MT. ASCUTNEY HOSPITAL AND HEALTH CENTER
FOR THE WINDSOR AREA COMMUNITY PARTNERSHIP
COMMUNITY BENEFITS ANNUAL REPORT 2016

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
COMMUNITY HEALTH SERVICES **WINDSOR AREA COMMUNITY PARTNERSHIP** **WACP – Mission Statement** It is the mission of the Windsor Area Community Partnership (WACP) to connect agencies, community leaders, and constituencies through a coalition that intentionally represents adults, youth, and elders in the Windsor area to promote the health and well-being of the community. **Strategic Plan** Goals and Objectives Established June 2005 – Updated in 2016 to include: As measured by the overarching goals of Healthy People 2020, our community will: (1) Attain high-quality, longer lives free of preventable disease, disability, injury and premature death. (2) Achieve health equity, eliminate disparities and improve the health of all groups. (3) Create social and physical environments that promote good health for all. (4) Promote quality of life, healthy development and healthy behaviors across all life stages. In addition: (1) Evolve, from our current state, to create an Accountable Community for Health and medical neighborhood that will promote the health and well-being of our community through a network of health and human service partners. Objectives are updated with each Community Health Needs Assessment. Last updated in October 2015.	Visioning and strategic planning process was accomplished in 2005 and reviewed each year thereafter to establish 1. Mission Statement 2. Strategic plans with goals and objectives 3. Reorganization of the Board with the establishment of Memorandum(s) of Understanding for all Board members 4. Created a job description for Board members 5. An evaluation process for the functioning of the WACP In 2016, by-laws were reviewed, revised, and approved. Board evaluation was analyzed and is repeated every two years. Action plans continue to be implemented in the areas of: A. Interagency Collaboration <u>WACP</u> 9 meetings with an avg. 9 in attendance, topics of collaboration includes Community Health Needs Assessment and implementation plan, Act 166, 2015 Annual Report, Parent Up, Bylaw review, 3-4-50 <u>PATCH</u> 10 meetings with and avg. 10 in attendance, topics of collaboration includes school performance, Network Study, Community Health Needs Assessment and Implementation Plan, Interagency Care Management, Turning Point and Adverse Childhood Experiences <u>Blueprint for Health Expanded Team</u> 8 meetings with avg. 16 in attendance, topics of collaboration includes Dental Care, Interagency Care Management, Homelessness, Choices for Care, Dr. Dynosaur, Adverse Childhood Experiences, Blue Cross/BlueShield Programs	The Board is composed of highly committed, skilled professionals and citizens. **Thank you!** Objectives have been established, action plans implemented, and progress monitored and evaluated. Strong, collaborative, cohesive and trusting community infrastructure with clear leadership and broad inclusion. Network Study Outcomes show: • Shared Goals at 87% compared to state avg. of 75% • Mutual trust at 87% compared to state avg. of 81% • Effective communication at 73% compared to state avg. of 61% • Clear roles at 80% compared to state avg. of 66% • Measureable Process and outcomes at 40% compared to state avg. of 35%

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
(1) Alcohol and drug misuse including heroin and use of pain medications (2) Access to mental health (3) Access to dental care (4) Access to affordable health insurance, cost of prescription drugs (5) Nutrition/access to affordable food (6) Lack of physical activity, need for recreational opportunities and active living (7) Income, poverty and family stress (8) Access to transportation (9) Access to primary health care (10) Health care for seniors (11) Smoking/tobacco use	<u>Windsor Area Drug Task Force</u> 9 meetings with avg. 5 in attendance, topics of collaboration includes Criminal Justice System, Substance Use Consumer Guide revision, Needle Exchange, Community Health Needs Assessment and Implementation Plan, and timely access to services <u>Windsor HSA Coordinated Care Committee</u> 4 meetings with avg. 25 in attendance, topics of collaboration includes COPD/Asthma QI, ED utilization study, Care of High Risk patients, Community Health Needs Assessment and Implementation Plan, Once Care Goals, Network study, White River Family Practice QI, Crab Report, PCMH Team based Care B. Community Health Needs Assessment Implementation Plan (1) Implemented and evaluated action plans to address needs identified in the 2012 community assessment (2) Conducted a new Community Health Needs Assessment in 2015 (3) Created and initiated an implementation plan based on the needs within the 2015 Community Health Needs Assessment	
Annual Evaluation	Annual evaluation completed November 2016 and reported in December. Evaluation is conducted biannually (next due November 2018).	Top domain strengths (1-4 consistently high since ‘12): 1. Partnerships with other organizations 2. Coalition Leadership 3. Coalition meetings and communications 4. Ability to collect, analyze, and use data 5. Effectiveness in Planning and Implementation * Top domain opportunities for improvement (1-3 & 5 since ’12): 1. Coalition structure and membership 2. Outreach and communication 3. Cultural competence 4. Fundraising and help to do so by Board of Directors * 5. Opportunities for member growth and responsibility * New to lists in 2016

