Addison County
Community Health Needs Assessment
2018

Conducted by:

Addison County Community Health Action Team (CHAT) Steering Committee

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Executive Summary

Since our last Community Health Needs Assessment, Addison County's healthcare and human service partners have taken many steps to improve the health and well-being our community. Our 2018 Community Health Needs Assessment describes this beautiful place we call home and how we, as community partners, have organized ourselves differently to be more effective. This report also shares various data sources we reviewed and includes highlights of a community survey we conducted in the spring of 2018.

Below are some of the data sources we reviewed as well as steps we have taken to solicit input on the top concerns and priorities for our community:

In December 2016, the Community Health Action Team (CHAT) hosted a strategic planning session with a range of partners. At that meeting, we prioritized the following needs in our community:

- Providing more family supports and community-wide programming & education
- Improving care coordination
- Increasing access to opioid treatment and affordable housing

We reviewed many Addison County data sources from across the lifespan during our first CHAT data meeting in December 2017. The most significant discovery from that meeting was identifying a lack of resilience among Addison County's school-age children.

Over the winter of 2018, we reviewed Addison County data for the health measures included in the Vermont Department of Health's Prevention Change Packets and found that improvement could be made in the following areas:

- Increasing percentage of Addison County adolescents receiving well-child visits
- Increasing adult BMI screening
- Improving adult type 2 diabetes control
- Improving pediatric weight assessment and control
- Improving practices for antibiotic prescribing

This spring we distributed a survey via survey monkey and received 594 responses from Addison County residents. The top social and environmental challenges identified in our 2018 community survey were:

- Accessing affordable housing
- Lack of a livable wage and employment opportunities
- Accessing childcare
- Transportation

The top health challenges identified in our 2018 community survey were:

- Addressing substance use disorder
- Increasing access to mental health services

- Addressing overweight and obesity
- Preventing and treating chronic conditions such as diabetes and heart disease
- Increasing access to healthcare services

The following pages will describe in detail the steps we've taken to garner input from community members and partner organizations. This report concludes with an implementation plan on how we will address many of the concerns and needs identified in this 2018 Community Health Needs Assessment over the coming months and years.

1. Overview of our Community:

Addison County is located in the lower Champlain Valley of Vermont with Lake Champlain and the Adirondacks to our west and the Green Mountains to our east. The unique landscape of Addison County, the fertile farmlands of the Champlain Valley and the predominately wooded settings near the foothills of the Green Mountains, provides a variety of lifestyles and a balanced blend of light industry and farming. Addison County is rural and known for its dairy farming. It has the most farm acreage in the state and leads the state in the value of agriculture products sold (US Census Bureau, 2012). The County is home to three local newspapers, seven service organizations and more than 100 faith communities. The major employers in the county include Middlebury College, Porter Medical Center and UTC Aerospace Systems.

Addison County is bordered to the north by Chittenden County, Vermont's most densely populated county, which includes Vermont's largest city, Burlington, and its surrounding suburbs. The northern portion of Addison County is considered a commutable distance to Burlington so residents have the option of traveling north for employment, healthcare, shopping and other services. Addison County is bordered to the south by Rutland County. Rutland County is home to Vermont's second largest city, Rutland. Residents who live in the southern portion of Addison County have the option of traveling to Rutland County for work, healthcare, etc. Addison County is bordered to the east by Windsor, Orange and Washington Counties. For the eastern Addison County communities of Hancock and Granville, accessing services within our county is challenging particularly in winter as this typically requires traveling over mountains.

According to the US Census Bureau, the 2017 population estimate for Addison County is 36,776 which is approximately 5% of the state's total population. According to population estimates, Addison County had 0.1% decrease in population since the 2010 census. 92.7% of Addison County residents are white non-Hispanic. Hispanic or Latino residents are Addison County's more prevalent minority population at 2.2%.

The percentage of Addison County residents who were uninsured was last measured in 2014 at 7.7%. However, the percentage of people living without health insurance is decreasing in Addison County and across the state. One estimate shows that the percentage of Addison County residents who are uninsured will drop to 3.28% by 2019. Vermont has one of the lowest rates in the country of people living without health insurance. According to a 2017 article, the statewide rate of uninsured has already dropped to 3.7%.

