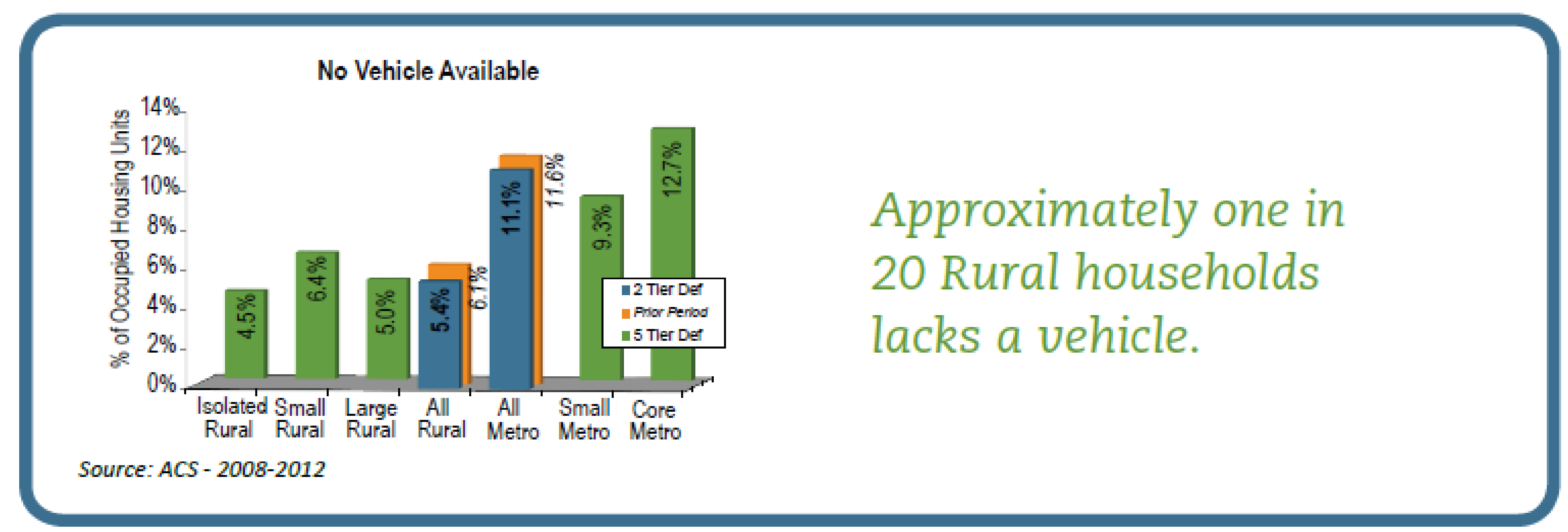

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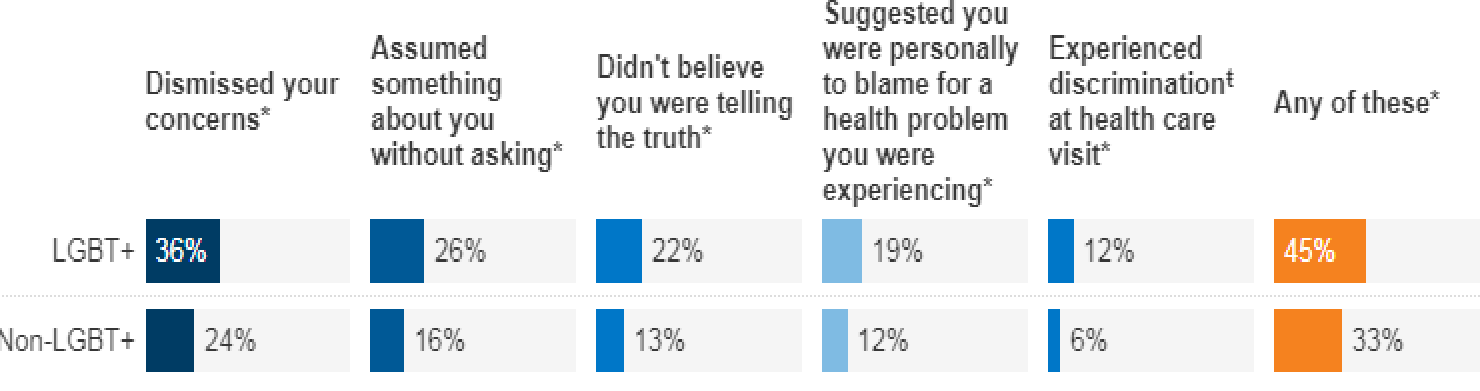

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Session 7 – Special Barriers to Well-being and Care
December 6, 2023

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- Brief housekeeping
- Didactic Panel: Jessica Goff, Seacoast Outright; Rikki Chapman, North Country Health Consortium
- Case presentation: Kris van Bergen, North Country Health Consortium
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- Summary
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Special Barriers to Well-Being and Care

Kris van Bergen

Jessica Goff

Rikki Chapman

Stigma, Bias and Spoons

Kris van Bergen, North Country Public Health Network

Stigma and Bias in Healthcare

- Stigma (OED) - a mark of disgrace associated with a particular circumstance, quality, or person.
  - stereotypes – beliefs about characteristics associated with the group and its members,
  - prejudice – negative evaluation of the group and its members,
  - stigmatizing behavior – exclusion from events, avoidance behaviors, gossip, and
  - discriminatory attitudes – belief that people with a specific health condition should not be allowed to participate fully in society
- Bias (OED) – (n) prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair; (v) cause to feel or show inclination or prejudice for or against someone or something.

