Vermont
Public Health Institute

VT Community Health Equity Partnership Webinar #2

The Importance of Data

April 11, 2022, 1-3pm

Agenda

- Reflection: Bishop Rev. James L. Mills, Jr.
- Two VT Data Model Approaches: Tin and Rudy
- Overview of the Health Equity Self-Assessment
- Facilitated Breakout Room Discussions
- Share-out
- Closing and Feedback Survey

Statement of Purpose

The Vermont Community Health Equity Partnership exists to assist the Vermont Department of Health to meet the goals of the CDC Grant to Address Health Disparities – specifically to "mobilize partners and collaborators to advance health equity and address social determinants of health as they relate to COVID-19 health disparities among populations at higher risk and that are underserved."

We Commit To

- Respect and trust each other
- Honor individual experience
- Embrace your right to risk
- Expect “imperfect ideas” and “messy musings”
- Be present and lean into discomfort

Source: ISP International

Action Learning Collaborative Summary

- March 2022 – May 2023
- Statewide learning and sharing through webinars and in-person trainings
- Shared library system for documentation and cross-referencing
- Facilitated local team meetings
- One-on-one coaching as needed

Goal

Provide information and resources to Vermont Department of Health Districts and community partners to help build capacity to create a culture for equity.

Objectives

- Address health disparities among those who have faced the greatest inequities throughout the COVID-19 pandemic.
- Mobilize around advancing health equity, focusing on the root causes of inequities.
- Bring people together and empower community voices.

Resources Available

Workshops and Webinars

April 15, 9:30-10:30am: The Use of Questions in VT CHEP: Padgett Coaching

April 26 – 28: Collective Impact Summit (*deadline to register April 15th)*

May 12, 10-12am and 2-4pm Webinar #3: Community Engagement

Coaching Support with Padgett Coaching - *reach out to them directly*
Coaching and collateral support to enable every team to do its best work. Using team coaching as an ideal tool to create sustainable change, they will help our teams see where they are as well as what they wish to achieve.

Health Resources in Action Consultations - *let Cathy know what supports you think you need and she will connect with HRiA*
Expertise built on their health equity framework – centered on racial equity – to guide our internal work, as well as our work with communities, partners, and clients. This framework relies on three foundational components to operationalize and advance health equity.

- Challenge assumptions and narratives about what promotes and hinders health
- Create and sustain authentic and diverse stakeholder engagement
- Strengthen capacity to correct power imbalances and address inequities

Today's Speakers

Laural Ruggles MBA, MPH worked in healthcare for 30 years, including medical office operations, marketing, and community health improvement. She has worked on state health reform issues including the Vermont Blueprint for Health, and efforts to align the Accountable Health Community and Accountable Care Organization models. She is currently working with the Vermont Public Health Institute on a state-wide project to improve regional capacity in health equity and reduce structural and system causes for health disparities. Laural is active in NEK Prosper - Caledonia and So. Essex Accountable Health Community – as a member of the Well-Nourished Collaborative Action Network and the NEK Prosperity Fund Advisory Committee. She volunteers in her town on the Danville Energy Committee and the Committee to Reimagine the Train Station on the Lamoille Valley Rail Trail. During the COVID-19 pandemic, she served with the NEK Medical Reserve Corp (MRC) helping out at regional vaccine clinics.

Bishop (Rev) James L. Mills Sr accepted the position of pastor at the First Congregational Church of Fair Haven in 2019. Mills brings more than 20 years experience as a minister and administrator to Fair Haven. The job might be new, but Mills and his two teenage children are no strangers to the area. He first visited Vermont in 2008 when he took a trip to Rutland while recovering from cancer. "In many ways, cancer brought me to Vermont, and the people healed me," he said. Mills says his decision to take the job at Fair Haven was an example of "the spirit at work." Prior to accepting the pastorship in Fair Haven, he served as administrative bishop at the Fellowship of Affirming Ministries, a multi-denominational, multinational, primarily African-American group of Christian leaders and laity who practice a theology of radical inclusivity, which engages and ministers to individuals on the margins of society. Mills hopes to bring those principles to the Fair Haven community, where issues of poverty, opioid addiction and an aging population are impossible to ignore.

Today's Speakers

Rudolph (Rudy) Fedrizzi, MD is the Public Health Services District Director for the White River Junction Office of Local Health (OLH) in the VT Department of Health. Previously, Dr. Fedrizzi was a practice facilitator for the UNH Institute for Policy and Practice's NH Citizen's Health Initiative and its Northern New England Practice Transformation Network, and a private healthcare consultant. From 2010 to 2018, he was the Director of Clinical Integration in the Center for Population Health at Cheshire Medical Center/Dartmouth-Hitchcock. Prior to that, he practiced Obstetrics and Gynecology for 16 years. He is currently Chair of the Upper Valley Medical Reserve Corps Advisory Board, President of the Public Health Council of the Upper Valley Board, Vice President of the Southern NH AHEC Board, a member of the NH Medical Society, the American Public Health Association and the Rotary Club of Lebanon, NH Charities Board. He is a graduate of St. Lawrence University in Canton, NY and received his Medical Degree from Washington University School of Medicine in St. Louis, MO.

Tin (Justin) Barton-Caplin, MPH, MHA has worked in public health for over 20 years and has significant experience in community-based assessment and data collection as well as health services research. He currently serves at the District Director for the Vermont Department of Health's Newport Office which serves Orleans and northern Essex Counties.