Addison County is similar to the state as a whole for unemployment and educational attainment. Addison County has lower poverty and a higher median income than the state. Below is data comparing Addison County to Vermont for unemployment, educational attainment, people living in poverty and the median household income:

	Addison County	Vermont
Unemployment Rate (April 2018)	3%	2.8%
% of Population with High School Diploma or Higher	92.5%	91.9%
% of Population with Bachelor's Degree or Higher	35.8%	36.3%
% of Population under the federal poverty level	8.7%	11.9%
Median Household Income	$61,020	$56,104

In Addison County, 17.4% of the population is age 18 and under while 18.5% of the population is age 65 years and older. This represents a significant shift in the age of the county's population. In our 2009 Community Health Needs Assessment, the population of Addison County youth age 18 and under was 21% while the population of seniors age 65 and older was 13.3%. According to a June 29, 2017 *Burlington Free Press* article, Vermont is aging faster than the nation as a whole. Vermont's median age is 42.7 while the median age for all Americans is 38-years-old. Further, the number of people under the age of 20 is declining in Vermont while the number of under- 20-year-olds is holding steady for the rest of the country.

Regarding education, many towns offer early education/preschool. However, it will be noted later in this report that accessing childcare is a high priority for the 18-34-year-olds who responded to our community survey. There are 23 public schools in Addison County serving 4,624 students. There are three school districts located within the county while the southern most communities of Addison County (Leicester, Whiting, and Orwell) are part of school districts that primarily serve Rutland County students. In addition to traditional secondary schools, the Patricia A. Hannaford Career Center offers an integrated work and learning program to students from the three Addison County school districts. Addison County is home to Middlebury College, a prestigious liberal arts college, the Community College of Vermont and Northland Jobs Corps, a residential and educational training program located in Vergennes for youth ages 16-24 years.

Population Centers:

Middlebury

Middlebury, the shire town of Addison County, was chartered in 1761 and was settled just after the Revolutionary War. Today, the village is listed on the National Register of Historic Places and is home to shops, businesses, churches and public buildings. Middlebury is the largest community in the county with a population of 8,600. Middlebury is home to the Middlebury College. Middlebury is also the hub for medical services in the county with the University of Vermont Health Network Porter Medical Center, a critical access hospital, Helen Porter Healthcare and Rehabilitation Center and many of the area's medical provider offices.

Vergennes

Established in 1788, Vergennes is Vermont's oldest incorporated city. Vergennes encompasses 1,200 acres of land that was carved from the three neighboring towns of Ferrisburgh, Panton and Waltham. It is where Thomas Macdonough built and armed the fleet that would defeat the British on Lake Champlain during the War of 1812. In the late 1990s Vergennes residents launched a Main Street revitalization effort and formed the Friends of the Vergennes Opera House to complete the restoration of the 1897 Opera House. Today, Vergennes is home to 2,600 residents and UTC Aerospace, one of the largest employers in the county.

Bristol

Bristol, known as the "Gateway to the Green Mountains," was founded in 1762 and is currently home to 3,900 residents. The town was originally known as Pocock, after a distinguished English admiral. The name was changed to Bristol in 1789 but the community still celebrates its heritage during the annual Pocock Rocks Street Fair. Bristol is also host to one of the largest July 4th celebrations in the state. The Bristol Band has presented outdoor summer concerts on the town green every Wednesday since shortly after the Civil War. Downtown Bristol is a National Historic District with small shops and restaurants and a vibrant artist community.

Smaller Towns and Villages:

Approximately 60% of Addison County residents live outside the three population centers. These outlying communities are rural with few local services. The communities are governed by select boards and most have their own elementary school, fire department and town office. There are small country and convenience stores/gas stations in some of these communities. The large grocery stores are located in the population centers along with other shopping, banking and healthcare services. Transportation is a significant issue in our county. Addison County Transit Resources provides bus and volunteer driver services but these services are somewhat limited to the outlying communities. Agencies such as the Addison County Parent Child Center and Elderly Services provide transportation for their clients for specific purposes but in general, transportation is a concern for those who do not drive and those without a reliable vehicle.