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
Objective 1 Alcohol and drug misuse including heroin and use of pain medications Reduce the number of students who consumed at least one drink of alcohol in the last 30 days, by 10% every 2 years. Healthy People 2020 target is 22.7%.Target setting method 10% improvement. Reduce the percentage of students who are binge drinkers by 10% every 2 years. Healthy People 2020 target is 8.6%.Target setting method 10% improvement. Decrease rate of adults who are "binge drinkers" by 10% every 2 years. (This is an increase of 1% from 2011). Healthy People 2020 target is 25.4%. Target setting method 10% improvement. Reduce the percentage of students who misused a stimulant or prescription pain reliever in the last 30 days by 10% every 2 years.	• Completed revisions to the Consumer Guide for Substance Use Treatment • Formed a task force to promote more timely access to treatment services • Medication assisted therapy, counseling and support for addicted moms is offered through the pediatric clinic • Partnership with Blue Cross/Blue Shield to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) training for substance use throughout the clinic and ED • Formation of the multidisciplinary functional recovery team and consult service for chronic pain patients • Care management provided through the CHT and Spoke Staff • A plethora of education and prevention initiatives including "Be Aware Don't Share," "Most Dangerous Leftovers," "Drug Take Back," prom and grad season education, retailer compliance recognition, work with Vermont league of cities and towns and regional planning boards regarding education on the impact of marijuana legalization • Built and continue to sustain county-wide prevention network, Windsor County Prevention Partners (WCPP), by working with 5 other coalitions in the county. • Wrote *Supporting Healthy Community* policy guide with Regional Planning commission partners • Worked with Law Enforcement to enhance underage drinking patrols to decrease alcohol consumption among minors. Regional Prevention Partnership (WCPP initiative) • Partnered with County Sherriff to continue collection and incineration efforts resulting in highest ever collected amounts. • Continuing comprehensive program to decrease prescription drug abuse, including drug drop box,	Alcohol 30-Day Use: 1997 YRBS Baseline 35% 65% 1999 YRBS Data 31% 58% 2001 YRBS Data 22% 73% 2003 YRBS Data 22% 68% 2005 YRBS Data 16% 48% 2007 YRBS Data 4% 45% 2009 YRBS Data 19% 40% 2011 YRBS Data 13% 52% 2013 YRBS Data 11% 46% 2015 YRBS Data 18% Too few Youth Binge Past 30 days: FY11 23%, FY13 26%, FY15 19%, Statewide 16% Adults binge: FY09 19%, FY11 16%, FY13 17%, FY15 13%, Statewide 17% Stimulant and Prescription Drug Use among Youth: Actual in 2013 was 7% ; Statewide average is 7% Actual in 2015 was 3%, Statewide average is 5% Drug Take Back # of pounds collected Windsor County: Spring: 2012 100, 2013 274, 2014 259, 2015 403, 2016 458 Fall: 2012 195, 2013 228, 2014 289, 2015 325, 2016 478 **Total: 2012 295, 2013 502, 2014 548, 2015 728, 2016 936**

<table>
<tr><th>GOALS</th><th>ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS</th><th>EVALUATION & ISSUES REMAINING</th></tr>
<tr>
<td>Decrease 30-Day use of 9-12th grade student marijuana use by 10% every 2 years. Healthy People 2020 target is 20%. Target setting method is 10% improvement.

Reduce the percentage of students who used marijuana one or more times during the past 30 days, by 10% every 2 years. Healthy People 2020 target 6%. Target setting method is 10% improvement.</td>
<td>community education, provider opioid management program, partner with DHMC on www.twinstatesafemeds.org website and campaign
• Working on Gold/Silver/Bronze retailer recognition project to decrease access and advertising to “adult only” products at point of sale
• Dissemination of statewide media campaigns around drinking/marijuana/RX drug/parenting
• 4 Community presentations on impacts of marijuana legalization, over 65 total attendance
• MAPP participated in Health Impact Assessment process at statewide level; distributed 50 reports at town meetings and via email to local representatives, decision makers, and partners
• With MAPP as resource, Town of Weathersfield passes Tobacco / drug paraphernalia zoning bylaw. Shared ordinance with area select and planning boards (25 persons total); shared with 14 media outlets
• Collaboration with All Together at DHMC on marijuana prevention marketing materials</td>
<td>30-Day Marijuana Use High School
<table>
<tr><th></th><th>FY09</th><th>FY11</th><th>FY13</th><th>FY15</th><th>Statewide</th></tr>
<tr><td>Youth 30-day marijuana use</td><td>17%</td><td>32%</td><td>26%</td><td>31%</td><td>22%</td></tr>
</table>