Todays Learning Objectives

- Attendees will be able to describe what and how colleagues in two local VDH Districts have used and learned from the data
- Attendees will understand how other Districts are assessing and planning
- Attendees will know where to look for national, state and local data sets
- Attendees will be able to describe the Health Equity Self-Assessment Tool, as well as how to use it in their own district

ONE Vibrant Communities

Tin (Justin) Barton-Caplin

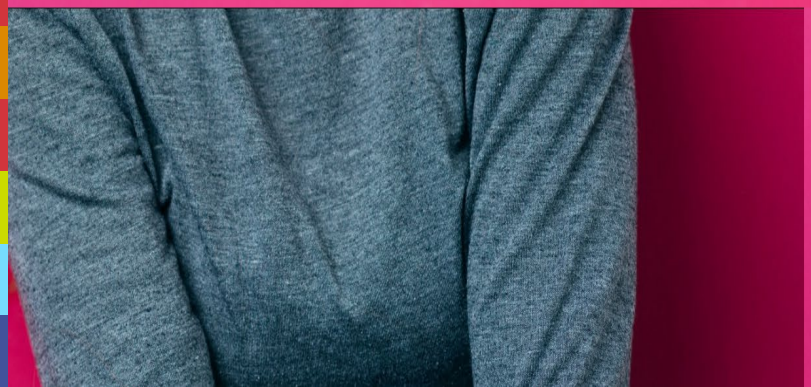
April 11, 2022

Agenda/Objectives

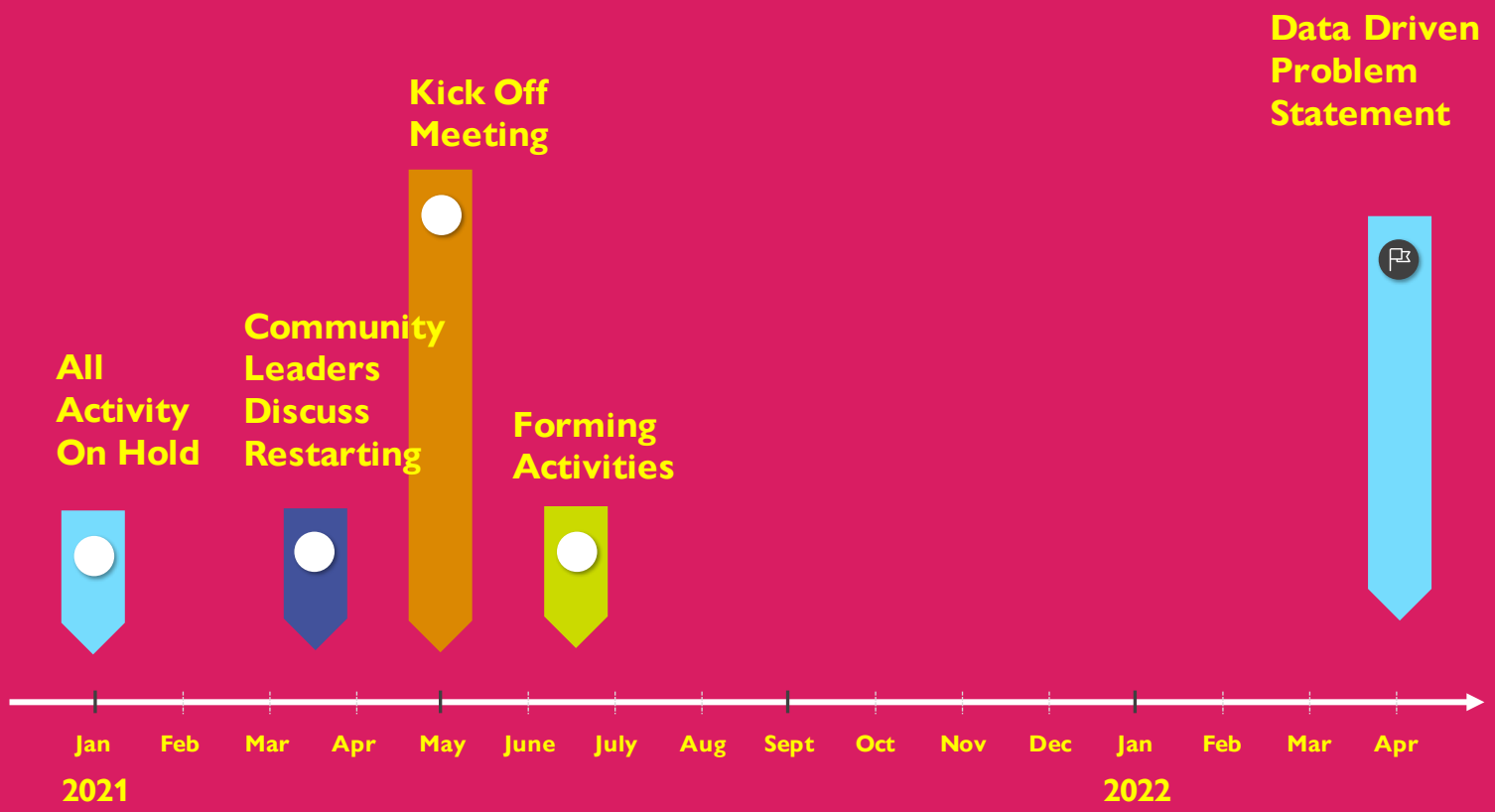
- Describe Transformation of ONE Vibrant Communities
- Review Timeline / Process
- Understand Value of Polling ONE Vibrant Community Members
- Provide Examples of Existing Data
- Describe Importance of Quantitative AND Qualitative Data
- Understand Importance of Data Driven Decision Making
- Review ONE Vibrant Communities Problem Statement

