

2017 • State Health Assessment & State Health Improvement Plan

Advisory Committee Meeting

Focus on the Future:

*In five years, if we have successfully worked towards achieving **health equity***, what would we have accomplished?*

What actions would Vermont institutions (e.g., health departments, schools, prisons, hospitals, corporations) have taken to contribute to health equity?

Vision: All people in Vermont have an equal opportunity to be healthy and live in healthy communities

- The gulf between the rich and poor has been reduced
- Investments are focused on prevention and underlying contributors to positive health outcomes
- All ages, all abilities, and all Vermonters – regardless of race, gender, and class – have access to the conditions that create health (e.g. quality insurance, healthcare, housing, education, economic security, food, transportation, justice)
- Services are available, accessible, affordable, coordinated, culturally appropriate and offered with cultural humility

* **Health Equity** exists when all people have an equal opportunity to be healthy, especially those who have experienced socioeconomic disadvantage, historical injustice and other avoidable inequalities that are often associated with race, gender, ethnicity, social position, sexual orientation and disability.

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Transcribed Notes from the Table Top Discussions

IN 5 YEARS...

Table 1:

- Increased coordination of referrals from medical providers to community service providers
 - Broaden care coordination to include social determinates of health
 - Proactive, direct referrals
 - Integration of coordination
- Recognition of ALL Vermonters (not just youth)
 - Aging Vermonters and Adults → services tend to end at early adulthood
 - People with disabilities
- Individuals: Cultural shift toward value and proactive health
 - Not just “systems-level” trying to change individuals
 - Comprehensive education for youth – adulthood
 - Core competency framework (VT Education Standards put more focus on health)
- Economic and social equality needed for health equity
- Shift from retroactive health services to proactive/ preventative care
 - Reduce operating in “crisis” mode

Table 2:

- Food security
- Housing for all
- Wellness where you are
- Broader training for providers
- Engaging communities around health inclusiveness
- Cultural humility
- Toxic stress reduction
- Aligned priorities and investment

Table 3:

*Equity includes age

- Living in intergenerational homes with access to community members, neighbors and health care
- Vermonters understand and embrace our health equity vision
- Access to preventative and necessary care (all care!) regardless of any financial barriers
- Access = informed providers; Access = public facilities and accurate information

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- No wait time for mental health services
- Co-located services – primary/pediatric care
- Vermont invests in early childhood and recognizes these investments are the key to long term positive health outcomes

Table 4:

- Emphasize prevention vs. treatment
- Comprehensive early education on health (unified message)
- Healthy food access and security
- Tobacco cessation (low income connection)
- Physical activity = keep people moving
- Universal basic mobility (transportation)
- Sugar consumption (beverages)

Table 5:

- Meeting individuals' needs according to where they are and their standards
- Access to the care people need (not just “care available”) (Nursing, dental, etc.) → and way to get there (transportation)
- Care is appropriate and relevant (adults – intel, disabilities have adult PCPs, not pediatricians, etc.)
- Care is more integrated for the under-served → change perceptions of disenfranchised and assumptions about people - decreased fear and comfort with *differences*
 - Understand everyone's contributions and worth
- Local solutions to needs
- Have someone on hand to communicate (interpreters, peers in recovery, etc.)

Table 6:

- Build out communities' social and environmental health
 - Focus on vulnerable populations (youth housing programs. Infrastructure, \$!)
- Promoting healthy behaviors and determinants and barriers
- Identifying conditions earlier through assessments (i.e., TBI, vis-à-vis, criminal justice) to potentially predict health outcomes
- Connect, communicate, collaborate (meta-level, by region)

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Table 7:

- Cost of healthcare (including Mental Health and S.A.)
 - So, access for all is _____ (transportation, enough MD's, interpreters, etc.) – Rational Funding
 - Big focus on prevention (not just traditional prevention)
- Access to good, healthy food and beverages
 - Good steps: EBT card to purchase seeds and at farmer markets
 - Gardens at prisons
- If you want to work on disparities, you must work with the leaders of the communities. They know what's going on on the ground.
- Livable wage/ economic stability
- Mobile clinics for health care/ dental/substance abuse
- Money going more to local communities
- Incentivizing does keep people healthy
- Good: Rule Changes for telemedicine

Table 8:

- More \$ invested in prevention
- Fewer ACES – all kids screened
- We have fully funded system of affordable child care
- Everyone invested
- All inmates will have an opportunity to work in garden
- All VT students have access to healthy food free of charge
- More public information easily accessible about demographics of VT
- Universal design and policies + programs → cultural competency
- What civil rights protections are in place and need to be preserved
- Reaching new Americans with disabilities
- State employees have access to healthy cafeterias
- Greater representation of New Americans in orgs around the state (like this one)
- Improved access to interpret and translation services
- Cultural competency training for service providers
- Improved transportation in Chitt. Co.
 - Improved care coordination and data collection/ sharing among key service providers
- Improved expanded culturally and linguistically appropriate mental health and social adjustment services to new Americans
- Analyze and align our investments in social determinants of health vs. med. Care
- Redesign delivery systems to ensure that svcs are available to people and when/ where needed
- Approach to equity would move from individual responsibility to systematic barriers
- Reduce smoking of pregnant women (currently 30% of low income women smoke)

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Table 9:

- Eliminate disparities in socio-economics
- Valuing all students, increase parent involvement
- Increase cultural and linguistic competencies
- Triangle policy and procedures with all populations in mind in designing systems
- Narrow the gap by empowering everyone in communities
- Communities would have a commitment and action plan
- Governments adopt a perspective on policy that considers health
- Cultural competency in cultural engagement
- Improving affordable access healthcare/ physical and mental
 - Schools/ youth
- Healthy activities year round
- Single payer – reducing burden of bureaucracy for everyone
 - Co-location of healthcare in schools
 - Invest in indoor activity CTRS accessible and affordable to all
 - Reduce gulf between rich and poor – increase access to quality insurance, healthcare, housing, education, economic security, food, transportation, justice
- Awareness and examination of policies and aligning with goal of reducing the gulf.

Table 10:

- Workforce
- Invest in home, community and peer support services
- Education – all school systems have k-12 Health education curriculum aligned with current statutes and rules
- Eliminate waiting for health services
- Housing-homelessness solutions – create them!
- What is the “right data” and how is it used
- Tax credit for family health education

...WILL LEAD TO INCREASED HEALTH EQUITY