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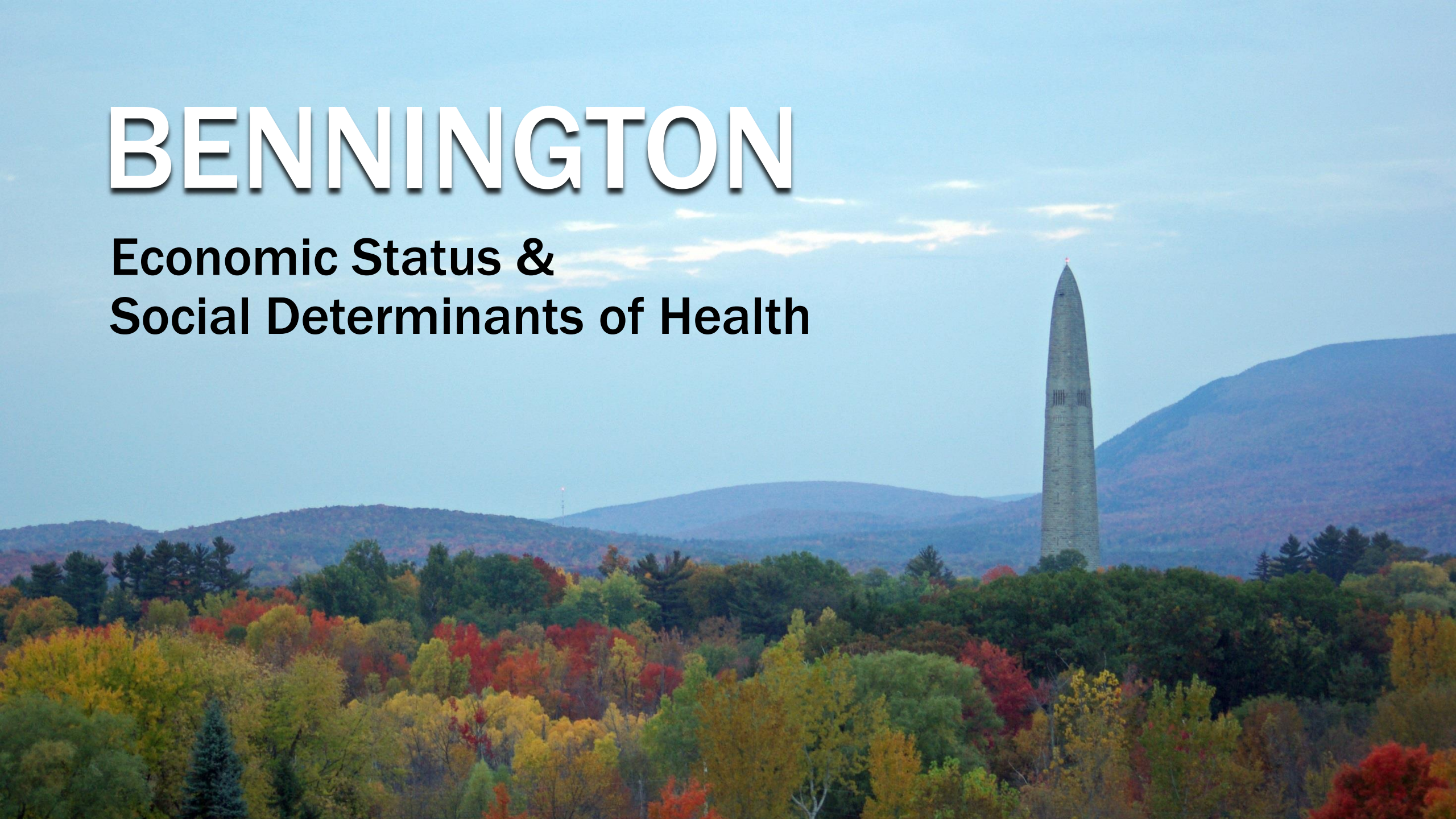
Economic Status & Social Determinants of Health



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Social Determinants of Health

What matters to your health:

- Income
- Education
- Affordable Housing
- Support Services

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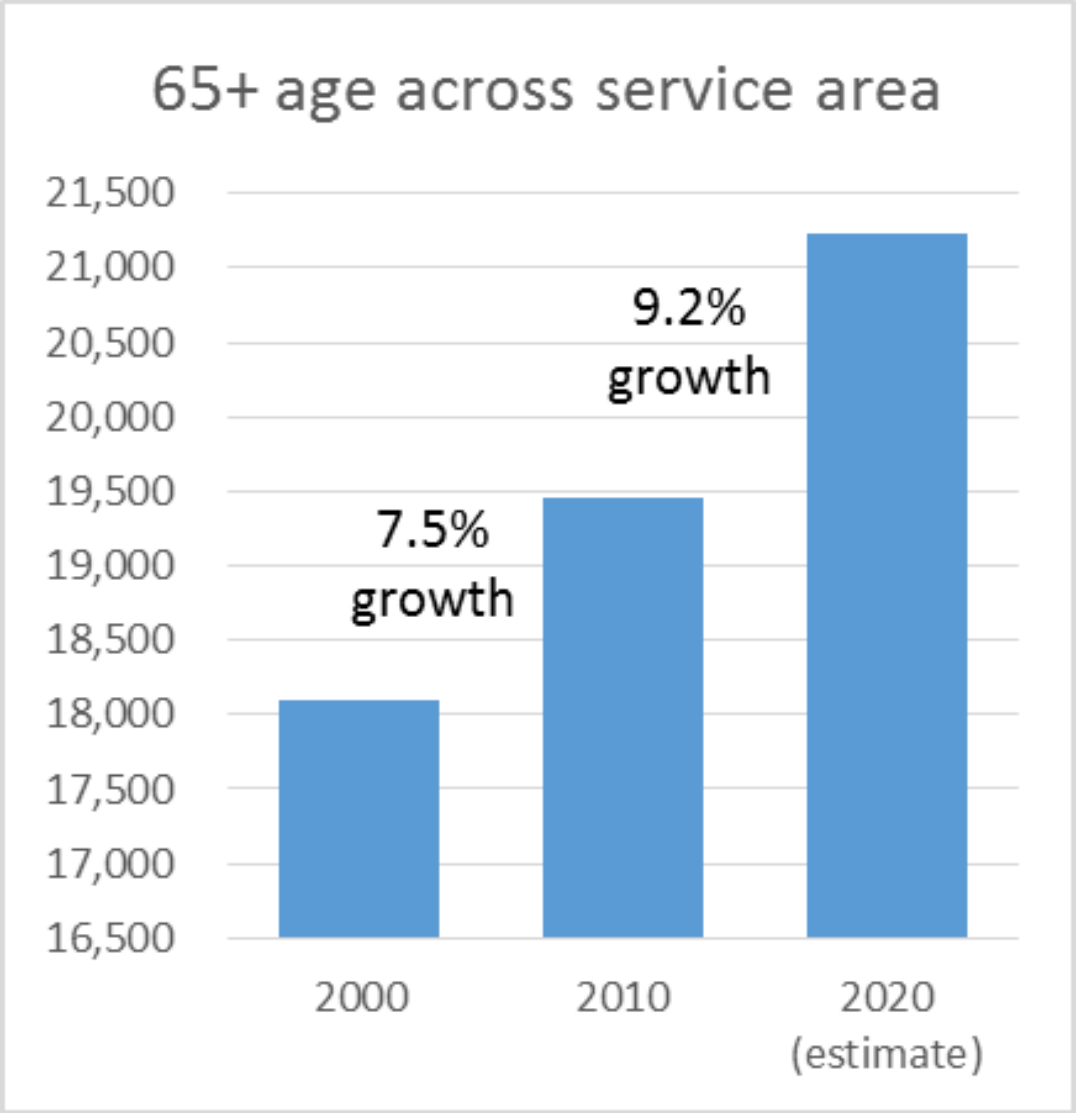
Demographics

Age

- 65+ age population growing
- 0-64 age population shrinking
- 15-35 age population shrinking
- Overall population declining
- Bennington is 4th out of 14 for oldest county