Transformation

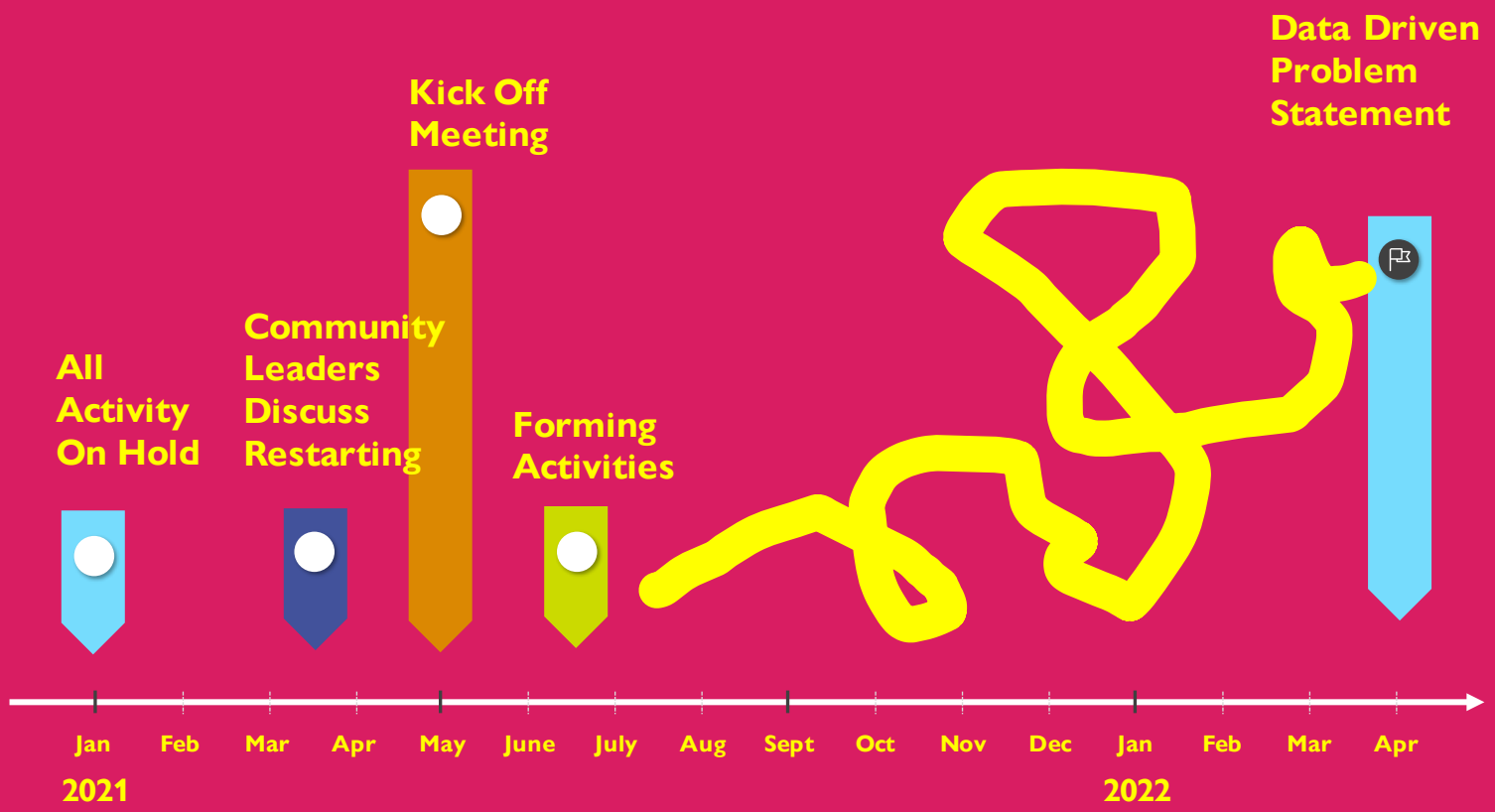
Orleans Northern Essex (ONE) Vibrant Communities the current transformation from our previous Accountable Communities for Health Upper Northeast Kingdom Community Council (UNKCC)