Commonalities in health-related stigma

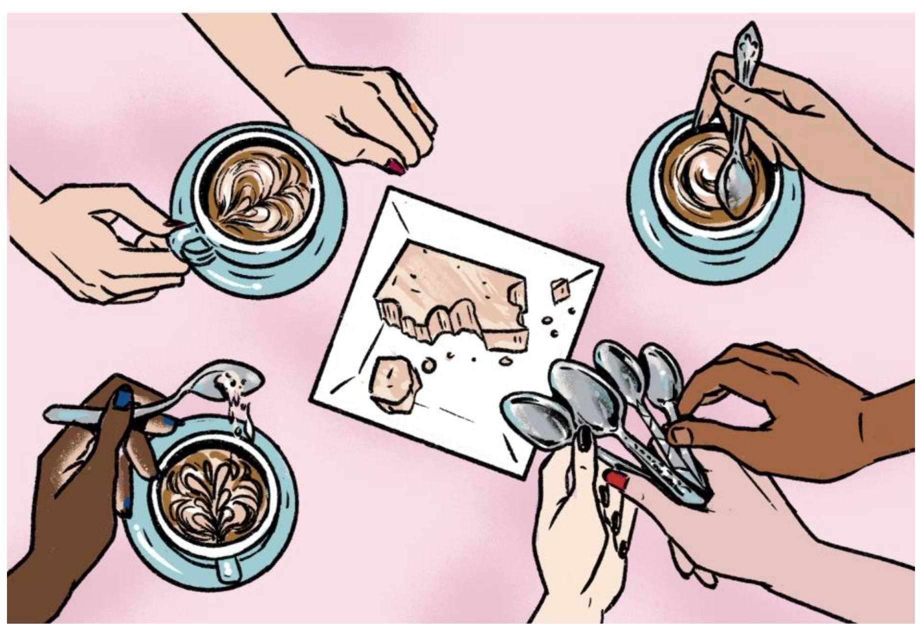
- Occurs across the socio-ecological spectrum (individual, interpersonal, organizational, community, public policy)
- Involves varying levels of social exclusion in response to a threat (physical or symbolic)
- Conditions vary in terms of visibility, which can impact external and internal stigma
- Coping with stigma results in increased levels of stress and underutilization of services

Stangl AL, Earnshaw VA, Logie CH, van Brakel W, C Simbayi L, Barré I, Dovidio JF. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Med. 2019 Feb 15;17(1):31. doi: 10.1186/s12916-019-1271-3. PMID: 30764826; PMCID: PMC6376797.

Examples

- Leprosy – fear of contagion, low-income status, visible deformity leads to delays in treatment and extended community exposure to source of infection
- Epilepsy – concealable and unpredictable, religious/supernatural prejudice leads to social rejection, decreased medication adherence and restrictive laws/policies
- Mental Health – stereotypes class MI as a moral issue, perceived threat to public safety, exacerbation of stigma in the race/gender overlap leads to lower self-efficacy/esteem/advocacy, can be helped by public policy
- HIV – perceived physical threat, concerns about longevity, moral judgement around routes of transmission and social norm reinforcement leads to exclusion, delayed access to care and internalized stigma

I don't have spoons for that ….



The Healthcare system is complex

- Clinically
- Economically

First, do no harm. But …

- World HAI rate = 10%, >3M deaths/year, 50-80% preventable
- US HAI rate = 3%, ~100K deaths, >$5B increased costs

Any illness or injury decreases capacity to engage

Chronic illness, chronic pain, grief, and caregiving cause a constant capacity deficit

LGBTQ+

Jessica Goff, Seacoast Outright

The harm in discrimination

- The types of discrimination associated with LGBT health harms include
  - interpersonal discrimination, such as bullying, harassment, or assault; and
  - structural discrimination, such as laws, policies, or practices that deny services, opportunities, or protections to LGBT people
- Discrimination is linked to health harms even for those who are not directly exposed to it:
  - The presence of discrimination, stigma, and prejudice creates a hostile social climate that taxes individuals' coping resources and contributes to minority stress.
  - Manifestations of this stress, including internalized stigma, low self-esteem, expectations of rejection, and fear of discrimination, help explain the health disparities seen in LGBT populations.

The Harm In Discrimination

From 2019 Cornell Study:

- Mental health consequences for LGBTQ+ people include depression, anxiety, suicidality, PTSD, substance use, and psychological distress.
- Physical health consequences include physical injury, elevated stress hormone levels, cardiovascular disease, and poor self-reported health.
- Protective factors:
  - peer, community, and family support
  - access to affirming health care and social services
  - establishment of positive social climates, inclusive practices, and anti-discrimination policies

The Impact on LGBTQ+ Youth

From 2022 Trevor Project Survey and 2020 Survey

- 36% of LGBTQ+ youth have been physically threatened or harmed due to their identity;
- 73% have experienced discrimination based on their identity.
- These youth are much more likely to display negative mental health outcomes, namely in the area of suicide risk. 1 in 5 trans and nonbinary youth attempted suicide in the past year.
- 73% report symptoms of anxiety
- 93% of transgender and nonbinary youth said that they have worried about transgender people being denied access to gender-affirming medical care due to state or local laws.