US Census Statistics

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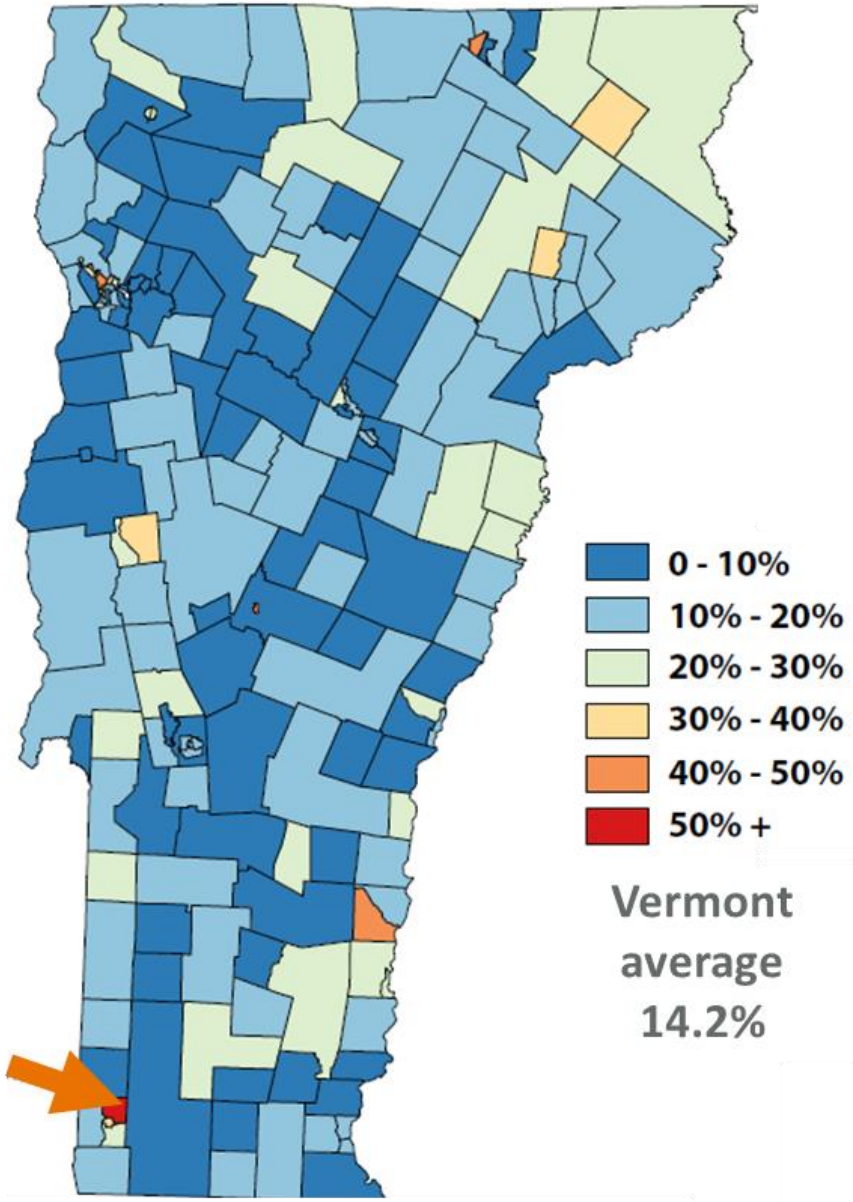
Demographics

Poverty

- 1 in 3 children live in poverty
- 81% of children on free/reduced school lunch
- Average wages at 75% of Vermont average
- House Hold Income is 188 out of 282 Vermont towns