Our ONE Recent History



Our ONE Recent History



Our ONE Recent History

All Activity On Hold

Community Leaders Discuss Restarting

Kick Off Meeting

Forming Activities

Data Driven Problem Statement

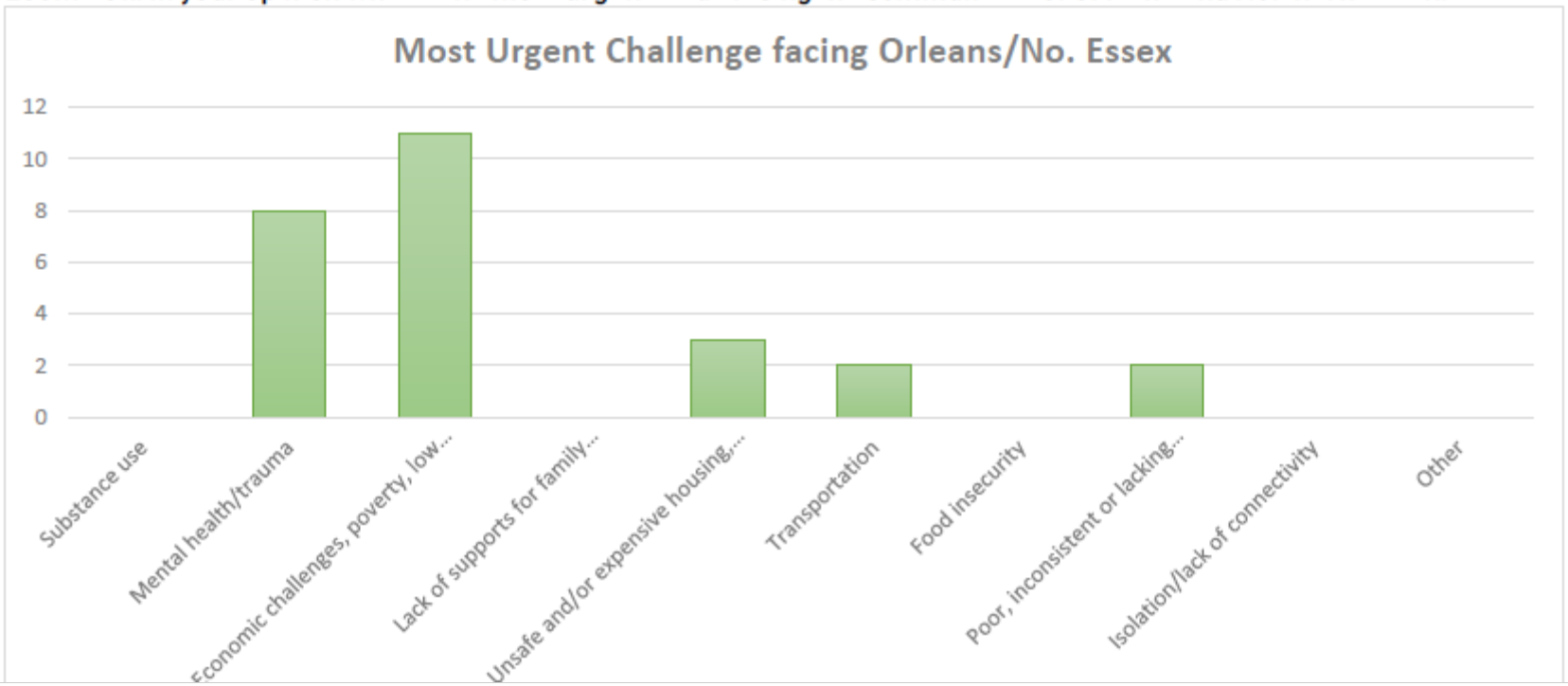
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr

2021 2022

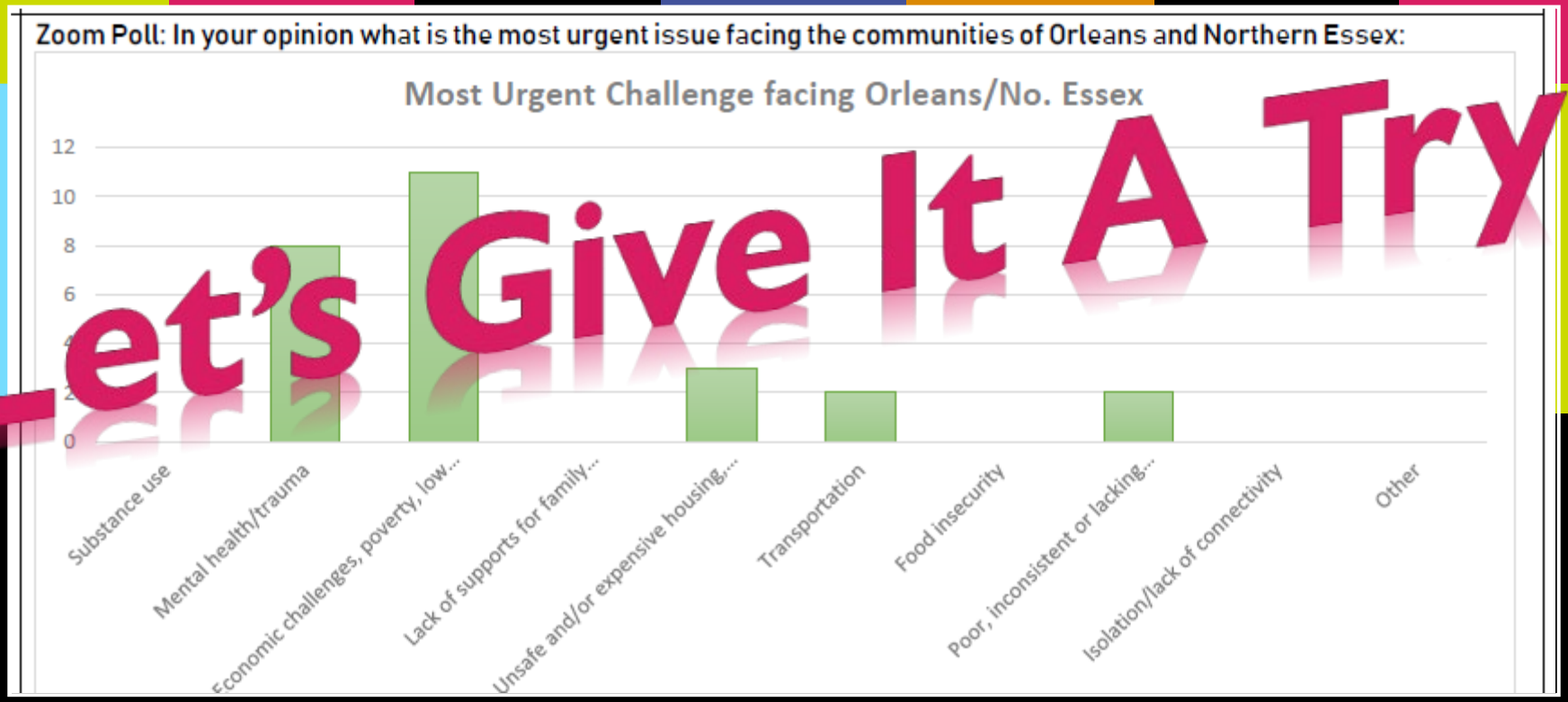
Polling


Collaborative
Leadership
Acceptance
Inclusion
Compassion
Equality
Alive
Aligned
Positive Impact
Partnership
Empowerment
Creativity
Resiliency
Engagement
Accessibility
Strengths Based
Connection
Participatory

Zoom Poll: In your opinion what is the most urgent issue facing the communities of Orleans and Northern Essex:



Polling


Zoom Poll: In your opinion what is the most urgent issue facing the communities of Orleans and Northern Essex:
Most Urgent Challenge facing Orleans/No. Essex
12
10
8
6
0
Substance use
Mental health/trauma
Economic challenges, poverty, low...
Lack of supports for family...
Unsafe and/or expensive housing,...
Transportation
Food insecurity
Poor, inconsistent or lacking...
Isolation/lack of connectivity
Other
Let's Give It A Try

Polling

Existing Data

Polling Data aligned with existing data:

- Community Health Needs Assessment data
- Domestic Violence Needs Assessment data
- Substance Use prevention Community Assessment Data

Existing Data

100 Cups of Coffee Listening Sessions
Prevention Coalition
Summer 2021

Participant Sectors (50 Interviews):

Question #1: What's your vision for a thriving NEK?

Label	Themes
Community	• Feeling a connection to the community • Community involvement • Sense of safety, growth and development
Things to Do	• Community based events • Increase in Parks and Recreation activities
Culture	• Support and inclusion for BIPOC, LGBTQ+ and disabled NEKers • Dismantling White Supremacy
Infrastructure/Services	• Affordable housing

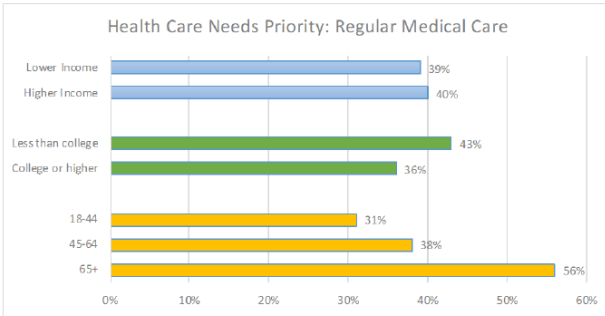


Figure 3: Health Care Priority Need #1

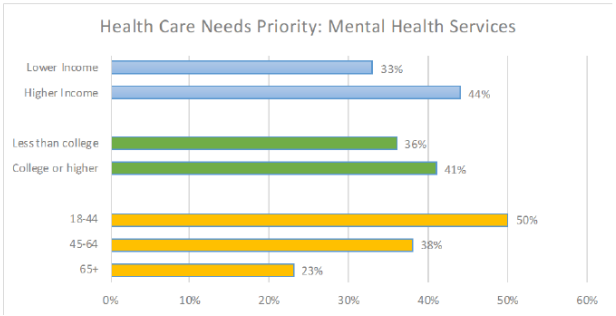


Figure 4: Health Care Priority Need #2



Value of Quantitative AND Qualitative Data

Hypothesis

Newport area needed additional supports for people coming to the ER or interacting with law enforcement while intoxicated

So an Action Team started working on designing a social detox program

Data Driven Decision Making

Data Driven Problem Statement

VIBRANT ONE (Orleans/No. Essex)

VISION: Orleans and Northern Essex is a vibrant, thriving, safe and inclusive community. We work collaboratively toward our shared vision: building on the strengths of our community; honoring voice and choice; and fostering health and wellness, dignity and respect.

WICKED PROBLEM/OPPORTUNITY STATEMENT #1: We are not providing the right mental health/substance misuse care, at the right place at the right time, every time and too many in our community are getting stuck at the wrong level of care/ wrong care location. This is frustrating, costly, and ineffective.

COMMUNITY ASPIRATION/RESULTS STATEMENT #1: Everyone living in Orleans/No. Essex will have easy access to person-centered and coordinated mental health and substance misuse services that are timely, close to home, at the appropriate level and with the appropriate transition supports for continued success in a person's home community.

ROOT CAUSES

What is holding the wicked problem in place?

(identifying the root causes will help point to strategies to address those root causes)

COMMUNITY ASSETS

Why isn't the problem worse (what's going well)?