<table>
<tr><th>Marijuana 30-Day Use:</th><th>8th Graders</th><th>12th Graders</th></tr>
<tr><td>1993</td><td>2.9%</td><td></td></tr>
<tr><td>1995</td><td>23.8%</td><td></td></tr>
<tr><td>1997</td><td>21%</td><td></td></tr>
<tr><td>1999</td><td>18%</td><td>37%</td></tr>
<tr><td>2001</td><td>12%</td><td>55%</td></tr>
<tr><td>2003</td><td>9%</td><td>50%</td></tr>
<tr><td>2005</td><td>10%</td><td>39%</td></tr>
<tr><td>2007 YRBS</td><td>5%</td><td>19%</td></tr>
<tr><td>2009 YRBS</td><td>8%</td><td>23%</td></tr>
<tr><td>2011 YRBS</td><td>8%</td><td>36%</td></tr>
<tr><td>2013 YRBS</td><td>10%</td><td>28%</td></tr>
<tr><td>2015 YRBS</td><td>15%</td><td>Too few</td></tr>
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<tr>
<td>Objective 2

Access to Mental Health</td>
<td>• Revision of brochure of Local Mental Health Counselors
• 57 referrals for WRAP workshops
• Completed agreement to embed masters level clinicians in pediatric clinics of MAHHC and OHC, in addition to the already functioning HCRS clinician in the adult clinic
• Partnership in interagency care management, PATCH and the Windsor Drug Task Force with HCRS</td>
<td>Psychiatrist hired by MAHHC.

Completed 2 WRAP workshops with 22 in attendance.

HCRS adult clinician continues to practice as an embedded service in our Patient Centered Medical Home. HCRS pediatric clinicians have not yet become an embedded service.

Partnership with HCRS, police and school resource officer is working well.</td>
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<tr>
<td>Objective 3

Access to dental health

Decrease the percentage of students who drank a can, bottle or glass of sugar-sweetened beverage, every day during the last 7 days.</td>
<td>• Dental clinic provided in Windsor Elementary School May 10-19, 2016
• New grant from Northeast Delta Dental received for 2017 clinic
• Application of fluoride in pediatric clinics
• Outreach to recruit a local dentist
• Dental vouchers for care through Windsor Community Health Clinic</td>
<td>
<table>
<tr><th>Indicator</th><th>2015</th><th>2016</th><th>Comparison</th></tr>
<tr><td># of students available for screening</td><td>246</td><td>244</td><td>↓2</td></tr>
<tr><td># of students returning consent forms</td><td>210</td><td>244</td><td>↑34</td></tr>
<tr><td># of students screened</td><td>82</td><td>82</td><td>same</td></tr>
<tr><td># of students screened with untreated decay</td><td>19</td><td>22</td><td>↑3</td></tr>
<tr><td># of students screened with treated decay</td><td>22</td><td>19</td><td>↓</td></tr>
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<table>
<tr><th>GOALS</th><th>ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS</th><th>EVALUATION & ISSUES REMAINING</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Indicator</th><th>2015</th><th>2016</th><th>Comparison</th></tr>
<tr><td># of students with history of decay</td><td>41</td><td>33</td><td>↓8</td></tr>
<tr><td># of students screened with at least one existing sealant on permanent molar</td><td>44</td><td>35</td><td>↓9</td></tr>
<tr><td># of students screened with sealant applied this year at school</td><td>46</td><td>62</td><td>↑16</td></tr>
<tr><td># of preventative dental sealants placed</td><td>445</td><td>585</td><td>↑140</td></tr>
<tr><td># of students receiving urgent treatment</td><td>4</td><td>6</td><td>↑2</td></tr>
<tr><td># of students receiving non-urgent care</td><td>15</td><td>16</td><td>↑1</td></tr>
<tr><td>Oral risk assessment</td><td>35</td><td></td><td></td></tr>
<tr><td>Fluoride application</td><td>90</td><td></td><td></td></tr>
</table>
Amount of dental vouchers given in FY2016: $3,390
</td></tr>
<tr><td><u>Objective 4</u>

Access to affordable health insurance, cost of prescription drugs

Increase the number of individuals who received assistance with access to health insurance through the Windsor Community Health Clinic at MAHHC.