Percentage of families with children in poverty

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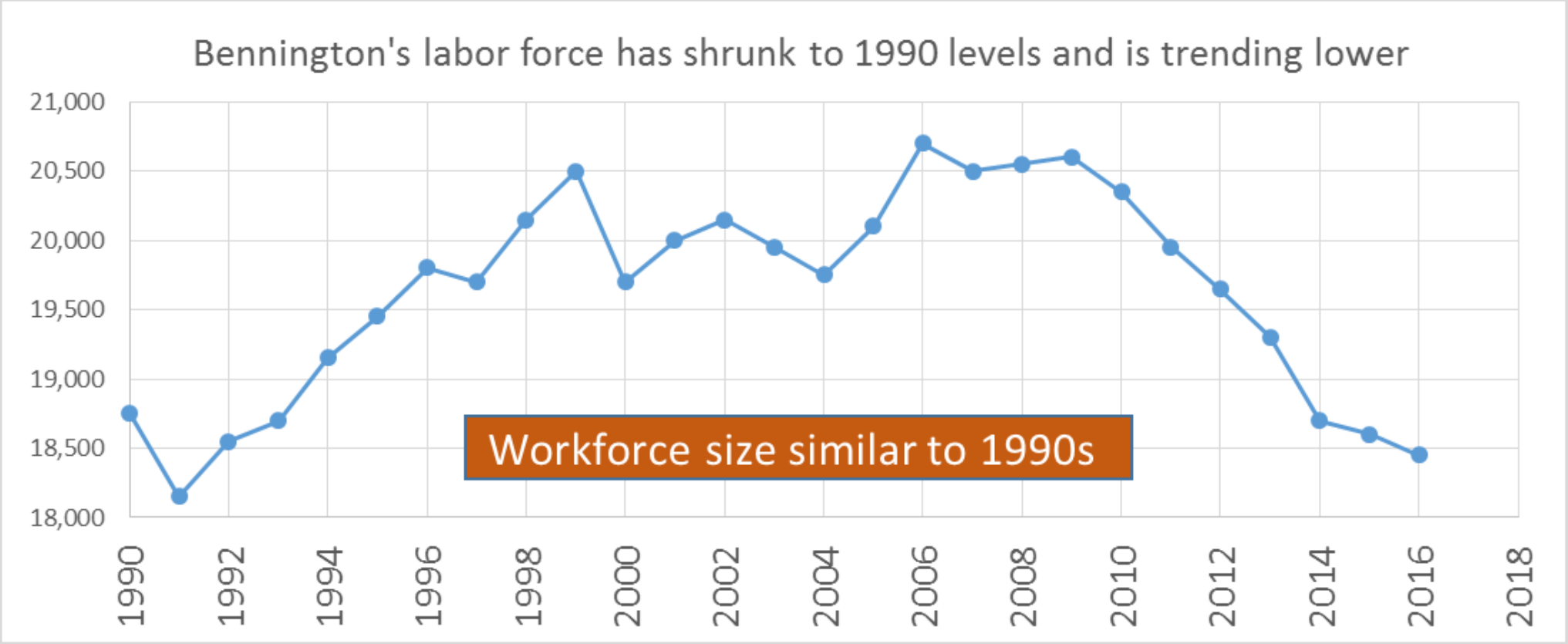
VT Department of Labor County Statistics

Labor Force

- Third highest unemployment rate across Vermont (4.4%, state average of 3.0%)
- Rapidly shrinking labor force



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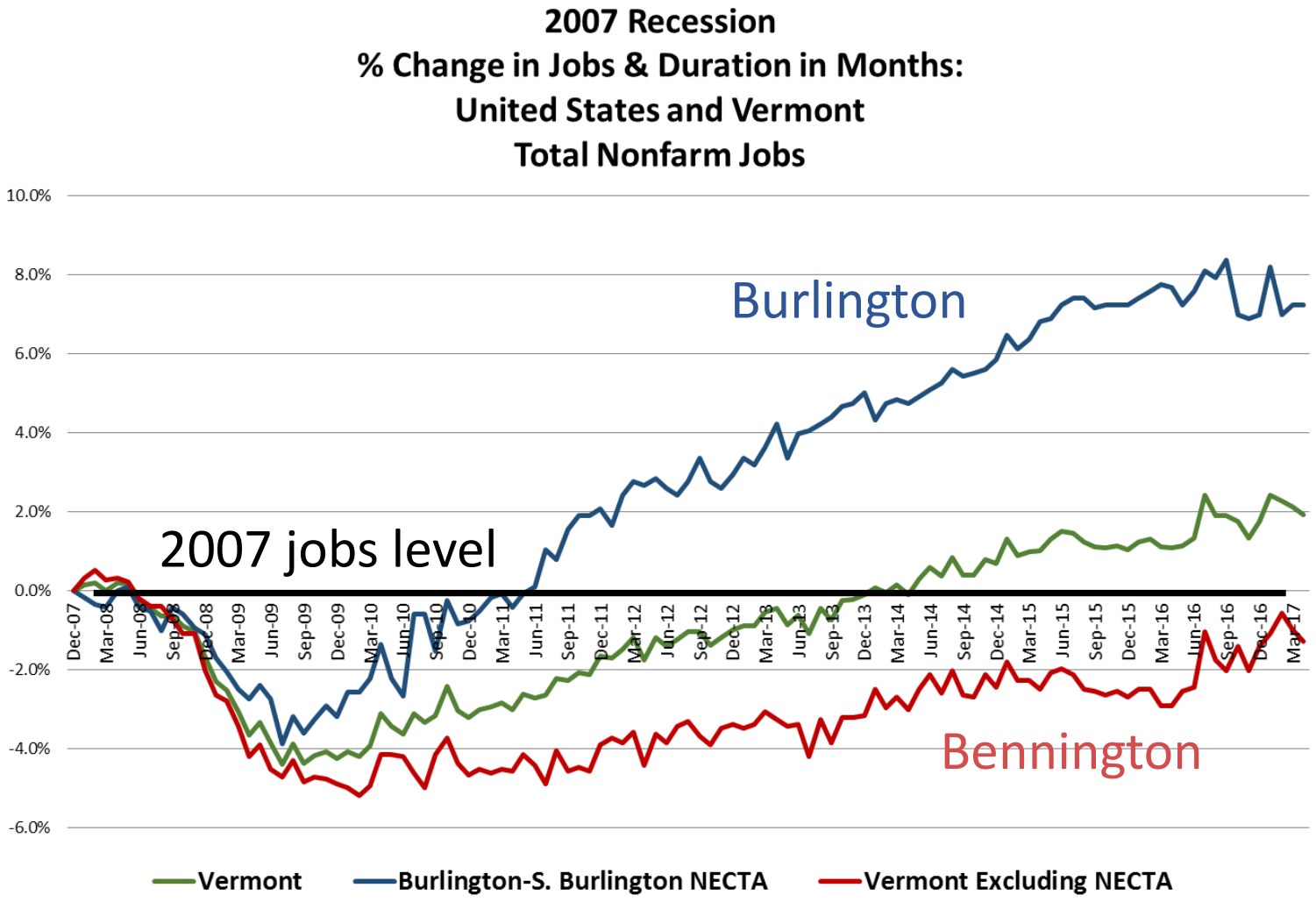
Jobs