The Impact on LGBTQ+ Youth

- Transgender and nonbinary youth with access to binders, shapewear, and gender-affirming clothing reported lower rates of attempting suicide in the past year compared to transgender and nonbinary youth without access.
- Transgender and nonbinary youth who report having their pronouns respected by all or most of the people in their lives attempted suicide at half the rate of those who did not have their pronouns respected.
- 12% of those who reported at least one in-person LGBTQ-affirming space attempted suicide in the past year compared to 20% of LGBTQ youth without in-person LGBTQ-affirming spaces.

The Impact on LGBTQ+ Youth

- 2021 NH Youth Risk Behavior Survey:
  - Lesbian, Gay, and Bisexual youth were more likely than straight youth to experience sexual violence and bullying.
  - They were more likely to vape, to have had their first alcoholic drink/ have tried marijuana before the age of 13, to take prescription medication without a prescription, to be sexually active, to be obese, and to have slept away from home because they were kicked out or ran away.
  - They were less likely to be physically active, to eat breakfast, to get 8 hours of sleep, and to see a dentist. They were less likely to see a doctor or nurse.
  - 63% of LGB youth noted that their mental health was not good most of the time or always.
  - Over 30% noted that a parent or other adult in the home most of the time or always swore at them, insulted them, or put them down.

The Bottom Line …

The Journal of Adolescent Health Article "Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth" sums it up:

> "Research demonstrates that gender-affirming care improves the mental health and overall well-being of gender diverse children and adolescents."

Complexity in the overlap

Human Rights Commission analysis of 2020 Behavioral Risk Factor Surveillance System (BRFSS):

- 36% of LGBTQ+ adults self-report having a disability (compared with 24% non-LGBTQ+ adults)
- 52% of transgender adults self-reported a disability.

Complexity in the overlap

From 2023 Food insecurity study:

- In the past seven days, 13.0% of LGB + (lesbian, gay, bisexual, and other non-heterosexual) New Englanders experience food insufficiency, nearly twice the rate of heterosexual people
- 19.8% of transgender+ (transgender, genderqueer, gender non-binary, and other non-cisgender people) New Englanders experience food insufficiency, 2-3x the rate of cisgender men and women.
- LGBTQ+ New Englanders of color experience devastatingly high rates of food insufficiency, with, for example, one in three Black transgender+ New Englanders not having enough food to eat in the past seven days.

Living with Substance Use Disorder

Rikki Chapman, CHW/PRC, North Country Health Consortium

Stigma and Substance Use Disorder

According to SAMHSA (2021) -

- 13.5% of young adults (18-25) had both a Substance Use Disorder and mental illness
- 46% of young adults (18-25) had either Substance Use Disorder or any mental illness
- 7 in 10 adults who have had SUD considered themselves to be in recovery or are recovering

Stigma and Substance Use Disorder

- Illicit drug use is the most stigmatized health condition in the world, with alcohol use close behind it.
- Women who use substances are the most stigmatized.
- 24.9% individuals were unable to utilize treatment for their SUD due to lack of health care coverage and costs

Up Next

- Next session: Cross Cutting Solutions on December 20th
- Please submit your cases/questions, track your attendance for CME/CNE and view course resources at the: DH ECHO Connect site
- Recordings will be posted on the D-H ECHO website https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials

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SCIENCE AND PRACTICES TO KEEP PEOPLE SAFE AND BUSINESSES PRODUCTIVE AS COVID-19 CONTINUES

SUMMARY OF THIS ECHO

OF SESSIONS

12

WHAT THIS ECHO WILL FOCUS ON

As the COVID-19 pandemic continues, understanding of the virus and strategies to keep people safely engaged in productive work and business encounters is evolving. This second DH ECHO series on COVID-19 for employers and organizational leaders will examine advances in scientific understanding of COVID-19 and its prevention and management. It will explore timely new topics of importance such as strategic distribution of COVID vaccines, emerging perspectives on aerosols and ventilation, business travel considerations, and operationalization of pods to safely maximize social and work interactions. It will update more familiar topics such as PPE, surface and facility hygiene, regulatory changes, and emotional health during COVID with the latest information. Critical new topics will be integrated as they emerge. Sessions include a brief didactic and robust discussion.

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1/27/2021	6/30/2021	Navigate to ECHO	View Cohort Roster

SUMMARY OF EACH SESSION

WELCOME to the

Rural Health Equity ECHO:
Tackling the Social Drivers of Health

Sponsored by the Dartmouth Health

Center for Advancing Rural Health Equity

Session 8 – Cross Cutting Solutions
December 20, 2023

Please let us know you are here: Type your name, email, organization into CHAT

Series Learning Objectives

After participating in the Rural Health Equity ECHO participants will be able to:

- Explain rural health equity and the complex issues that come together to produce unfair health outcomes in northern New England (NNE).
- Apply key equity principles to working with others in order to overcome barriers to health equity in NNE.
- Engage in actions that promote greater health equity in NNE.