Improve the duration of quality life, and reduce disability associated that impacts the health and well-being of the community.</td><td>• Windsor/Woodstock Navigator Program and Windsor Community Health Clinic assistants with Vermont Health Connect, and Medicare and Medicaid applications
• CFO communication with Vermont Health Connect and Green Mountain Care Board
• Medicare Boot Camps provided in both Windsor and Woodstock for the uninsured and underinsured

Windsor Community Health Clinic (WCHC) continues to serve uninsured and under insured community members

▪ Active member of the Vermont Coalition of Clinics for the Uninsured.
▪ Grant supported Case Manager.
▪ Provides a 5-day-a-week program to improve access to care.
▪ Expanded program to include Ottauquechee Health Center providing education and support to the Community Care Coordinators.
▪ Expanded program to assist with Medicare D and</td><td>Navigators and WCHC staff helped community members throughout 2016 apply to Vermont Health Connect.

$4,986 given in voucher for medications.

<table>
<tr><th></th><th>2015</th><th>2016</th><th>Comparison</th></tr>
<tr><td>BCBS/MVP Enrollment</td><td>40</td><td>64</td><td>↑24</td></tr>
<tr><td>BCBS/MVP Follow-up</td><td>4</td><td>115</td><td>↑111</td></tr>
<tr><td>Case Management</td><td>1,209</td><td>1,682</td><td>↑473</td></tr>
<tr><td>Consults</td><td>506</td><td>1,149</td><td>↑643</td></tr>
<tr><td>Dental Referral</td><td>92</td><td>54</td><td>↓38</td></tr>
<tr><td>Distinct Patients</td><td>574</td><td>586</td><td>↑12</td></tr>
<tr><td>Financial Applications</td><td>407</td><td>507</td><td>↑100</td></tr>
<tr><td>VT Health Connect Consult</td><td>278</td><td>515</td><td>↑237</td></tr>
<tr><td>VT Health Connect (Status Calls)</td><td>146</td><td>459</td><td>↑313</td></tr>
<tr><td>Medicaid Application</td><td>298</td><td>115</td><td>↓183</td></tr>
<tr><td>Medicare Assistance</td><td>86</td><td>149</td><td>↑63</td></tr>
<tr><td>Outreach Enrollment</td><td>250</td><td>348</td><td>↑98</td></tr>
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<table>
<tr><th>GOALS</th><th>ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS</th><th>EVALUATION & ISSUES REMAINING</th></tr>
<tr>
<td></td>
<td>Vermont Health Connect Program providing certified navigators.
▪ Worked with dentists to connect patients to dental homes, discounted care and dental vouchers.
▪ Negotiated an agreement with Hanover Oral Surgery to provide discounted care and accept Vermont General Assistance Care and WCHC Dental Vouchers.
▪ Established a new Transportation Voucher Program for rides to medical appointments working with GMAC Taxi.
▪ Built new partnerships with Dr. Kramer and Dr. Abbott in Claremont to see our dental patients. Dr. Abbott makes dentures!
▪ Added a VHC navigator to do outreach at OHC.</td>
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<table>
<tr><th></th><th>2015</th><th>2016</th><th>Comparison</th></tr>
<tr><td>Outreach Enrollment Follow-up</td><td>382</td><td>653</td><td>↑271</td></tr>
<tr><td>Non-Vermont program enrollment</td><td>218</td><td>154</td><td>↓64</td></tr>
<tr><td>Patient Assistance Program (PAP) Enrollment (enrolled/re-enrolled)</td><td>44</td><td>24</td><td>↓20</td></tr>
<tr><td>Pharmacy Vouchers</td><td>44</td><td>62</td><td>↑18</td></tr>
<tr><td>Social Security Disability</td><td>6</td><td>6</td><td>--</td></tr>
<tr><td>Transportation</td><td>8</td><td>40</td><td>↑32</td></tr>
<tr><td>New Patients (44 NH)</td><td>385</td><td>349</td><td>↓36</td></tr>
<tr><td>New VT patients</td><td>385</td><td>305</td><td>↓80</td></tr>
<tr><td>Number of VT Patients</td><td>452</td><td>463</td><td>↑11</td></tr>
<tr><td>Total Patients Seen</td><td>574</td><td>586</td><td>↑12</td></tr>
<tr><td>Total Interactions</td><td>1,386</td><td>1,828</td><td>↑442</td></tr>
</table>
A total of $5,088.41 of free medications were provided to WCHC clients through Dorothy Byrnes' Foundation. ***Thank you!***

Total of free medication through the Patients Assistance Programs from pharmaceutical companies for FY16 was $37,270.96!

Dental vouchers were provided in the amount of $2,518.20.

Total of $450.00 worth of rides provided ($100 in gas cards, and $350.00 in taxi vouchers).

