DRAFT - RSA 126:A:13
Health and Human Services Oversight Committee
February 21, 2020
Legislative Office Building Room 205

Present: Representatives Weber, Nordgren, MacKay, Campion, Wallner; Senator Rosenwald
Absent: Representative McMahon; Senator Fuller-Clark

The meeting was called to order at 10:00 AM.

1. Review of Minutes: With a quorum present the committee reviewed the minutes of September 27, October 25, November 22, 2019 and January 24, 2020 regular meetings. Rep. Mackay moved that the minutes be approved, and Rep. Nordgren seconded. The minutes were approved unanimously with Sen. Rosenwald abstaining.

2. HHS Oversight Subcommittees (Updates): Health and Human Services Oversight Subcommittee on Emergency Management Services pursuant to RSA 126-A:15 – Representative Gary Woods and Leigh Cheney, Director, Emergency Services Unit, New Hampshire Department of Health and Human Services.

   The Subcommittee met and drafted Senate Bill 756, sponsored by Sen. Fuller-Clark. It was introduced in Senate Commerce yesterday (3/3/20).

   Ms. Cheney described work to-date. They met with stakeholders from Depts. of Fish and Game and Insurance, NH Hospital Association, Primex and municipalities. Identified gaps, which led to the creation of draft legislation.

   Chair Weber asked in the Subcommittee needs to continue, or if members will continue in support of legislation. Sen. Rosenwald asked if insurance is required will volunteers need to bring their insurance vs the state providing coverage. Rep. Norgren asked if a FN will be needed – Mr. Williams indicated that it would.

   Rep. MacKay moved and Rep. Campion seconded that the Subcommittee be thanked for their work and dissolved.
   Update: Sen. Commerce voted Interim Study on SB 756, at Sen Fuller-Clark's recommendation, so that additional meetings with stakeholders could be held.

3. DD and ABD Waitlist Quarterly Report – Deborah Scheetz, Director, Long Term Care Support Services, and Sandy Hunt, Administrator, Bureau of Developmental Services. (Report Summary dated 2/21/20).

   Ms., Scheetz described the current status of the waitlist. There was a delay in allocating funds to clients on the waitlist due to the administrative work associated with the continuing resolution and the 3/1% increase in Medicaid reimbursement rates. Agencies continue to report workforce concerns despite the rate increase. These are especially

present in the North Country and Lakes Region, particularly for clients with dual diagnoses.

4. Newborn Screening Advisory Committee Annual Report – Tricia Tilley, Deputy Director, Division of Public Health Services, New Hampshire Department of Health and Human Services. (Report dated February 21, 2020)

   Of all NH births (11,807) only 1 infant missed screening. Ten infants were identified with one or more of the rare conditions.

   One condition was added in 2019 – Spinal Muscular Atrophy (SMA). If recognized early, early treatment is most effective. The Advisory Council recommended the addition of three more conditions, a recommendation for which will be sent to the Commissioner following development of screening protocol.

   DHHS needed to renegotiate the contract with University of Massachusetts Lab for the first time in over seven years. Cost increased from $71 to $104, due to increase in number of disorders screened and the addition of Sunday courier.

   An RFP was developed for a vendor to provide hospitals with equipment for newborn congenital heart disease. A different screening process is required.
   Rep. Weber asked how often the panel meets- they are required to meet twice a year but will meet to consider additional conditions if the need arises.

5. SB 118 (2019) Child Fatality Review Committee Annual Report - Tricia Tilley, Deputy Director, Division of Public Health Services, New Hampshire Department of Health and Human Services. (Memo dated December 15, 2019)

   SB 118 codified work previously conducted per an Executive Order. The committee has been reconstituted and began to meet in September. No annual report has been created yet, however; data presented to-date. Our numbers reported as follows:

   Infants 0-1= Sudden unexplained infant death - Leading cause of preventable death

   1-9y.o = drowning. Often occur in open water, especially in young school age kids. Therefore, strategies different. Committee will begin to look at these drowning deaths

   Age 10-19 = MVA deaths. Stress importance of teen seatbelt use focus on safety when kids learning to drive.

   Age 15-19= deaths by suicide- firearms, suffocation, poisoning. Know that teens need particular strategies. Thanks for work being done, especially with Rep. MacKay's leadership

   Rep. MacKay – sometimes have difficulty in getting information from mental health centers re: fatality. Too soon to know whether Suicide Prevention Council may have success in getting info.
   Ms. Tilley – SB 118 in part designed to codify access to data in a confidential way.

Data summary: 2009- 2018 – 925 total deaths (146 accidental; homicide 125; natural 597; suicide 81; 61 undetermined)

6. HB 127 (2019) State Office of Rural Health (SORH) Annual Report – Alisa Druzba, Administrator, Division of Public Health Services, New Hampshire Department of Health and Human Services. (Report dated February 21, 2020).

Ms. Druzba reviewed the health status of rural residents and the first report of health workforce data collection.

Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection

- In national rankings, New Hampshire often is in the top ten, in its healthcare delivery system as well as in population health and overall well-being.
- This is attributed to low unemployment, a more educated workforce, low poverty rate
- But this does not account for pockets of high uninsured rates in places such as the northern rural areas, particularly among young adults, and in the southern urban areas among Hispanics
- And the drug overdose rate has been steadily increasing and severely straining the health care system as a whole
- Rural residents face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals
- Significantly older, poorer, & less educated than non-rural residents
- Far more likely to be unemployed or out of the labor force, and rural workers are more likely to be self-employed or to work in industries where health insurance benefits are less available.
- Significantly less likely to be insured for health services, but more likely to be on Medicaid.
- Rural residents are also less likely to be insured for dental services. **Refer to visualizations**

Demographics

- While the greatest statistical difference in race between rural and non-rural NH is visible in the White-only indicator in Figure 2 above, it is only by 3 percent (95.3% v. 92.1%).
- Surprisingly, rural and non-rural NH are also statistically similar in population age, with the greatest difference found in those 65+ years old (20.7% and 15.4%, respectively).

Behaviors

• Rural and non-rural NH differences in health behaviors are most notable for smoking and health care coverage.

- BRFSS data indicates a 4% difference in the rate of rural and non-rural current smokers (20.1% v. 16.2%); however, when examining maternal smoking during pregnancy, the differences appear more significant.

- While 13.3% of maternal smoking anytime during pregnancy was reported in rural NH compared to 7.8% by their non-rural counterparts, the greatest gap in smoking between rural and non-rural exists for smoking during the 3rd trimester, where approximately 9% more rural residents reported this health behavior (21.5% v. 12.6%).
- Slightly more rural residents (11.8%) reported no health care coverage compared to non-rural residents (8.2%).

Mortality

- Consistent with the national trend, accidental and intentional overdoses for drugs, including opioids, are slightly higher in non-rural NH than in rural NH ($average\ (\bar{x})$ = 4%) as seen in Figure 4 above.
- Also, of note are the insignificant differences between rural and non-rural NH when considering alcohol related deaths and youth suicide.

Rural Status not that different from non-rural so it comes down to interventions

- Same Triple Aim goals as everywhere:
- Better care
- Better health
- Lower cost
- But there are persistent rural priorities
- Access to services (includes how to finance)
- Community focus (IOM Report - Quality Through Collaboration: The Future of Rural Health)
- Innovative use of personnel and facilities **What we do**

- Access - To increase access to quality health care services for rural and underserved populations
- Quality - To improve the quality of care provided at Critical Access Hospitals and Rural Health Clinics.
- Sustainability – To improve financial and operational outcomes of Critical Access Hospitals and Rural Health Clinics.
- Workforce – To quantify and increase the number of health care providers serving rural and underserved populations.

Data Collection

Since the amendment to RSA 126-A:5, XVIII passed in July 2019, only one (1) provider type, physician assistants has relicensed with the Division of Health Professions under the Office of Professional Licensure and Certification (OPLC).

Physician Assistant Response Rate

- Of the 903 physician assistants (PAs) due to renew their license, 837 renewed (92.7%), reducing the percentage of NH-licensed PAs by just over 7 percent since 2018.

Five of the eight participating health professions licensing boards have formally adopted survey rules: the Board of Medicine, the Board of Nursing, the Board of Mental Health Practice, the Board of Alcohol and Other Drug Use Professionals, and the Board of Psychologists.

- The administrative rules process has commenced for the Board of Dental Examiners and will conclude prior to the anticipated 2021 survey implementation.

- The remaining two boards, the Boards of Allied Health Professionals and Pharmacy, are slotted to enter the administrative rules process two years after full implementation with primary care-associated licensing boards, in 2024.
- Workforce reports with aggregated provider data will be developed annually for each participating provider type that relicenses together in one given year; and bi-annually for each participating provider type that relicenses all licensees in two years

7. DHHS Commissioner's Update and Dashboard Report including highlights of implementation of MCM and other core initiatives – Commissioner Lori A. Shibinette.

   Commissioner Shibinette described the work of DHHS as she is settling in to her new role. The Dept. is working on revamping the dashboard to create a visual tool to be able to see trends more easily.

   It has been several years since the development of a Strategic Plan. There is a need to balance priorities with being proactive, looking five years out. The Commissioner is establishing several working groups to identify concerns before a crisis hits, to include a Long-Term Care working group and a Mental health for first responders working group.

   Comments from Committee members included:
   Rep. MacKay indicated that he excited to hear of the interest in first responders. He noted the continuing education on mental health and first responders.

   Rep. Weber – we have observed that the state is reactive, would like to move toward a more proactive perspective especially as it related to community housing for those with mental illness. The Commissioner indicated that data from NH Hospital addressed that need – the back door in a log jam b/c we couldn't discharge people to appropriate housing. Those discharged to independent housing were more likely to be readmitted

   Rep. Nordgren stated that transition beds were in the budget.

   Sen Rosenwald requested that the dashboard continued to include Table 5, vacancies. She asked whether after transfer of $3.4 million out of salary line, will there be sufficient money to fill vacant positions. Ms. Shibinette indicated that every vacant position could be filled and paid for through the end of the biennium.

8. Adjournment
   Chair Weber adjourned the meeting at 12:00 noon.