- Bennington has fewer jobs today than before the recession (2007)
- Burlington has considerably more jobs today



VT Department of Labor County Statistics

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Jobs - Bennington County has lost 2,000 jobs since 2001

- Bennington County Employment:
  - 2001 18,925 jobs
  - 2016 16,934 jobs

    1,991 fewer jobs

US Bureau of Labor Statistics

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Education System Challenges

- 2 out of 3 children attend a school with limited performance
- Less than 35% of 11th graders are proficient in math

School	Math	Language Arts
Vermont State	41%	55%
Monument Elementary	46%	72%
Bennington Elementary	19%	43%
Molly Stark Elementary	20%	27%

2016-2017 Balanced Assessment, Vermont Agency of Education

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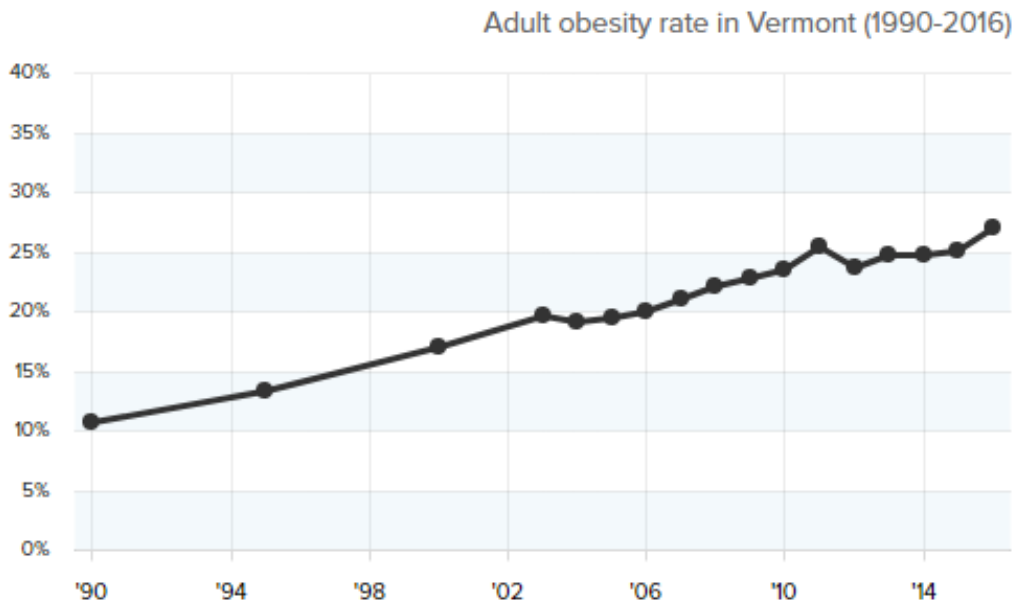
Poor Health