(identifying community assets will help point to strategies to make use of assets)

POPULATION GOAL #1a: By 2025 we will have reduced the number of ED visits/length of stay for MH

POPULATION GOAL #1b: By 2025 we will have reduced the number of ED visits/length of stay for SUD

POPULATION GOAL #1c: By 2025 we will have reduced the number of opioid related deaths

POPULATION GOAL #1d: By 2025 we will have reduced the number of suicide deaths

POPULATION GOAL #1e: By 2025 we will have reduced the number of poor mental health days

BACKBONE/DESIGN GROUP ROLE
- Guide Overall Vision and Strategy
- Support Aligned and High-Leverage Activities
- Establish Shared Measurement Practices
- Cultivate Inclusive Community Aspiration, Engagement and Ownership
- Advance Policy
- Mobilize Resources
- Provide Strategic Learning Opportunities
- Cultivate Systems Change Leaders

SOCIAL DETOX ACTION TEAM

Rapid learning through iteration (accelerated process) to build proposal to bring back to Steering Committee

IDEAS of POP LEVEL INDICATORS (how will we know we are achieving our aspiration?)
- Fewer ED visits for MH/SUD
- Shorter ED stays for MH/SUD
- More texts to Crisis Text Line
- More local options for "less than crisis-level care"
- Decrease in poor mental days
- Reduced opioid deaths
- Reduced suicide deaths
- More MAT providers
- More MH/SUD providers

Data Driven Problem Statement

Wicked Problem / Opportunity Statement #1:

We are not providing the right mental health / substance misuse care, at the right place at the right time, every time and too many in our community are getting stuck at the wrong level of care / wrong care location. This is frustrating, costly, and ineffective.

Beginning to Explore Health Equity Data in the Upper Valley

Rudy Fedrizzi, MD

April 11, 2022

Potential Sources of Locally Relevant Data

Using the Social Factors that Influence Health Lens

Source: Dahlgren and Whitehead, 1991

Guiding criteria for Indicator selection:

1. Aligned to the SDoH
2. Data available at county, state and national level
3. Windsor County under performs VT
4. Potential exists to improve the indicator

Upper Valley Disparity Data Dashboard

SD	Indicator	Windsor	Orange	Grafton	Sullivan	VT	NH	US	Source
Education	**Childcare capacity** - the # of Head Start and Early Head Start programs located in or within 0.5 miles of a county boundary per 100,000 population. (2020; U.S. DHHS Administration for Children and Families)	5.4	20.7	5.6	4.6	13.3	4.6	9.3	US News & World Reports - https://www.usnews.com/news/healthiest-communities/rankings
Housing	**% spending >30% of income on housing -** the percentage of cost-burdened households, where housing costs (mortgage or rent, utilities, taxes and other costs) are 30% or more of total household income. (2015-2019 American Community Survey 5-year estimates, U.S. Census)	33.2	31.6	31.5	33	32.8	30.6	23.4	US News
Housing	**Affordable housing shortfall** - the availability of affordable housing for families that earn less than 30% of median area income. Negative numbers indicate a shortfall; (2015-2019 American Community Survey 5-year estimates, U.S. Census)	-68.9	-51.9	-50.9	-54.3	-61.9	-60.1	-62.3	US News
Healthcare Access	**Dental Providers/population** Ratio of population to dentists. The 2021 Rankings used data from 2019 for this measure.	1:1620	1:3210	1:1120	1:2540	1: 1370	1: 1300		County Health Rankings - https://www.countyhealthrankings.org/
Mental Health	**Deaths of Despair -** the rate of deaths due to suicide, alcohol-related disease and drug overdoses per 100,000 population. (2012-2018; CDC)	48	40.9	37	49.6	41.6	53	43.3	US News
Safety	**Injury Deaths** - # of deaths due to injury per 100,000 population. The 2021 Rankings used data from 2015-2019 for this measure.	101	89	81	81	86	89		County Health Rankings
Lifestyle	**Excessive Drinking**	23	20	22	19	20	20		County Health Rankings
Lifestyle	Youth MJ Use LGBTQ+ vs hetero	65 **vs 23**				27			YRBS
Environ-ment	**% children testing high for lead -** Blood Lead Levels (>5µg/dL) among Children < 72 Months of Age, 2017	2.4	2.5	1.9	4.0	1.5	2		CDC https://www.cdc.gov/nceh/lead/data/state.htm
Social	Kids believe that matter LGBTQ+ vs hetero	23 **vs 65**				59			YRBS
Social	**Poor Mental Health Days-** Average # of mentally unhealthy days reported in past 30 days (age-adjusted). The 2021 Rankings used data from 2018 for this measure.	4.5	4.6	4.4	4.7	4.2	4.6		US News
Health	**Premature Death -** Years of potential life lost before age 75 per 100,000 population (age-adjusted). The 2021 Rankings used data from 2017-2019 for this measure.	6700	6000	5600	6100	6300	6400		County Health Rankings

Using the Draft Dashboard as Engagement Tool

Greater Upper Valley Integrated Services Team prompting questions:

1. How do these indicators relate to or are meaningful for your work?
   - Will give us the big picture, how to "personalize" data?
1. What data is missing that would enhance our knowledge?
   -More lifestyle measures, transportation, food access, environment, opioid, obesity, poverty, afterschool, recreation, etc. etc.
2. What are other possible data sets?
   - Health Equity Tracker, VT211, Mental Health America, BRFSS
4. How would you like data presented and reviewed?
   - Give us options to react to, find ways to trend over time