15 MDs, 6 NPs, 17 nurses, 1 Mental Health Provider, Admin, 4 PTs, 8 Radiology and Lab Techs, and 8 Business Office staff participated in the program.
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<td><u>Objective 5</u>

Nutrition/access to affordable food

Reduce the percentage of youth (12-19) who are obese (95th BMI percentile) as measured by the Youth Risk Behavior Survey. Healthy People 2020 target 16.1%.

Reduce the percentage of adults who have obesity. Healthy People 2020 target 30.5%.

Target setting method 10% improvement.</td>
<td>• Membership in the Upper Valley Hunger Council
• Work with the school and Windsor Food Shelf to provide Summer Food Program
• Promotion of Cash Crop Program and Farmers Market coupons
• Promotion of vegetable intake through product for vegetable sauces and spices
• Summer Food Drive for the Food shelf
• Strategic planning for 3–4–50
– Participation in the summer weekend food distribution to families.
– Reduce Obesity and Increase Exercise
– Health Community Design through MAPP
– Farm-to-School Partners; regional plan for</td>
<td>
<table>
<tr><th></th><th>FY11</th><th>FY13</th><th>FY15</th><th>Statewide</th></tr>
<tr><td>Youth Obesity</td><td>8%</td><td>14%</td><td>14%</td><td>13%</td></tr>
</table>
Windsor County FY15 Data
High School = 14%, Statewide = 12%

<table>
<tr><th></th><th>FY11</th><th>FY13</th><th>FY15</th><th>Statewide</th></tr>
<tr><td>Adult Obesity</td><td>23%</td><td>25%</td><td>27%</td><td>27%</td></tr>
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GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
Increase the number of students who eat five (5) or more servings of fruits and vegetables per day. Increase the percent of adults who eat five (5) or more servings of fruits and vegetables per day.	sustainability developed; director hired by WSESU	**FY11 FY13 FY15 Statewide** Students 5 fruits & veggies 21% 22% 23% 24% Windsor County FY15 Data High School = 23%, Statewide = 24% **FY15 Statewide** Adults fruit consumption 35% 35% Adult vegetable consumption 19% 19%
Objective 6 Lack of physical activity, need for recreational opportunities and active living Increase the students participating in at least 60 minutes of physical activity every day during the past week." Increase the percentage of adults who exercised moderately at least 2 hours and 30 minutes (150 minutes) each week. **Objective 7** Income, poverty and family stress Maximize local services and demonstrate an increase of 10% every 2 years in the number of youth and families accessing services at Windsor Connection Resource Center.	• *"Supporting Healthy Communities"* policy guide includes physical activity strategies for planners • Strategic planning for 3–4–50 • Applications made to two grant funders • Health Community Design through MAPP • Farm-to-School Partners; regional plan for sustainability developed; director hired by WSESU • Walking School Buses • Safe Routes to School in Windsor and West Windsor, participate in "walking school bus" events annually The WCRC worked throughout 2015 to achieve its mission of furnishing its PATCH Team members with collocation to bring vital services, education, and enrichment opportunities to the community, offering information, referral, advocacy, and case management services while building a positive sense of community.	**FY11 FY13 FY15 Statewide** Students – Physical Activity 31% 37% 25% 23% **FY11 FY13 FY15 Statewide** Adults – Physical Activity 61% 66% 62%* 63%* *Windsor county rates, Adults meeting national physical activity guideline recommendation Actual served in 2015 was 3,403 and in 2016 was 2,434. This is a decrease of 969.

GOALS

Healthy People 2020 approach to social determinants of health is a science-based organizing framework which includes:

- Economic stability
- Education
- Social and community control
- Health and healthcare
- Neighborhood and build environment

ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS

Statistics for 2016 include:

FY 2016

Total served	2434
Walk-ins	589
Telephone	1643

Windsor	1301	Hartland	340
Brownsville	164	Weathersfield	262
Weathersfield	122	Reading	10
Other	461		

Type of Service: FY 2016

Alcohol and Drug	194
Child Care	4
Housing	26
Community Health Outreach	157
Computer/Email	291
Crisis/Fuel, Electric, Shelter, Etc.	21
Dept. of Correction	35
Economic Services	160
Education:	
Adult	224
Early	15
5-18	420
Employment (VABIR)	19
Giving Room	581
Disability	77
Mental Health	875
PATCH	111
Phone/Fax/Copier	408
Taxes	61
Tobacco	17
Other	126

EVALUATION & ISSUES REMAINING

Change in service provision:	**Increase of**	**Decrease of**
Alcohol and drug	71	
Child care		34
Housing	13	
Community Health Outreach		113
Computer/Email		395
Crisis/Fuel/Electric, Shelter, Etc.		75
Dept. of Correction		94
Economic services		28
Education:		
Adult		153
Early		19
5-18	252	
Employment (VABIR)	15	
Giving Room		307
Disability		44
Mental Health		761
PATCH		44
Phone/Fax/Copier		37
Taxes		5
Tobacco		19
Other		33

Actions taken to increase presence of supportive housing and economic services in Windsor and at the Windsor Connection Resource Center.

