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Aligning Systems with Communities to Advance Equity through Shared Measurement:

Vermont Health in All Policies

Lead Organization:	Vermont Department of Public Health
Lead system:	Public health
Partner systems:	13 state agencies, departments, and organizations, including health, transportation, agriculture, education, human services, and natural resources
Location:	Vermont
Population:	Primarily rural, 94% White
Year founded:	2015
Measurement:	Health impact assessments, total health expenditure analyses, performance dashboard

How did the initiative get started?

In Vermont, 65% of residents live in one of 11 rural counties. Rural residents are often older, poorer, and have fewer physicians to care for them than urban residents. Rural residents are also less likely than urban residents to have employer-provided health care coverage, and if they are poor, they may not have health insurance at all. Since rural areas are isolated, residents often have a lower socio-economic status, higher rates of health risk behaviors, limited job opportunities, and greater difficulty accessing health services due to transportation than their urban counterparts.

Following major health care reform efforts to expand health care access and improve community health, the former state Governor Peter Shumlin signed an executive order in 2015 to create a "Health in All Policies" approach to achieving health equity. This approach integrated health within nonhealth-related systems, such as transportation, agriculture, and education. Specifically, in this approach, nonhealth systems could consider health in budgeting, program planning, and policy creation. These efforts were supported by a Health in All Policies Task Force, a cabinet-level group appointed by the governor. The task force serves as a network to share information among systems and identify opportunities for collaboration and support.

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How does the initiative used shared measurement?

Vermont Health in All Policies uses measurement to generate buy-in and identify points of cross-system collaboration. The executive order prompted state government leaders to meet as a collaborative task force that prioritized health care access, affordability, and equity in all cross-system work. Its representatives included members from departments of administration, agriculture, commerce and community development, education, human services, natural resources, transportation, and public service, among others. The approach emphasized opportunities to show systems what they were already doing to contribute to a Health in All Policies framework. Suzanne Kelley, Healthy Communities Coordinator at the Vermont Department of Health, said, "*It takes time to feel safe collaborating. If one agency feels like something is their area, they may feel threatened and wonder why this other agency is coming in and taking over. Or they may feel happy someone is helping. The challenge is in defining roles and identifying how agencies could work together versus everybody working in their separate siloes addressing the issue from different areas the way they always have. I think it's a shift in culture and thinking for different agencies*."

The Health in All Policies initiative used health impact assessments and total health expenditure analyses. Heath impact assessments looked at proposed projects and policies in nonhealth systems to see how their work was related to improving health. In transportation and city planning decisions, for example, a health impact assessment showed the possible health effects of proposed changes. Increased walking improves health. Increasing the number of sidewalks or providing adequate street lighting for better visibility could make residents feel more comfortable walking.

Total health expenditure analyses showed how much a system's budget contributed to health. For example, after completing a total health expenditure analysis, the Vermont Agency of Agriculture learned that 74% of its 2015 spending related to health. The budget included spending on food availability and access, food safety, and occupational health. In all, spending on health-related areas amounted to more than $13 million. These efforts helped create buy-in and collaborative thinking across different government agencies.

"We weren't calling people together to tell them that we need to start this and it's all new," says Ms. Kelley. *"We started by talking to people in specific agencies and asking how they are already contributing to this Health in All Policies philosophy, and then asking what more they can do. It was a matter of getting people to the table and having them see that they are already doing this work, so it wasn't a big lift right away. And then nudging people to the next step asking what more can we do? What else can we do?"*

Using data and measurement to make decisions about how to budget money and resources. The Health in All Policies Task Force developed a dashboard to track progress related to the shared commitment to include Health in All Agencies policies, programs, and budgets. The dashboard helped identify communities with high needs and poor health outcomes, which enabled government agencies to consider funding decisions based on need. "*When funding comes down to communities*," said Ms. Kelley, "*we're always looking at the highest risk and the health data to identify those pockets of highest need. That's where we try to focus our energy and funding*."

How did systems work together?

The task force creates opportunities to identify areas for agencies to work together. Each task force representative is responsible for programs in their own agency. However, regular task force meetings offer representatives from different agencies the chance to come together, learn from one another, and find ways to collaborate. As Ms. Kelley said, "*I may be working on something, but I don't know if agriculture has a program that's related because I don't know agriculture well enough. If I'm talking about increasing use of [food stamps] at farmers market[s], they can say, 'Well, we do all this work with farmers markets. How can we work together?' I think it's okay if everyone has separate measures, as long as we're talking and sharing and looking for potential to collaborate*."