Today's Program

- Brief housekeeping
- Didactic Panel: Andy Lowe, New England Rural Health Association and Rudy Fedrizzi, Vermont Department of Health
- Case presentation: Rudy Fedrizzi
- Case discussion: Andy Lowe
- Summary: Kris van Bergen-Buteau
- Up Next: Post course survey

Notes

- Please let us know you are here. Enter name, email, organization, questions in Chat
- Raise virtual hand or enter comments in chat at any time. We will call on you when it works. Please mute otherwise.
- To protect individual privacy, please use non-identifying information when discussing cases.
- We will be recording the didactic part of these sessions. *Participating in these session is understood as consent to be recorded. Thank you!*
- Closed Captioning will be enabled during sessions
- Questions to ECHO Tech Support thru personal CHAT or ECHO@hitchcock.org

CME

- One hour of free CME is available for every session attended, up to 8 sessions.
- Track participation via DH ECHO Connect site
- Link to claim your credits: https://app.smartsheet.com/b/form/16ff74fafed54133b568b59bcce06e35
- Instructions are also available on the connect site

Core Panel

- Elisabeth Wilson, MD, MPH, MS-HPEd - Chair and Professor, Department of Community and Family Medicine, Dartmouth Health and Geisel School of Medicine
- Kris van Bergen-Buteau, CPHQ - Director, Workforce Development & Public Health Programs, North Country Health Consortium
- Rudy Fedrizzi, MD - Public Health Services District Director, Vermont Department of Health
- Andrew Loehrer, MD, MPH - Staff Physician, Dartmouth Health
- Andy Lowe - Executive Director, New England Rural Health Association
- Angela Zhang, MSW - Program Services Director, LISTEN community services
- Chelsey Canavan, MSPH - Manager, Center for Advancing Rural Health Equity

Disclosure Statement

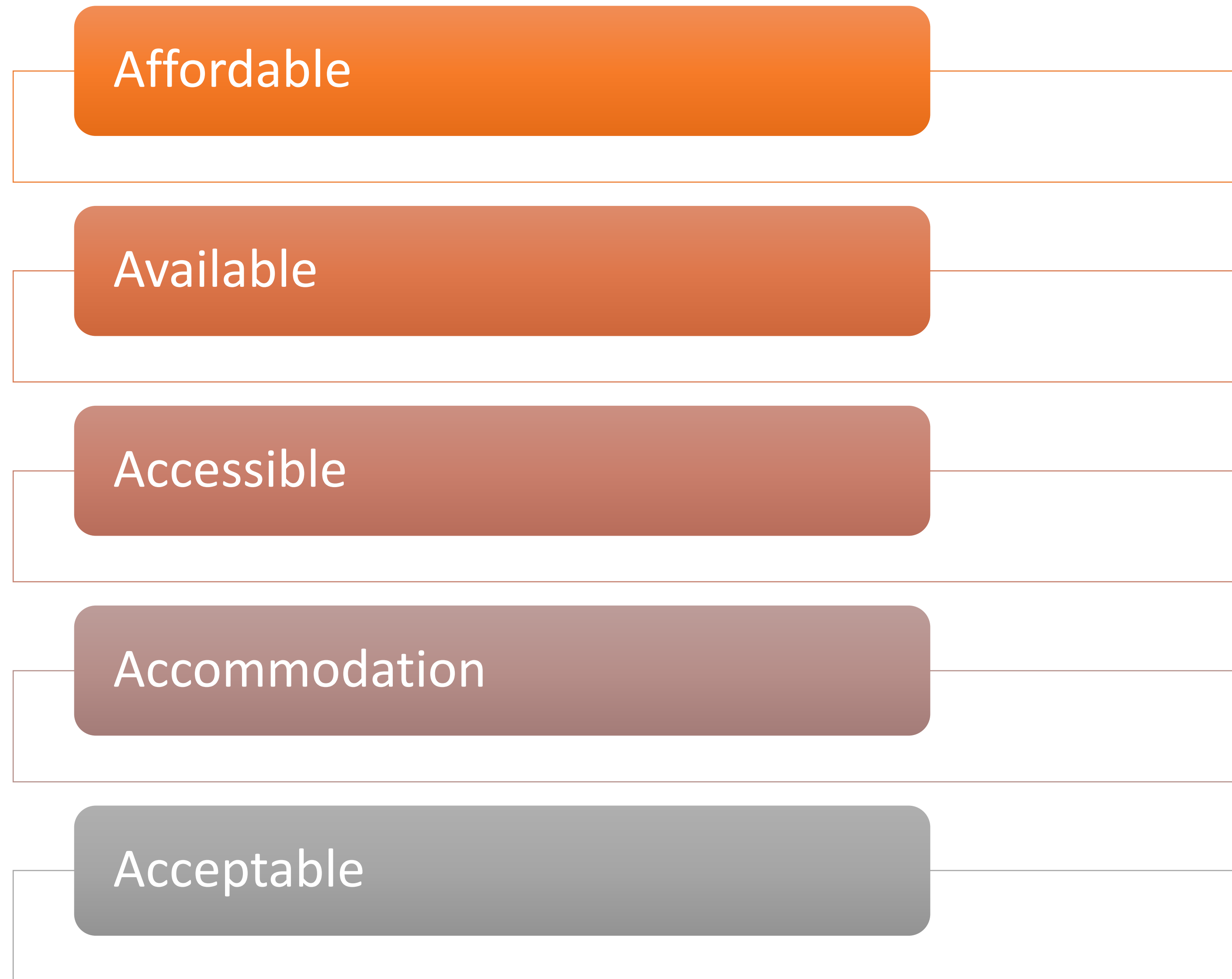
No Relationships to Disclose

WELCOME to the
Rural Health Equity ECHO:
Tackling the Social Drivers of Health
RURAL
HEALTH
AHEAD
Sponsored by the Dartmouth Health
Center for Advancing Rural Health Equity
Session 10 - Cross-Cutting Solutions
December 20, 2023