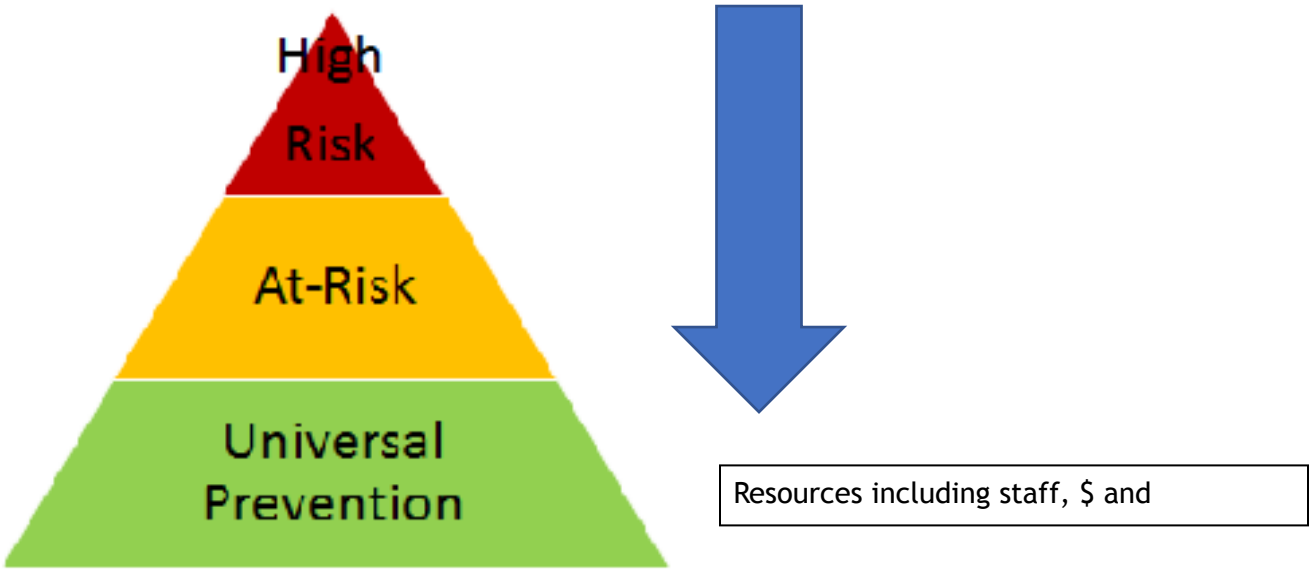
There are ample opportunities for outdoor physical activity in Addison County including walking, running, biking, swimming in lakes, streams and outdoor public pools and use of recreation fields. However, there are concerns that the roads are dangerous for pedestrians and cyclists due to fast moving traffic and narrow shoulders. The Walk-Bike Council of Addison County formed in response to three cyclists deaths in the county several years ago and is working to make walking and biking safer for everyone.

2. Organizing to Address the Health and Wellbeing of Addison County Residents

Addison County Integrating Family Services:

Addison County's human service organizations have a solid history of collaboration. For many years, we had a strong regional partnership called the People of Addison County Together (PACT). About 8 years ago, Addison County had the opportunity to become the pilot community for a new state initiative called Integrating Family Services (IFS). IFS is a bundled payment mechanism to the Counseling Service of Addison County and Addison County Parent Child Center that strives to enhance services for our prenatal through 22-year-old population.

Addison County IFS adopted the triangle model, with its three risk levels (shown on page 8), to organize our work. The Universal/Prevention level is what all children and families need to be well including basic needs (housing, healthcare, transportation, food, clothing), quality education, community connections, recreation, arts and leisure activities. The At-Risk level provides additional supports for families who need some assistance. At-Risk level of supports include respite care, mental health counseling, additional supports in schools, and job training. High-Risk supports include one-on-one care, residential mental health and substance use treatment, and programs that support individuals coming out of incarceration. The intent of this model is to drive more interventions, services and programming down to the universal level (or at least from the high-risk to at-risk level), so that all children and young adults have what they need as soon as possible to be healthy, vibrant members of our community.