A champion in a leadership position can push a Health in All Policies approach forward. Leaders who prioritize collaborative efforts to address community health can advocate collective approaches to address health equity. According to Ms. Kelley, "*Heidi Klein spearheaded the Health in All Policies initiative and our health commissioner at the time, Dr. Harry Chen, had a strong public health background. Tracking health outcomes was a high priority for them, and they were able to use that to make a case that this would benefit the state in multiple ways."*

How did the initiative address equity?

Equity is an important aspect of this work. Many measures are broken down based on income and geography (urban or rural). Given the state's population, the initiative's work on equity has focused primarily on equity in health outcomes according to geography and income. The state is also beginning to explore ways to address racial equity for its small population of people of color.

How did the initiative engage community members?

The initiative engaged community members for specific projects when government resources could address community needs. For example, if a government agency was funding a new sidewalk, then it might decide where to put it based on relevant data and community input. Community leaders could advocate to put the sidewalk in their neighborhood while generating buy-in among community members. Ms. Kelley indicated that, "*Community leaders are the voices and the advocates. To make their decision, the government agency is using data, and they're also listening as community leaders are making a case. It's kind of a top down and bottom up when it works well*." In this way, agency leaders and community leaders can identify mutual interests.

Spotlight on Using Shared Measurement: Weatherization

Vermonters in low-income households are more likely to live in housing where insulation, heating and cooling systems, and water heaters do not function properly, leading to higher spending on utilities for such households compared to those living in medium- to high-income households. Vermonters in low-income households are also more likely to have a variety of chronic health conditions and fewer resources to treat and manage these conditions. Weatherization, or weatherproofing, is the practice of protecting a building and its interior from temperature changes and moisture intrusion. It includes modifying a building to reduce energy consumption and optimize energy efficiency, resulting in cost savings for residents and reduced greenhouse gas emissions. Weatherization and electrical efficiency also improve the health of residents and community members.

The state weatherization program had been in place for years before the Health in All Policies Task Force was established. Led by the Department for Children and Families under the Agency of Human Services, the weatherization program provides insulation improvements, smoke and carbon monoxide detectors, and mold and asbestos evaluations for low-income households. As part of the Weatherization+Health initiative and supported by the Health in All Policies Task Force, when residents receive weatherization services, they are screened for additional health, energy, and housing needs and referred to other systems to provide necessary support using the One Touch referral system. Screening includes questions related to smoking cessation support, moisture and mold in the home, and testing children in the home for lead levels in the blood. Partnerships with hospitals have targeted integrated weatherization and health services to patients who have trouble breathing or are at risk of injury from falling. Measures to track progress include data collection that will help partners understand how common unhealthy housing conditions are and allow the health department to track improvement over time. Weatherization goals are also included in Vermont's State Health Improvement Plan. Health department staff estimated that, over a 10-year period, weatherizing 2,000 low-income homes in Vermont would help prevent more than 200 emergency department visits while reducing hospitalizations and deaths associated with asthma, cold, and heat. The health department is also working with relevant partners to measure whether receiving weatherization services changes healthcare utilization and costs.

The task force generated a set of best practices for nonhealth systems to advance their goals while also investing in improving community health. Best practices for the energy sector highlight the weatherization program and its contributions to improving community health. In addition, task force leadership continues to pursue additional funds to increase the scale of the program. Jared Ulmer, program manager for climate and health at the Vermont Department of Health, says *"Any conversation about climate action in Vermont includes recommendations to expand weatherization, and we know that would also be great for health. A big barrier is funding, as I'm sure is the case everywhere - how do we come up with extra dollars to expand weatherization services? Our governor and legislature have supported weatherization with extra resources when possible, but public funds can only be stretched so far. The Task Force is helping to identify creative funding sources and partnerships to pursue, focusing on weatherization as a health investment."*

Lessons Learned

- A shift in work culture is a challenging—yet necessary—means of supporting the alignment of systems. This shift involves defining roles, identifying opportunities to collaborate, learning about decision-making processes in other systems, and finding collective solutions to improve community health.
- Initiatives could embed alignment-related work into existing mandates and identify existing efforts to showcase actions already underway to foster cross-system collaborations that improve health. This could build momentum and lead to identifying additional points of collaboration.
- Developing a shared vision and framework for healthy communities that highlights the shared values of access, affordability, and equity and recognizes the contributions of different systems could also generate buy-in.

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