- 28% of adults are obese
- 11% diagnosed with diabetes
- 25% are regular smokers
- 35% of moms smoked during pregnancy
- 18% had at least one tooth removed
- Drinking water contamination in three communities
- Opioid epidemic- 300% increase in treatment volumes
- 38% higher teen pregnancy rate than across Vermont



Obesity is on the rise

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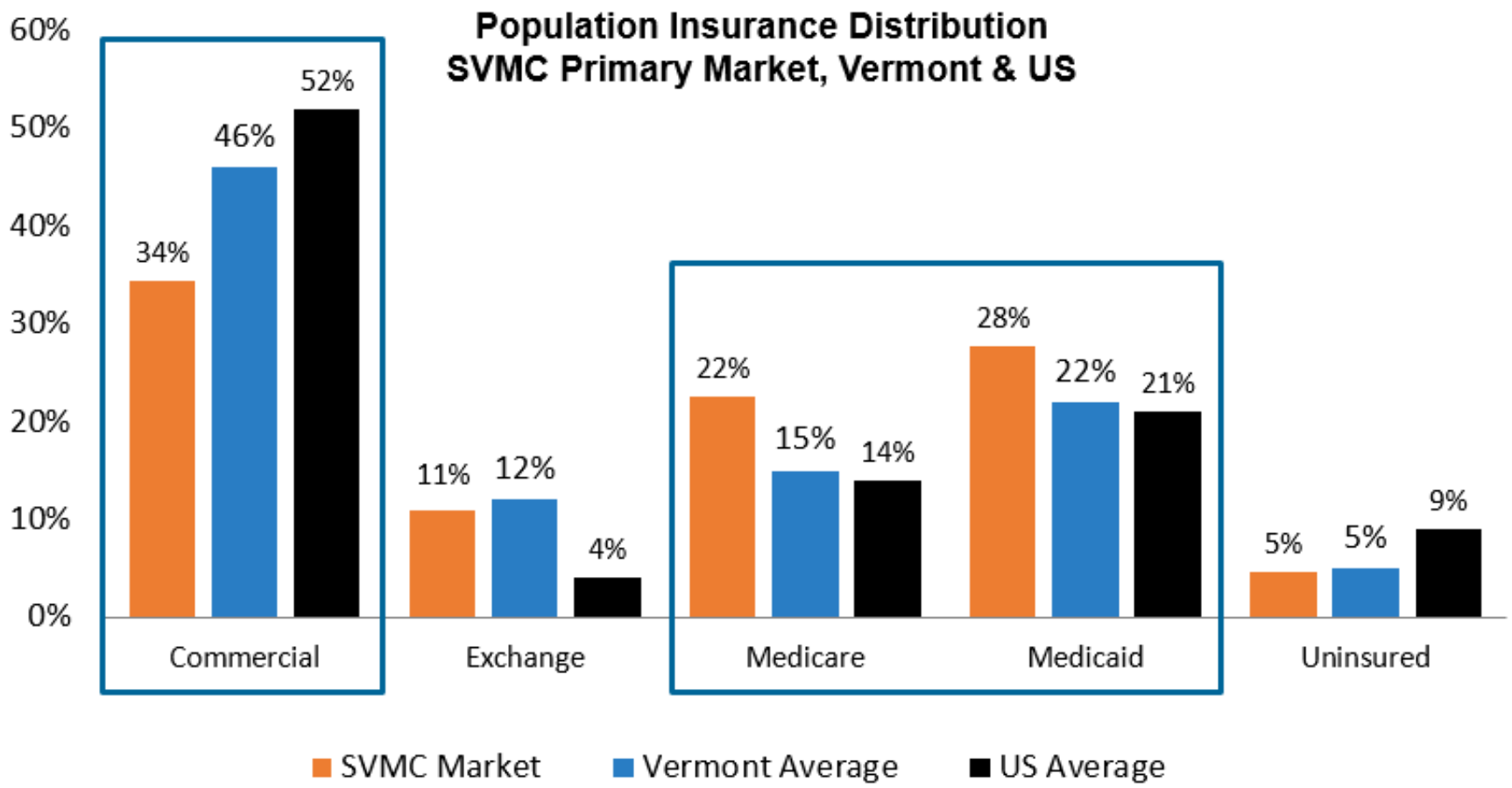
Bennington has a low commercial insurance segment

1 in 2 people is insured by Medicare or Medicaid.