Wrapping It Up

- We have heard about many aspects of how SDOH contribute to wellness and impose unique challenges to access for rural populations
  - Housing
  - Nutrition
  - Transportation
  - Childcare
  - Health Access
- Now let’s bring it full circle and look at some cross-cutting solutions that can help address these challenges

Remember the 5 A's of Access



Strength-Based Solutions: 4 C's

Rural communities are rich in traditional assets :

- Community
- Collaboratives
- Connections
- Commonalities
  - Connection to the land
  - Shared life experience

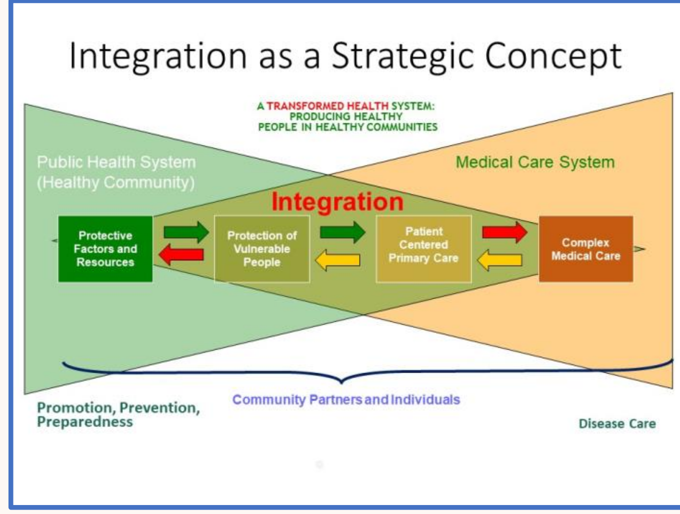
Coordination of Services

Durable change takes ALL partners participating as active collaborators…

Silos Belong on the Farm

At ALL levels…

Maybe even Clinical-Community Integration…



Community-Based Services

Meet people where they are: Outside the walls of the clinic/hospital

- CHWs
- Doulas
- Peers
- Coaches

- Co-location of services

Focus at Three Levels

- Micro
- Meso
- Macro

Micro-Level

Service Delivery

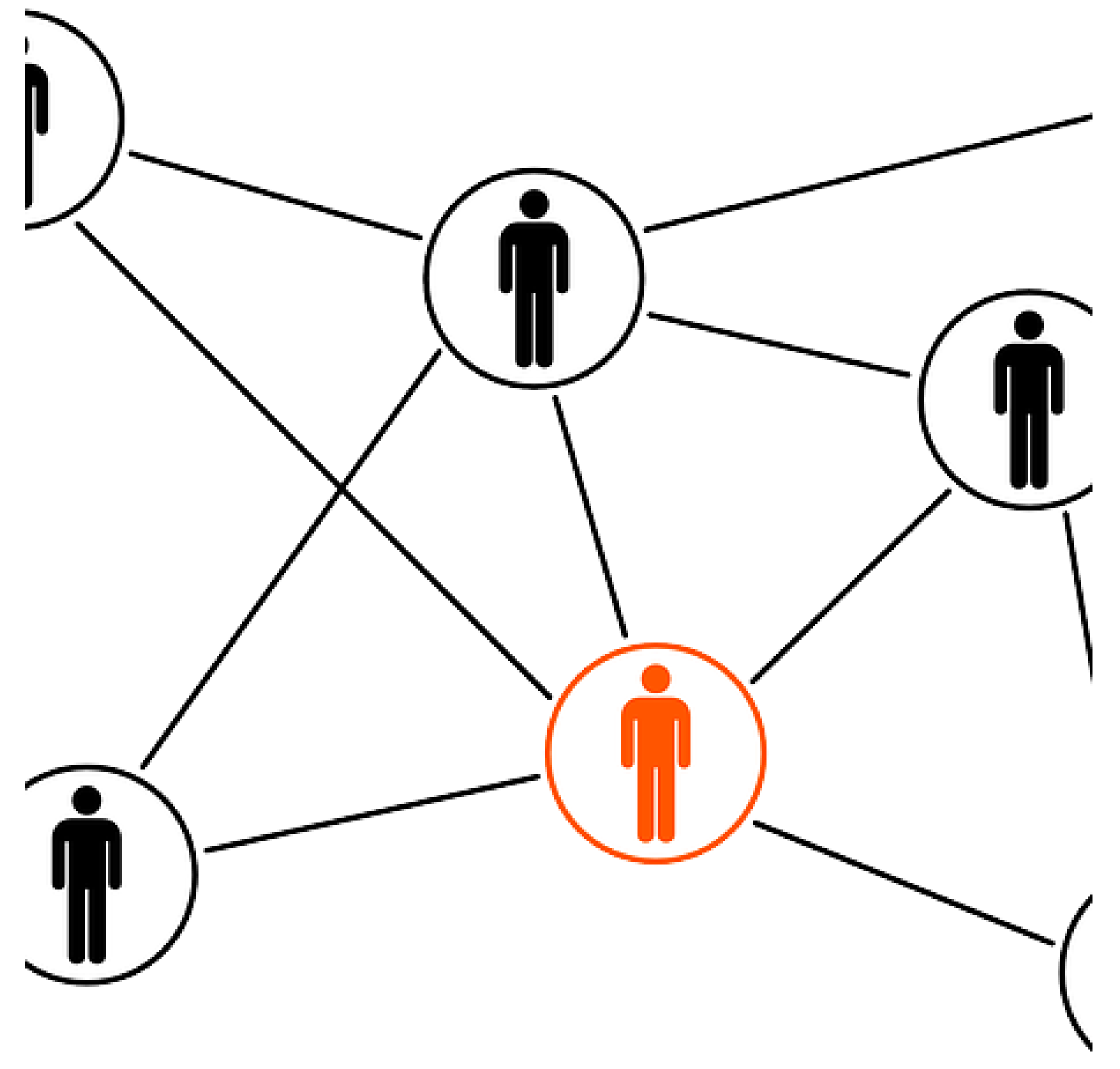
- Patient/person/family-centered…Person-led?
- Person-to-person
- Clinician-to-patient