Disparity Data Measurement

In "Achieving Health Equity: A Guide for Health Care Organizations," IHI advocates for these guiding principles in measuring health disparities:

1. Select a reference point – generally the group with the best outcomes
2. Measure in both absolute and relative terms – improvements can occur in two populations, but disparities can still widen
3. Express measures in terms of adverse events
4. Use pairwise comparisons (though this doesn't capture intersectionality - i.e., race, gender, income, educational attainment)
5. Include summary measures

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

Ways to Make Data Compelling

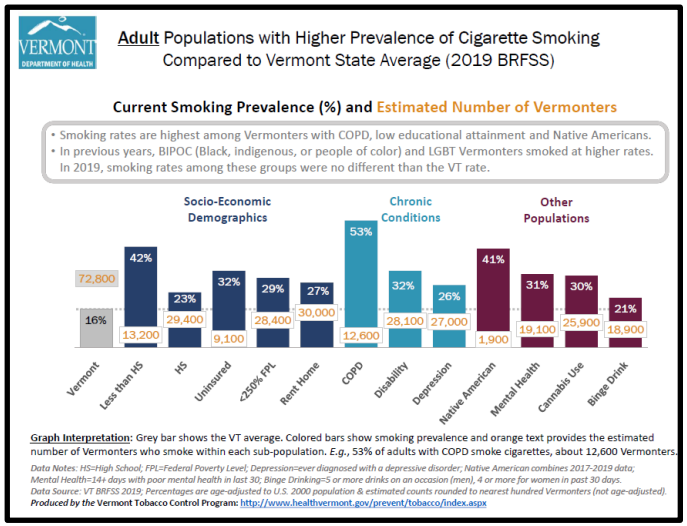
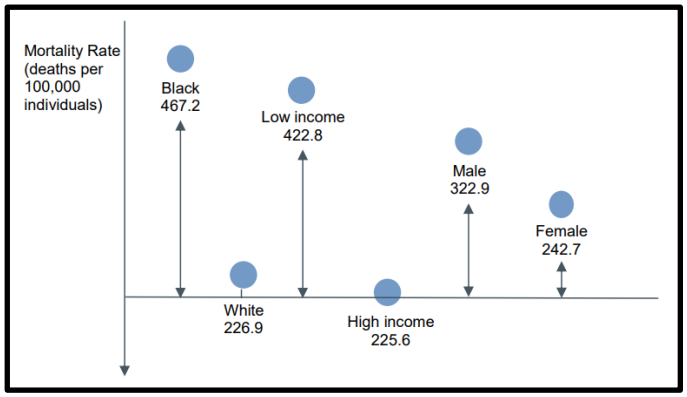
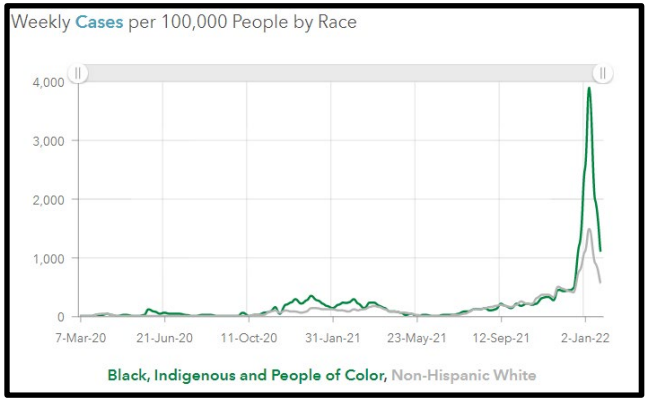


Photo Voice and Other Approaches





Engaging Student Interns

Questions?

Rudy: Rudolph.Fedrizzi@vermont.gov
Tin: Justin.barton-caplin@vermont.gov

The ABLe Self-Assessment Tool

"To help everyone become a powerful agent of change within their community.

Use the self-assessment to identify which Change Agent practices you are most interested in building. "