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Active steps to improve the social determinants of health

Bennington Revitalization:

- Putnam Redevelopment Projects
- Southern Vermont Economic Development Zone
- Workforce Development Initiatives
- Building the entrepreneurial ecosystem
- Partnering with schools

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Community Collaborative

Definition of Health

Population Health

Health is the state of complete, physical, mental, and societal well-being and not merely the absence of disease or infirmity

Reference: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Model for an Accountable Community for Health

Health Outcomes

↑

Health Factors

↑

Policies & Programs

- Healthy Behaviors **30%**
- Clinical Care **20%**
- Social & Economic **40%**
- Physical Environment **10%**

Partners

Battenkill Valley Health Center
Bennington Blueprint
Bennington College
Bennington Free Clinic
Bennington Home Health & Hospice
Centers for Living & Rehabilitation
Council on Aging
Dartmouth-Putnam Physician Group
Department of Health
Primary Care
Agency of Human Services
OneCareVT
Shires Housing (SASH)
SVMC
United Counseling Services
United Health Alliance

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"Building a Healthy Bennington"

Community Collaborative Goals

All Payer Model Goals	Current Strategies	Future Strategies
Improve Access to Primary Care	• Community Health Team • Patient Centered Medical Homes • Universal Care Plan • Bennington Free Clinic	• Downtown Express Care • Dental Clinic • Virtual Primary Care
Reduce Deaths from Suicide and Drug Overdoses	• Building Bright Futures, ACEs Team • SBIRT, Medication drop box • Women's Health Initiative • Spoke Program	• Methadone Hub Services • Universal risk screening
Reducing Prevalence and Morbidity of Chronic Disease	• 3 – 4 – 50 Vermont • Rise Vermont • Self-Management Programs • Tobacco Cessation Programs, Pre-Diabetes Program	• Telemedicine

Commitment to the OneCare Vermont Risk Model

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Barriers & Challenges

Source: Accountable Communities for Health Survey

Conducted by the Vermont Blueprint for Health, August 2017

- **Funding:** most common request
  - Funding for the participating organizations
  - Capture of shared savings

- **Other Challenges:**
  - Silos of organizations and operations
  - Transition from fee-for-service to population health

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Alya Reeve, MD, MPH, FANPA, FAAIDD

Medical Director; interim director of Community Rehabilitation Team

United Counseling Services

- 25 year old female participating in opiate treatment delivering third baby at SVMC. Hx of PTSD, OCD, Opiate Abuse disorder in recent remission, Attention Deficit Disorder, Major Depression in remission. Presented having not slept for three nights; developed severe mania, depression and psychosis immediately after delivery. Infant had to go into temporary DCF custody. She was not able to transfer to inpatient psychiatric care due to lack of available beds; staff worked with consulting and emergency team to keep her safe, allow antipsychotic to work and to have a plan for reintegrating with her children.

- Partners involved in this case: SVMC staff, DCF, Emergency Clinician, On-call psychiatrist, outpatient substance abuse treatment team.

- Outcomes: Psychiatric consultation & liaison to the SVMC has occurred since May 1, 2017, Monday – Friday, ranging from 2 – 12 per week; improved dialog with DCF and community medical providers

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Stephanie Lane

Executive Director

Shires Housing: Support & Services at Home (SASH)

- Betsey is a SASH participant in Bennington, who was extremely anxious. She was spending hundreds of dollars on QVC. Due to having credit card debt on several accounts, she was unable to pay her home health charges (Choices For Care patient share), the invoices reached over $3,000 dollars. The SASH Coordinator connected her to American Credit Counseling Service (non profit debt consolidation) and called Ethan her CM to arrange for a money management volunteer. Betsey now has her debt reduced with continued support from her care team.

- The partners engaged in this case : SASH Coordinator, home health, money manager

- Outcomes: SASH participants experienced a reduction in total average annual Medicare expenditure growth, saving $1,536 per beneficiary per year . Increase in advanced directives, decrease in rate of falls, increased in control of hypertension.