Appropriate Modalities

- Telehealth not a panacea
- Shared Decision-Making Tools

Meso-Level

- Inter-organizational coordination
- Community-based collaboratives
- Coordination vs. Management
- Pervasive change begins here
- Special tools/skills required!



Macro-Level

Taking the long view toward real change

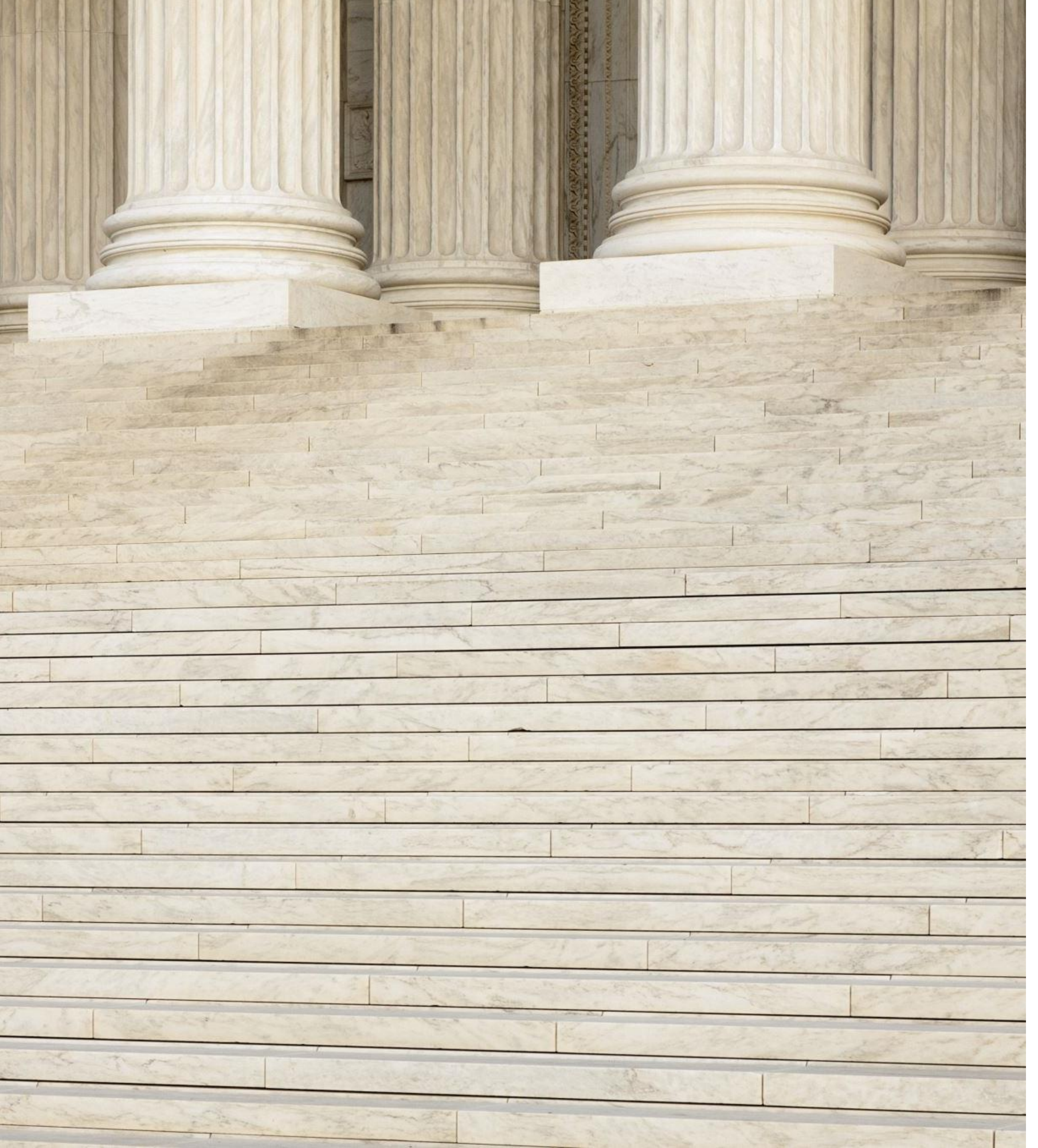
Policy

Advocacy

Workforce

Education

Research



Policy, Governmental Affairs, and Advocacy

Advocacy vs. Education vs. Lobbying

- Data → Information
- Specific skills
  - Make technical information accessible to lay audiences
- Grassroots education and organizing
- Ex.: CMS finalized payment for CHWs for “community health integration services”

Grow/Strengthen Workforce

- Rural residencies, internships, fellowships
- SDOH impacts on healthcare workforce too!
  - Housing
  - Transportation, etc.
- Recruit migrant/immigrant populations for health workforce

