Health Haves, Health Nots
Panel Discussion

Dr. Dottie Morris, Moderator

Dr. Mark Levine, MD, Vermont Commissioner of Health

Dr. Elizabeth Talbot, MD, Professor Geisel School of Medicine at Dartmouth, New Hampshire Deputy State Epidemiologist

Bobbie Bagley, MS, MPH, RN, Director of the Division of Public Health and Community Services, Nashua NH

Dr. Fay Homan, MD, Family Practice physician Wells River VT and primary care advocate serving on the Board of the Vermont Academy of Family Physicians
When Racism and a Pandemic Collide as Public Health Emergencies

Mark A. Levine, MD
Commissioner
Vermont Department of Health

November 10, 2020
Health equity exists when all people have a fair and just opportunity to be healthy, especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systematic inequities that are often associated with social categories or race, gender, ethnicity, social position, sexual orientation and disability.
Vermont Department of Health’s framework for addressing health inequities
How can the pandemic in Vermont teach us the important lessons of health equity?
A sampling of our experiences thus far

- Chittenden County large outbreak early in the pandemic: multigenerational households
- Slate quarry outbreak VT and NY: congregate living
- Apple orchards guest worker program: congregate living
- Chittenden County modest social gathering: strong sociocultural network of households
- Correctional facilities: one in VT, Vermonters in Mississippi
1 in 4 Vermont residents with COVID-19 are BIPOC. Rates of COVID-19 are 4 times higher for BIPOC compared with white non-Hispanic Vermont residents.

Rates per 10,000 Vermont BIPOC or white non-Hispanic residents

*Please note the difference is statistically significant.
**BIPOC with COVID-19 have a higher hospitalization rate than white non-Hispanic people with COVID-19.**

Rate per 10,000 Vermont BIPOC and white non-Hispanic residents

<table>
<thead>
<tr>
<th></th>
<th>BIPOC</th>
<th>White Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>4.7*</td>
<td>1.8</td>
</tr>
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</table>

*Please note the difference is statistically significant.

9 days
Average hospital stay among BIPOC with COVID-19
Rates of BIPOC with COVID-19 and a chronic disease are higher than white non-Hispanic people with COVID-19 and a chronic disease.

Rate per 10,000 Vermont BIPOC or white non-Hispanic residents

<table>
<thead>
<tr>
<th>Chronic Disease</th>
<th>BIPOC</th>
<th>White Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>2.2</td>
<td>4.3*</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.6</td>
<td>5.4*</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>2.9</td>
<td>6.5*</td>
</tr>
<tr>
<td>Former or Current Smoker</td>
<td>4.2</td>
<td>0*</td>
</tr>
</tbody>
</table>

*Please note the difference is statistically significant.

BIPOC with COVID-19 have higher rates of chronic diseases compared to white non-Hispanic people with COVID-19.
Rate per 10,000 Vermont BIPOC or white non-Hispanic residents

Due to small numbers, not all chronic diseases are shown.
Systemic and structural racism, and oppressive systems affect the conditions in which people are born, grow, live and work.

People in communities that are underserved may:

• have higher rates of underlying medical conditions.
• work in jobs with higher risk for exposure and have less paid sick time.
• be more likely to live in multi-generational housing or congregate living spaces.
• have less access to personal protective equipment and hand sanitizer.
What must be done about the Black, Indigenous and people of color disparities we see?

• Fund racial justice advocacy organizations
• Fund community health workers
• Focus on primary prevention efforts
• Acknowledge that Vermont Department of Health messages and services miss many Vermonters
• Engage the community in determining the most effective ways to reach all people
Health Equity and Community Engagement Team

As part of the Department of Health’s COVID-19 response, a Health Equity and Community Engagement (HECE) Team was created to engage partners across the state and enhance the Health Operations Center’s (HOC) educational, prevention, and outbreak response strategies.

• The team focuses on applying a health equity lens to the following areas:
  • Priority populations disproportionately impacted by COVID-19
  • Partnerships with organizations serving BIPOC communities
  • Internal and external communication
  • Data collection
  • Culturally appropriate COVID-19 plans
  • Workforce Development
  • Providing support for Coronavirus Relief Fund distribution
Coronavirus Relief Funds (Act 136)

• Funding for continuum of services for priority populations to assist them in meeting essential needs for food, shelter, health care, and emotional support.
• Populations include any that face adverse health outcomes based on factors such as:
  • Race or Ethnicity
  • Immigrant status
  • SOGIE (sexual orientation, gender identity and expression)
  • Disability
  • Age
  • Geographic location
Coronavirus Relief Funds (Act 136) Continued

Organizations may:

- Provide education and resources regarding prevention of COVID-19 in languages and formats appropriate to the population
- Assist with access to COVID-19 testing and treatment
- Identify and address difficulties in safely meeting essential needs, including food, shelter, health care, and emotional support, during the public health emergency.
Complementary Roles in Addressing Racial Equity

Clinical and Community
1. Interpretation services at visits
2. Case managers
3. Culture vision: JEDI committee
4. Core Mission: Safety net
5. Integration: Healthcare, individuals

Public Health
1. Culturally appropriate materials/messaging
2. Health equity coordinator
3. HECE – workforce development, policies, budget
4. Grantees
5. Population health
Dr. Elizabeth Talbot, MD, Professor Geisel School of Medicine at Dartmouth, New Hampshire Deputy State Epidemiologist
New Hampshire Response

- Situational Awareness
- Contact Tracing
- Medical Surge
- Community Supports
- Community Mitigation Policy
- Testing
- Education

NH DIVISION OF Public Health Services Department of Health and Human Services
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Situational Awareness
Global Epidemic Curve
(new cases per day)