<table>
<tr><th>GOALS</th><th>ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS</th><th>EVALUATION & ISSUES REMAINING</th></tr>
<tr><td>Increase the percentage of students who agree with the statement, “In my community, I feel like I matter to people”, by 10% every 2 years from 29% in 2005.</td><td>

PATCH services at the Windsor Connection Resource Center from October 2015 through September 2016 Include 160 visits for economic services, 875 visits for mental health counseling and 19 visits for employment counseling.
Four Parent-to-Parent Collaborative Problem-Solving Programs have been completed serving 23 families. Courtney McKaig and 7 WSESU school staff completed Collaborative Problem solving Training Tier II.
A Family Wellness Program has been embedded in the pediatric clinic based on the research effective Vermont Family-Based Approach Program after receipt of grant funding and consultation and training with Dr. Hudziak and his staff.

We served 43 MAHHC families and 5 OHC families
All of the Pediatricians completed initial training and A team of 3 MAHHC staff and 5 School staff completed 2 days for Vermont Family Based Approach

The series of trainings were organized for Health and Human Services clinicians regarding adverse childhood experiences.
Our Behavior Specialist/Wellness Coach was appointed to the School Coordinated Health Committee for the WSESU.
In Woodstock, a CHT and our Behavioral Specialist/Wellness Coach have expanded interagency care management with the Woodstock HS Guidance Program.

Youth Engagement – MAPP continues to sustain 5 regional youth groups with a total of 47 students participating.

Regional Prevention Efforts now extended to provide services in Woodstock as well as leadership to Ottauquechee Community Partnership (OCP.) OCP leads Mentoring and VT Youth Action Network (VYAN).
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There were a total of 67 substantiated cases in 2014and 71 in 2015:
<table>
<tr><th></th><th>2014</th><th>2015</th><th>Comparison</th></tr>
<tr><td>Physical abuse</td><td>19</td><td>17</td><td>↓2</td></tr>
<tr><td>Sexual abuse</td><td>24</td><td>29</td><td>↑4</td></tr>
<tr><td>Risk of sexual abuse</td><td>10</td><td>9</td><td>↓1</td></tr>
<tr><td>Risk of harm</td><td>28</td><td>29</td><td>↑1</td></tr>
<tr><td>Emotional/Neglect</td><td>10</td><td>4</td><td>↓6</td></tr>
</table>
There were a total of 413child abuse and neglect reports in 2015.

14 professionals were trained through the Vermont family-based approach.

48 families were served by the family wellness program.

22.6% of families have income less than 200% of the poverty level compared to 22.8% in Vermont and 16.8% in New Hampshire

The median income in Windsor is 40,472 compared to 54,267 in Vermont and 64,916 in New Hampshire

<table>
<tr><th></th><th>FY11</th><th>FY13</th><th>FY15</th><th>Statewide</th></tr>
<tr><td>Youth who say I matter to the community</td><td>49%</td><td>50%</td><td>48%</td><td>50%</td></tr>
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GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
Increase # of youth receiving leadership trainings and adult/student mentoring matches across Windsor and Woodstock areas.	Windsor Schools has expressed desire to have adults mentor students after school. WCSU currently has 5 active mentoring programs – Woodstock E/M/H Schools, Barnard, Reading	**FY15** **FY16** Youth Trained by VYAN 130 170 # of mentor matches 20 25 *WCSU only
Objective 8 Access to transportation	• Participating in Regional Transportation Coalition • Volunteers in Action provision of rides • Use of transportation vouchers • Successful receipt of Rides to Wellness Demonstration and Innovation Coordinated Access and Mobility Program	Transportation demonstration grant activities are pending $450 given in vouchers of elderly transportation Volunteers in Action: 43 volunteers drove a total of 14,447 miles transporting patients.
Objective 9 Access to primary health care	• Initiation of team-based care model on April 25, 2016 • Participated in the Geriatric Workforce Enhancement program: Education on Geriatric Care Innovation, Health Risk Assessment, Annual Wellness visit, Social Service Linkages, Dementia care and pharmacology, Chronic Disease, Advance Care Planning, Chronic Care Management , Communication Skills, and Care Coordination • Providers who left in FY16 included Margaret Sullivan, APRN (.78), Patrick Lyons, PA-C (1.0) • Providers who were hired in FY16 included Sean O'Brien, PA-C (1.0) MAHHC completed year 9 as a Blueprint for Health Community MAHHC has received a Blueprint for Health Grant and organized: A. Physician Best Practice B. Community Health Team C. Self-Management Team D. IT E. NCQA recognition F. Tobacco Cessation G. SASH H. Medication Assisted Therapy	In 2016, the Patient Centered Medical Home received a score of 73.8 in response to the question got appointment for checkups/routine care when needed compared to the NRC average of 71.3 and received a score of 74 in response to the question got urgent care when needed compared to the NRC average of 67.1 Patient Centered Medical Home is rescoring for the 3rd time. We maintained highest level of accreditation for the last three years. Community Health Team continued to serve high risk complex patients, interagency care management, managing high risk transitions of care, increasing self-management, quality of life, safety, and decreasing avoidable ED and inpatient admissions. Continued work on mental health access demonstrated an increase in care through the WRAP Program and Erin Boxer and case managers from HCRS. SASH and MAT staff evaluated as highly effective with strong positive impact. SASH has enrolled and supported 104 elders by a case manager and nurse. MAT has worked with three provider practices with two Masters level counselors and two RNs. Recruitment and retention plan developed by Self-Management Staff and Community Health Team.