Community-Based Participatory Research

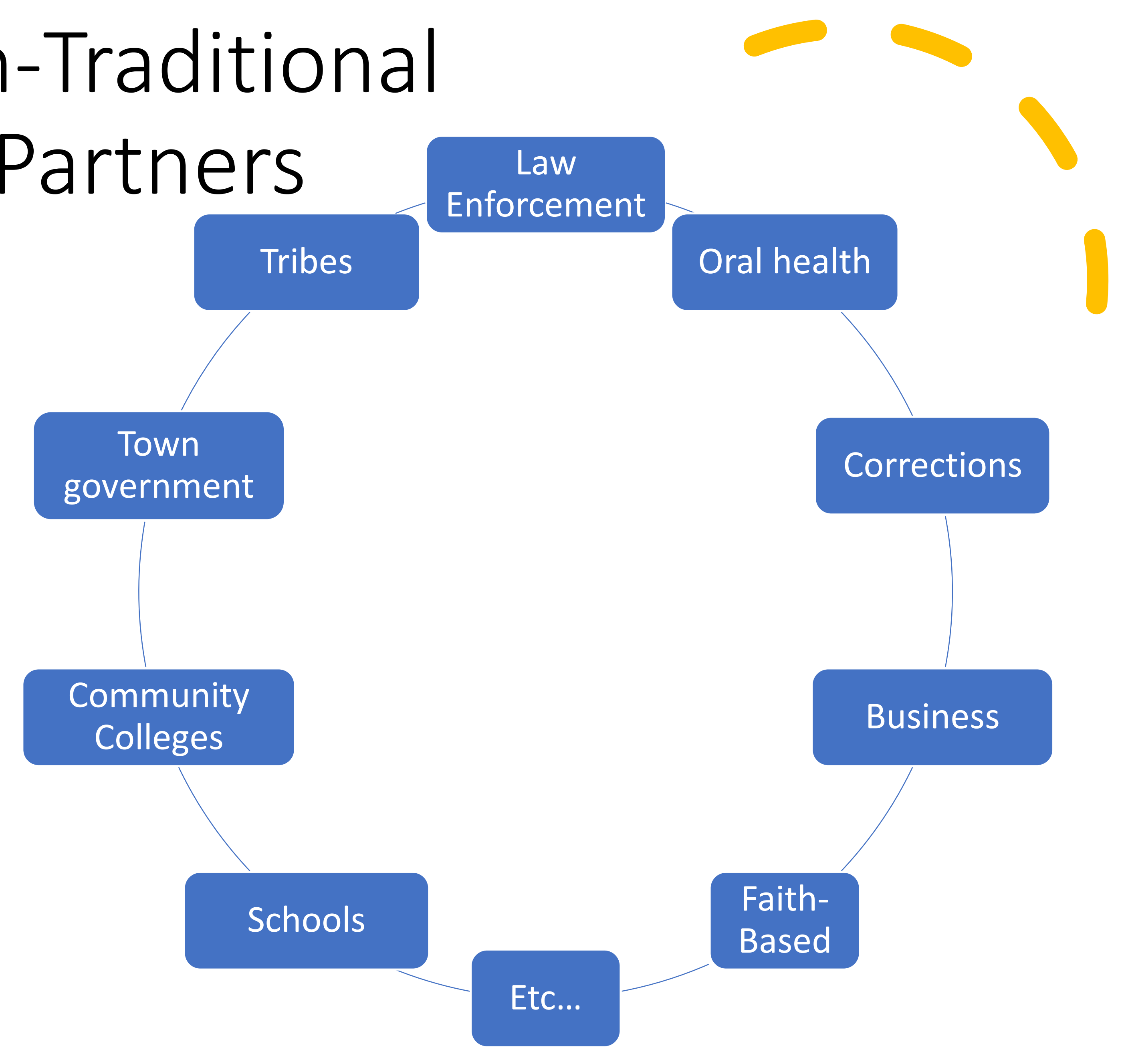
- Identify emerging/best practices
- Rural-specific models
- Disseminate replicable models
- Enable quality improvement
- Engage communities as active partners
  - What’s important to them?

Rural Health Networks

- CBOs
- All sizes and shapes
- Natural aggregators of:
  - Diverse partners
  - Shared funding
  - Needs assessment
  - Community-designed solutions