Addison County Building Bright Futures:

Building Bright Futures (BBF) is a statewide initiative dedicated to improving the well-being of young children, age 0-8, and their families. BBF has three focus areas: building community through 12 regional councils, making data available to the public and improving policies that impact the lives of Vermont's children and families.

In Addison County, because IFS and BBF have similar goals and an overlap in the populations we serve, it made sense for these initiatives to merge. In 2014, Addison County BBF merged with Addison County IFS to develop a combined strategic plan and a single steering committee.

Community Health Action Team:

Addison County's Community Health Action Team (CHAT) formed in 2014. CHAT is a community collaborative that promotes integration of health and human services to address both medical and non-medical needs.

CHAT initially met monthly to discuss a variety of health and healthcare topics but meeting participation started waning and CHAT members were struggling to find a focus. In 2016, CHAT applied to be part of the Vermont Accountable Communities for Health Peer to Peer Learning Lab. A committee of CHAT members participated in the Learning Lab sessions that gave us opportunities to brainstorm how to strengthen CHAT meetings and prioritize our work.

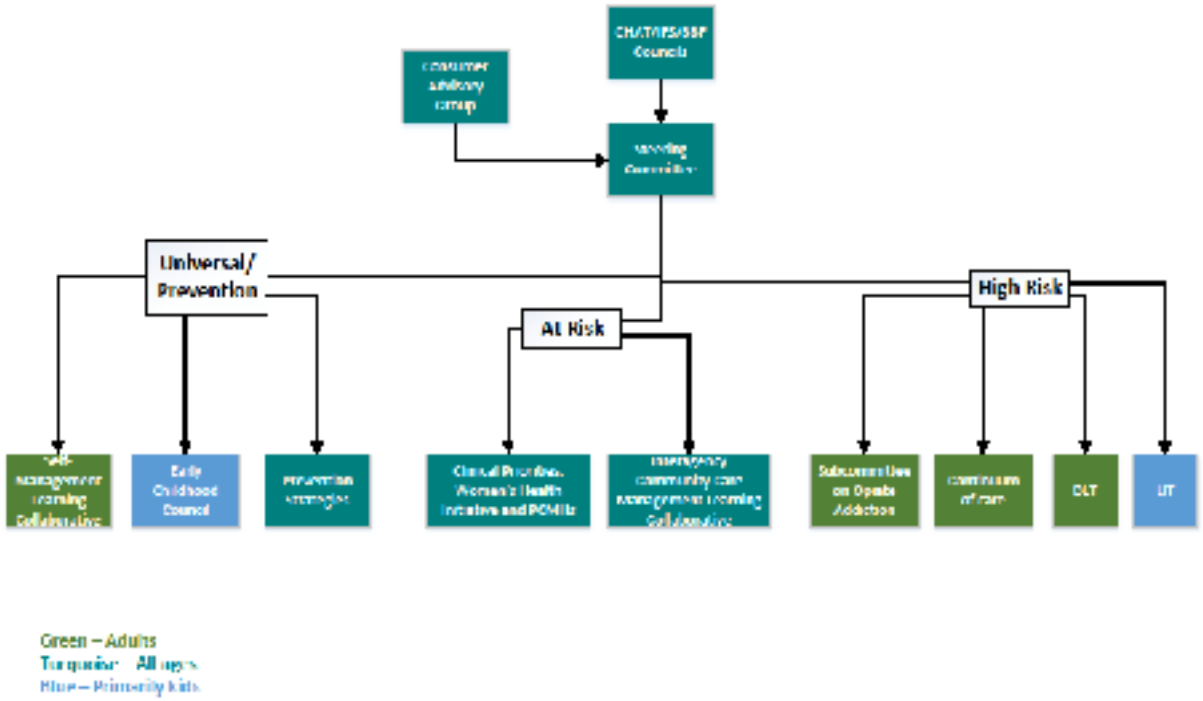
In December 2016, we hosted a strategic planning meeting for CHAT with more than 50 community members in attendance. We had decided to adopt the Addison County IFS triangle model and asked community members to prioritize needs for Addison County's adult population age 23 and older. The group generated many different ideas to assist Addison County adults and then narrowed the priorities to the following:

Universal level: family supports, programming & education

At-Risk level: coordinated care

High-Risk level: opioid treatment and housing

Over the winter of 2017, we created an organizational chart (shown below) that combined the work of Addison County IFS, BBF and CHAT. We felt this was important to identify and agree upon shared priorities, reduce duplicative meetings and improve communication. The proposed organizational chart was put before the larger Addison County IFS, BBF and CHAT councils and received approval. We also sought and received approval from the larger councils to fully merge the Addison County IFS, BBF and CHAT steering committee. This meant that there would be one organizing body focused on the health and well-being of Addison County residents from prenatal through our oldest community members.