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Billie Lynn Allard, MS, RN

Administrative Director of Ambulatory Services and Transitions of Care

Southwestern Vermont Health Care

- Harvey is a 55 year old male with severe pulmonary disease & 6 hospitalizations in the past 3 months(in ICU on a ventilator), 6 ED visits. Transitional Care Nurse meets with Harvey and his family, develops a relationship and shares information from one setting to the next

- Visit to home = oxygen tank on the bedroom on second floor. Harvey incapable of using breathing treatment correctly, has not filled prescriptions (no money), cupboards bare without food, lives alone despite saying he lives with his son, no transportation or social support

- Partners: 3-months later = home visits by TCN who attends MD appointment with Harvey, connected with social worker (Food, funds for medications), clinical pharmacist(conferred with MD/Adjusted medication to critical ones), attended pulmonary rehab 6 week program, on wait list for SASH

- Outcomes: Transitional Care Nurses have partnered with 1,000 individuals over the past 3 years and **reduced hospitalizations for this population by 50%**

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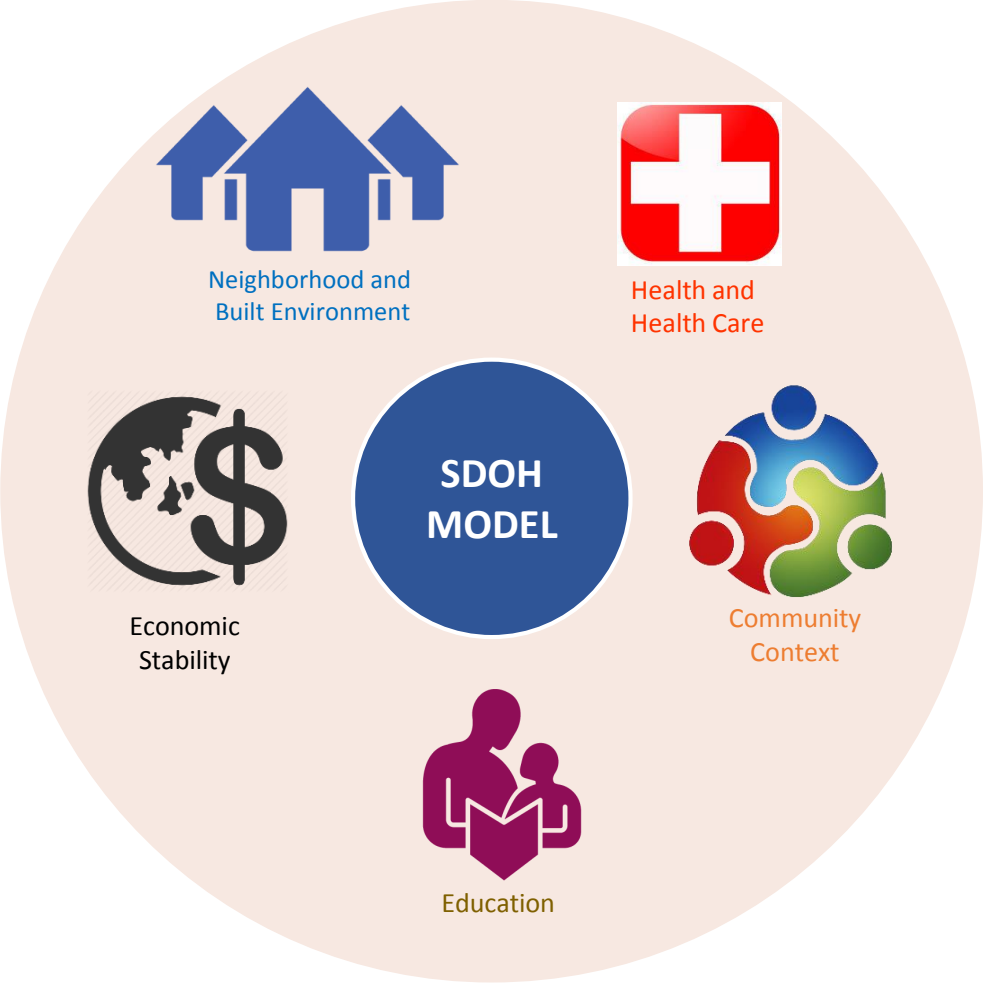
Future Vision…Population Health Enterprise

Create a business plan

- Governance structure
- Budget and funding stream
- Formal community partners
- Data analytics
- Communication and documentation platform
- Accountability