Non-Traditional Partners

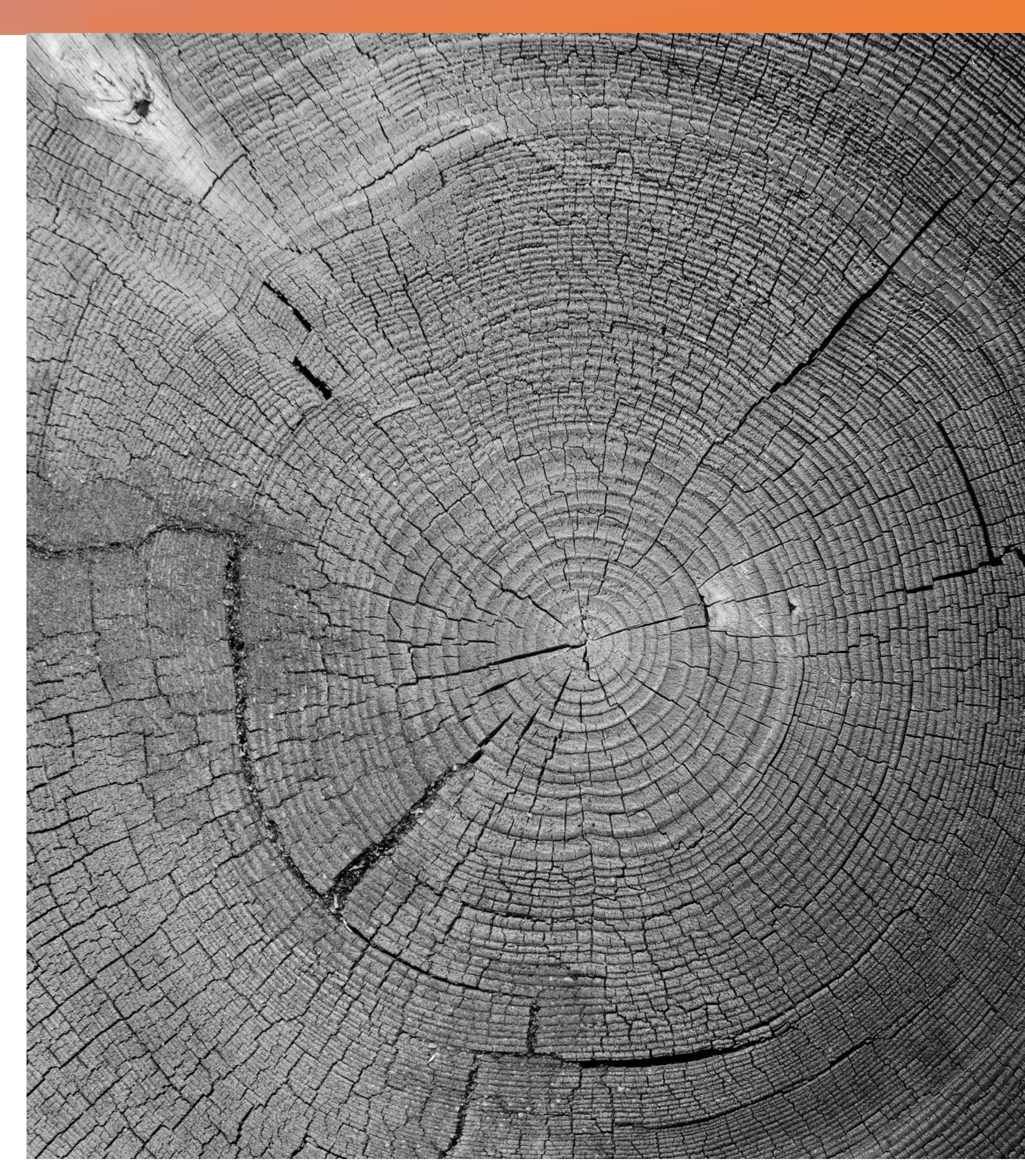
- Rural Health Networks and other CBOs can multiply impact
- They attract a diverse partner set with a common interest in community health



Funding
• Money → Mission
• Reimbursement
• ACOs
• CMS
• Private payers
• Leveraged funding
• Shared, not competitive (silos again)

Rural Shared Strengths: A Case Study

- Multi-town region in Downeast Maine
- Disparities in income, access to services
  - "Summer People", seasonal workers
- Area health center and human services agencies have a history of collaborating
- Originally ad hoc, networking
- Some relationships uneasy (turf, funding)
- But… The ground is prepared



2018: A New Start

- 3 active members (Health Center, Women's Health NFP, COA) decide to create a more formal structure
  - Steering Committee
  - Permanent venue
  - 20+ members
  - Monthly meetings
  - Agenda!
- Retreat
  - Mission
  - Roadmap for the future
- Still mostly networking—what's missing?

2019: The Next Step

- Health center gets HRSA Rural Network Planning grant
- Move from "The Wellness Collaborative" to "Downeast Rural Health Network"
- Part-time Coordinator
- Technical Assistance
- Develop formal Mission, Vision, Strategic Plan
- Begin governance model
- Focus on action

2020-22: (In Spite of) COVID…

The DRHN perseveres!

- Zoom meetings → better attendance
- Continued TA & training in facilitating CBO's
- New members (and some drop off)
- Workgroups on shared projects
- Office of Rural Health grant → Full-time Coordinator
- Housed at Women's Health NFP (fiscal agent)

2023: Not Looking Back

- DRHN still growing/diversifying with members from:
  - Police/Corrections
  - Chamber of Commerce
  - Schools
  - Community College
  - Church (Jamaican migrant/immigrant population)
- Incorporating as 501(c)(3) to accept funding directly
- Funded projects
  - Equity Root Causes
  - Healthcare/Law enforcement/Courts partnership to prevent incarceration due to SUD/BH
- Outreach booth at ethnic/cultural festivals to recruit new partners, inform minority needs assessments

Questions for Conversation

Can this model work in any rural community? Why or why not?

What conditions are needed to prepare the ground for healthy growth/sustainability of such networks?

What are other models that can encourage the transition from ad hoc networking to formal collaborative action?

Up Next

- Please complete the post course survey: https://redcap.hitchcock.org/redcap/surveys/?s=EX4RL38CPTYMNXKT
- Link to claim your credits: https://app.smartsheet.com/b/form/16ff74fafed54133b568b59bcce06e35 and instructions available here: DH ECHO Connect site
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