<table>
<tr><th>GOALS</th><th>ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS</th><th>EVALUATION & ISSUES REMAINING</th></tr>
<tr><td></td><td>Implemented these programs with completer rates:

<table>
<tr><th></th><th colspan="2">#Workshops</th><th colspan="2"># Registered</th><th colspan="2">% Complete</th></tr>
<tr><th>Program</th><th>2015</th><th>2016</th><th>2015</th><th>2016</th><th>2015</th><th>2016</th></tr>
<tr><td>Chronic Pain</td><td>3</td><td>1</td><td>43</td><td>10</td><td>30%</td><td>10%</td></tr>
<tr><td>HLW</td><td>7</td><td>2</td><td>16</td><td>20</td><td>42%</td><td>30%</td></tr>
<tr><td>Tobacco</td><td>8</td><td>5</td><td>45</td><td>37</td><td>74%</td><td>70%</td></tr>
<tr><td>WRAP</td><td>3</td><td>2</td><td>37</td><td>22</td><td>32%</td><td>45%</td></tr>
</table>

• Implemented Self-Management Action Plans for Health in Medical Home
• Participated in the Interagency Care management Peer Learning collaborative
• Participated in the Accountable Communities for Health Peer Learning Collaborative
• Recertified ADA Self-Management Program operation with RN, CDE and RD, CDE
• Individual classes
• Group classes
• Monthly support group (10-15 members)
• Member of the Vermont Association of Diabetic Educators
• Provided Staying Healthy with Diabetes, and Meter Tune-up at Olde Windsor Village</td><td>Self-management programs need to improve in the number of facilitators available to lead workshops, incorporation into pre-visit planning for patients and the development of a systematic calendar to improve access.</td></tr>
<tr><td><u>Objective 10</u>

Health care for seniors</td><td>• Interagency care management in partnership with Senior Solutions and SASH
• Participation in Geriatric Workforce Enhancement Program at both MAHHC and OHC
• A CHT staff member in Woodstock has established an interagency care management program with an affordable housing community
• A member of our CHT and Director of community Health have participated in a task force for adult day care in the Woodstock area</td><td>Senior Solutions is a strong community collaborator.

The partnership of CHT and Senior Solutions in interagency care management can be strengthened, particularly in the area of choices of care.

SASH is an integral member of our team.</td></tr>
<tr><td><u>Objective 11</u>
Tobacco use/smoking

Reduce the percentage of students who smoke cigarettes one or more days during the past 30 days, by 10% every 2 years. Healthy People 2020 target is 15%.</td><td>• Regular cessation groups and 1:1 counseling has been provided. There were 109 new referrals for tobacco cessation. 83 patients followed through for 1:1 coaching
• Strategic planning for 3–4–50
• Community education about the impact of vaping provided included 16 different classes at 2</td><td>
<table>
<tr><th></th><th><u>FY11</u></th><th><u>FY13</u></th><th><u>FY15</u></th><th><u>Statewide</u></th></tr>
<tr><td>Youth 30-day cigarette use</td><td>17%</td><td>9%</td><td>10%</td><td>11%</td></tr>
</table>

<table>
<tr><th><u>Cigarette Use</u>:</th><th><u>8th Graders</u></th><th><u>12th Graders</u></th></tr>
<tr><td>1999</td><td>19%</td><td>44%</td></tr>
<tr><td>2001</td><td>17%</td><td>44%</td></tr>
<tr><td>2003</td><td>4%</td><td>37%</td></tr>
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</td></tr>
</table>