http://systemexchange.org/

Vermont Public Health Institute

VERMONT DEPARTMENT OF HEALTH

The ABLe Change Philosophy

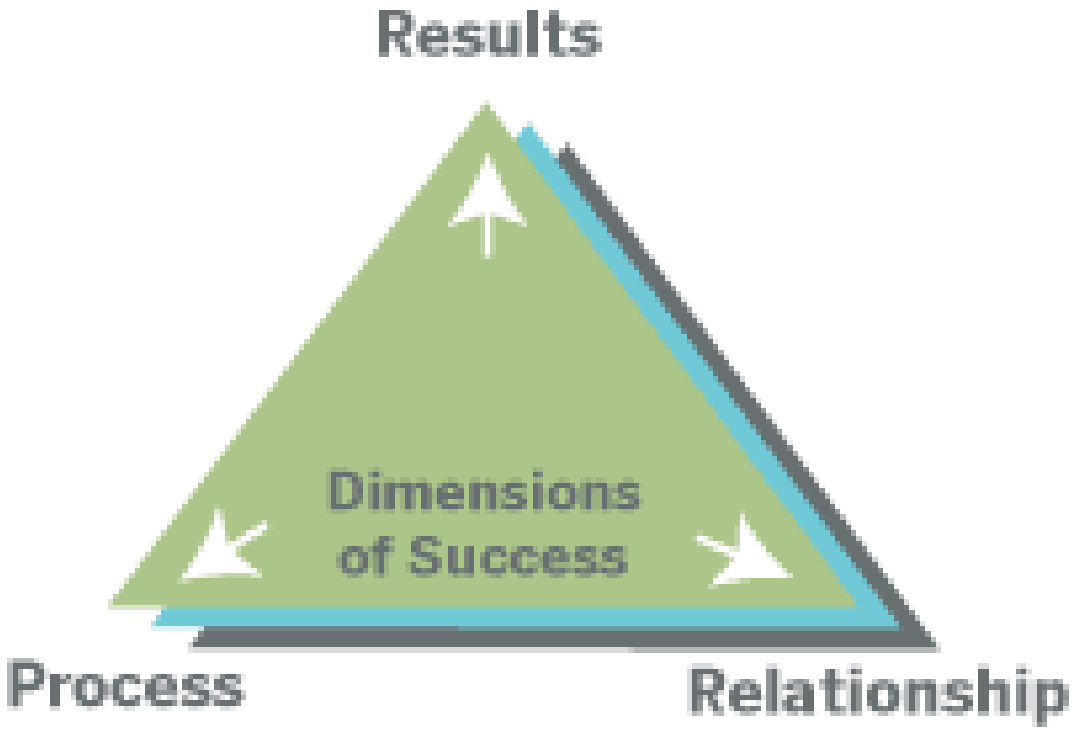
- **Think Systemically:** Change efforts often target the surface of problems, not the underlying systemic conditions causing local problems. Thinking systematically attends to and shifts system characteristics and their interactions, and the more effective the solutions.
- **Engage Diverse Partners:** Diverse stakeholders hold unique perspectives on the systems, its problems, and possible solutions. Engaging diverse perspectives leads to more comprehensive understanding of the system and how to change it.
- **Incubate Change:** Transformative change is accelerated when communities create the conditions for rapid innovation to occur across the community system. Incubating change includes fostering small actions across multiple community layers as well as leveraging systemic feedback loops to reinforce the change.

The ABLe Change Philosophy, continued

- **Implement Change Effectively:** Great strategic designs for promoting community change are not enough; systems change efforts must also attend to how effectively their proposed strategies are carried out by assessing and building a climate for effective implementation.
- **Adapt Quickly:** Problems facing our communities today are complex and ever-changing. Transformative change requires an ongoing, dynamic process, where understanding, learning and adapting become more important than planning. To adapt quickly, you must identify and quickly respond to emerging problems and opportunities.
- **Pursue Equity:** In order to really shift the status quo, one must understand disparities in outcomes and opportunities. Pursuing social justice includes identifying, acknowledging, and tackling the inequities that exist.

When Traditional Outcomes are Not Enough

The Interaction Institute for Social Change's **R-P-R Triangle**



Source: https://interactioninstitute.org/means-and-ends/

Self-Assessment Questions

To what extent does your team:

- **Engage** local residents to support your efforts (e.g., by providing input, selecting priorities, co-designing strategies, taking action roles, etc.
- **Ask questions** to understand the **systemic reasons** why problems are happening before designing solutions.
- Use **action learning** and gather rapid feedback from diverse perspectives on the implementation and impact of your efforts to promote continuous improvement.
- **Ask questions** during planning and **decision-making** processes to ensure your efforts are contributing to equity rather than unintentionally contributing to local inequities

Ways to Use the Information

For the local teams:

- To identify current conditions and practices in place within your group supporting equity.
- Help teams determine where to focus efforts.
- To provide teams direction for building an equity strategy and promote conversations within the team to improve health equity.

For VtPHI:

- Provide information to VtPHI on learning opportunities for future webinars/presentations.
- Evaluate VtPHI on how we did in reaching our goals of the grant.

Your turn -
What are your experiences with assessments?

The Self-Assessment Process

- Time today to discuss as a team how best to complete the Self-Assessment
- Local Integrators submit the Assessment to Cathy: vtpublichealth@outlook.com.
- Complete the Assessment again in May 2023

District Location:
Date:

Habits	Activities that tell the Story	Outcomes
Engage local residents to support your efforts. Ask questions to understand the **systemic reasons** why problems are happening before designing solutions. Use **action learning** and gather rapid feedback from diverse perspectives on the implementation and impact of your efforts to **promote continuous improvement**. **Ask questions** during planning and decision-making processes to ensure your efforts are contributing to equity.		• Address health disparities among those who have faced the greatest inequities throughout the COVID-19 pandemic • Mobilize around advancing health equity, focusing on the root causes of inequities. • Bring people together and empower community voice.

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 systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation and disability."

Breakout Rooms Instructions

1. Please select the VDH District you are associated with.

2. You will have thirty minutes together to discuss the following questions:
    - How can we best use what we learn from completing the assessment to guide our health equity work?
    - How can we engage people to complete the assessment for our team?
    - Set some specific action next steps.

3. Choose someone to report out to the larger group one of the following on one “Aha” moment.

Sharing

Round Robin- Each group share one “Aha” moment

Closing

- Please fill out the evaluation
- An email will be shared in the next few days on how to access this and future webinars, data resources, and a template on the data driven problem statement
- Self-Assessment shared with Cathy: vtpublichealth@outlook.com.
- Share Point one-stop filing system coming soon

Thank you!

If you have any questions, please do not hesitate to reach out to Cathy at vtpublichealth@outlook.com.