JHU Dashboard
U.S. Epidemic Curve
(new cases per day)
Number of Daily New Cases per 100,000 Population (7-Day Rolling Average)

Hover over visuals for more details

Risk Levels: Green Yellow Orange Red

https://globalepidemics.org/key-metrics-for-covid-suppression/
NH New Cases by Day

- Stay at Home
- Stay at Home 2.0
- Safer at Home

Mar 1, Apr 1, May 1, Jun 1, Jul 1, Aug 1, Sep 1, Oct 1, Nov 1
New Hampshire Response

- Contact Tracing
- Medical Surge
- Community Supports
- Community Mitigation Policy
- Education
- Testing

Situational Awareness
Community Mitigation

Community mitigation is a package of actions that don’t involve medicines or vaccines and are important for stopping the spread of COVID-19:

1. Staying home
2. Keeping a safe distance of at least 6 feet from others
3. Moving to remote learning for schools
4. Encouraging tele-work for businesses
5. Cancelling mass gatherings
6. Closing non-essential businesses
New Hampshire Response

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COVID-19 Testing Landscape

Symptom Onset

RNA Detected

Ag Detected

IgG-positive Antibody Test

Weeks Post-Symptom Onset

Exposure

Quarantine Period 14 days

Isolation Period 10+ days

RNA Detected

Ag Detected

IgG-positive Antibody Test

NH DIVISION OF Public Health Services
Department of Health and Human Services
What Are Antigen Tests?

• Detect fragments of proteins on or within the virus
  o Intended to detect acute infection

• Advantages: cost less to manufacture (cost ~$20), bulk availability, fast TAT, POC

• Disadvantage: higher probability of returning false negative and false positive results
How Does NH Public Health Recommend Antigen Testing Be Implemented?

• Antigen testing recommendations depend on a number of different factors:
  – Symptom status (symptomatic vs. asymptomatic)
  – Setting of use (hospital or congregate living vs. outpatient)
  – Purpose/intent of testing – diagnostic vs. screening vs. surveillance
  – Previous diagnosis of infection AND duration of time since initial infection

• This leads to different guidance for different situations, and really complicated testing algorithms!
New Hampshire COVID-19 Ideal Testing Recommendations Algorithm

**DRAFT Example – Not For Further Distribution**
New Hampshire Response

- Contact Tracing
- Medical Surge
- Situational Awareness
- Community Supports
- Community Mitigation Policy
- Testing
- Education
Clinical Course of COVID-19

~81% mild/mod
5% Critical
14% Severe
Solidarity Trial

- 11,266 hospitalized adults randomized in 405 hospitals in 30 countries to
  - 2,750 remdesivir
  - 954 hydroxychloroquine
  - 1,411 lopinavir
  - 651 interferon plus lopinavir
  - 1,412 interferon only
  - 4,088 no study drug

- Little or no effect on overall mortality, initiation of ventilation, and duration of hospital stay
  - Other trials had shown a modest effect of remdesivir on duration of hospital stay
  - Dexamethasone reduces mortality for inflammatory phase

- No game-changer antiviral drug identified
COVID-19 Vaccines

The Great Challenge to All of Us:
Candidates, Ethical Allocation and Effective Distribution
Bobbie Bagley, MS, MPH, RN, Director of the Division of Public Health and Community Services, Nashua NH
Dr. Fay Homan, MD, Family Practice physician Wells River VT and primary care advocate serving on the Board of the Vermont Academy of Family Physicians
Health Disparities During the Covid Pandemic: a view from rural Vermont

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Patient stories

› Abe, 87 yrs, mild dementia. Wouldn’t eat, drink or get out of bed. No specific complaints, “just done”.

› Missy, 60 yrs, severe shortness of breath for 5 days.

› Gina, 92 yrs, severe arthritis, assisted living
Most affected groups

› Seniors

› Those with mental illness
  - anxiety disorders
  - Substance abuse disorders

› Young adults
Seniors

› Loss of social outlets:
   – senior centers and adult day care closed
   – Senior transportation halted
   – Limited family visits
   – Digital divide

› Loss of physical outlets
   – Senior center exercise
   – Confined to rooms in long term care
   – Walking while shopping/errands

› Loss of advocates
   – Loss of in-home caregivers
   – Family not allowed at appointments
Health outcomes for seniors

- Muscle weakness
- Falls
- Fractures
- Pressure sores
- Pneumonia
- Increased joint pain
- Depression
- Loss of will to live
Mental health, especially anxiety and substance abuse disorders

- Delaying or avoiding health care
- Loss of support groups
  - MAT programming
Young Adults

- Depression and Anxiety
  - 1:4 people aged 18 – 24 considered suicide in the past month
    - https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

- Loss of independence

- Loss of vocational and educational opportunity

- Loss of hope
Excess deaths not directly related to Covid

- 100,000 excess deaths since March not attributed to Covid

  - Why?
    - Delayed acute care
    - Delayed preventive care
    - Declining mental health
    - Physical decline

www.cdc.gov/mmwr/volumes/69/wr/mm6942e2.htm
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What went well

Quick adaptation
  drive-through testing, isolation rooms, phone visits, telehealth, driveway visits, Covid team

Collaboration
  Food insecurity
    Willing Hands, Everyone Eats
    Care coordinators (Blueprint)
    Local nonprofit
    Town-based volunteer networks
  School-based healthcare and counseling
Thoughts for the Future

Primary care as hub for wrap-around services
  Save specialty resources for the sickest
  Increasing focus on social determinants
  Data, staff, infrastructure
  Community bond/trust
In closing

Thank you for joining us today!

Please complete your evaluation using the program evaluation icon to the left of the screen

Stay well and be kind!