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
Decrease rate of adults who smoke cigarettes by 10% every 2 years. Healthy People 2020 target is 12%.	different schools in the 3rd to 8th grade reaching 270 children • Students participated in "Counter Balance" survey, where retail stores were assessed for prevalence of alcohol and tobacco products/marketing • VKAT (middle school) – Weathersfield, Windsor and Hartland Schools—10 VKAT and OVX students worked on Aerosol tobacco education projects. • OVX (high School) – Windsor and Woodstock Schools • Conducted store surveys with 20 retailers. Windsor OVX members were interviewed on Point Radio Show about retail survey efforts. • OVX also interviewed on VPR related to youth alcohol use after participating in Sticker Shock event. • Students worked with Autumn Moon Festival committee to create smoke free zones. Attended Prevention Day in January at Statehouse where they gave the dedication, met with local legislators, and sat in on meetings. • VT Quit Partners at MAHHC continues to provide 1:1 coaching services and group classes for cessation • Promotion of 802 Quits: 45 social media posts, 3 press releases • 802 Quit materials distributed at autumn moon, PATCH meetings, summer camp expo, Union Sq. Pizza Night • Continued partnership with Health Connections of Upper Valley to run cessation groups in WRJ area at the Haven, Listen Center, Turning Point, and WIC clinics • Cessation services continue in Hub and Spoke Program and at OHC • MAPP fully participating in statewide "Counter Balance" campaign, increasing community awareness of tobacco marketing influence at point of sale. www.counterbalancevt.com	2005 7% 39% 2007 6% 15% 2009 9% 9% 2011 3% 22% 2013 too few to report 13% 2015 too few to report too few to report **FY11 FY13 Statewide FY15** Adults who smoke cigarettes 20% 17% 18% 15.7% Adult Tobacco Cessation: 4 trained adult cessation coaches serving the area 76% sign up rate for tobacco cessation. Suzette Barbour RN, a spoke/mat staff member saw 47 of the 83 tobacco patients. This is an amazing rate for patients in an addiction/MAT recovery program

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
	Volunteers in Action – Provides robust and needed community support. Mt. Ascutney Hospital organizes Volunteers in Action which provides a myriad of services: • **Monthly Community Meals**: ➢ Windsor – Mt. Ascutney Hospital Board Room (usually 1 hospital volunteer and 3-4 community volunteers), approximately 30 participants. ➢ Hartland – Recreation Center (usually 5-8 community volunteers & 4 middle school children), approximately 30 participants. ➢ Ascutney – Mr. G's Restaurant, serving approximately 55 participants and 1 volunteer. • **Transportation** for seniors, etc. needing to get to doctor's appointments, hospital appointments, hair appointments, grocery shopping. ➢ Towns serviced: Windsor, Hartland, Reading, West Windsor, Ascutney, Weathersfield, Plainfield, Cornish (2 weekend hospital volunteers, 43community volunteers). • **Meals On Wheels**: ➢ Towns serviced daily Monday-Friday: – In-town Windsor: 4 community volunteers and 9 Pathways volunteers from Claremont and Newport – Weathersfield/Ascutney: 5 community volunteers. – Hartland: 3 community volunteers. – Four (4) volunteers in the Stoughton House kitchen preparing meals. ➢ Towns serviced 2-3 days per week Monday, Wednesday and Friday: – West Windsor and Reading – 4 community volunteers. ➢ Total substitute Meals on Wheels drivers: 12 community volunteers.	

GOALS	ACCOMPLISHMENTS & PROGRESS TOWARDS GOALS	EVALUATION & ISSUES REMAINING
	• **Mt. Ascutney Hospital**: ➢ Jobs/Departments: Greeters – 5 days/week – 39 community volunteers/5 substitutes. ➢ Mail assistant, emergency room and emergency reception, housekeeping, and pet walkers. ➢ Knitters and sewing donate items to all hospital departments, and distribute to churches, food shelves, Haven, VA Hospital, and Hospital Giving Tree – Total: 10 community volunteers/2 substitutes ➢ Chaplains: 2 community volunteers ➢ Vigils: 7 community volunteers ➢ Patient Advocacy Team: 2 volunteers ➢ A volunteer called a neighbor every morning from 7/30/16 to 11/1/16 • **Area Nursing Homes** – HHR, Davis House, Cedar Hill – singing, friendly visitations, Stoughton House Kitchen preparation of Meals on Wheels and dining room helpers, exercise leaders, food shelves - 15 community volunteers.	

Respectfully submitted,

Jill Lord, RN, MS
Director of Community Health