Once we had approval to move forward with a combined IFS, BBF, CHAT steering committee, we recruited members to better represent various sectors of our community. We agreed that organizations, not individuals, will serve as members of the combined IFS, BBF, CHAT steering committee. During the spring and summer of 2017, we recruited the following combined steering committee member organizations:

- Vermont Blueprint for Health Middlebury
- Addison County Building Bright Futures
- Agency of Human Services

- Counseling Service of Addison County
- Department of Children and Families Middlebury District, Family Services
- Department of Children and Families Middlebury District, Economic Services
- Parent Child Center of Addison County
- Vermont Department of Health Middlebury District Office
- Addison County Community Trust
- Middlebury College
- University of Vermont Health Network Porter Medical Center
- One Care Vermont
- Elderly Services
- Mountain Health Center
- Addison County Home Health and Hospice
- United Way of Addison County
- Addison County Regional Planning Commission
- School Representative, Addison County's three school districts have designated one person to participate on their behalf

In September 2018, the combined IFS, BBF, CHAT Steering Committee adopted a charter that defines the steering committee membership, our role and how we govern ourselves. (Appendix A: CHAT Charter)

3. Review of Addison County Data

For the second year in a row, Addison County was ranked first in health outcomes among Vermont's 14 counties by the Robert Wood Johnson Foundation County Health Rankings. While we have some good health outcomes there is still have room for improvement. According to the 2015-2016 Behavioral Risk Factor Surveillance System (BRFSS) data for the Middlebury Health District, 26% of Addison County adults have been diagnosed with hypertension and 34% have high cholesterol. 23% of Addison County adults have been diagnosed with depressive disorder and 7% did not visit the doctor in the last year due to cost.

Additional BRFSS data for the Middlebury Health District and Vermont is provided below:

Health Status Indicators:

	Addison County	Vermont
Have personal health care provider	87%	88%
Did not visit doctor due to cost, in last year	7%	8%
Poor physical health	10%	11%
Poor mental health	11%	12%

Disabled	20%	23%

Risk Factors:

	Addison County	Vermont
Adverse Childhood Experiences (ACEs), four or more	12%	14%
Binge drinking, in last month	16%	18%
Heavy drinking, in last month	8%	9%
Marijuana use, in last month	8%	12%
Prescription drug misuse, ever	7%	7%
Smoke cigarettes, currently	14%	18%
No leisure time physical activity	20%	18%

Disease Prevalence:

	Addison County	Vermont
Arthritis, ever diagnosed	27%	28%
High cholesterol, ever diagnosed	34%	34%
Depressive Disorder, ever diagnosed	23%	22%
Diabetes, ever diagnosed	10%	8%
Hypertension, ever diagnosed	26%	25%
Overweight, ages 20+	32%	34%
Obese, ages 20+	31%	28%

Annual Data Meeting:

As outlined in the CHAT Charter, we decided that the larger councils would meet twice a year meaning there are two large meetings for BBF, two meetings for IFS and two meetings for CHAT. We also decided it would be important to do an annual review of Addison County data to get a yearly status update on the health and wellbeing of our community.

In December 2017, we hosted our first annual Addison County data meeting. More than 40 people attended the meeting and were asked to bring one piece of data that influences their work. We presented data on Addison County residents across the lifespan including information from IFS, One Care Vermont, Blueprint for Health, Vermont Department of Health and Elderly

Services. We then broke into small groups based on our three risk levels (universal/prevention, at-risk, high-risk) to dig deeper into the data. (Notes from the data meeting breakout sessions are included in Appendix B.)

The most significant discovery from our data review was a lack of resilience among children in Addison County. Two of our school districts and the Counseling Service of Addison County conduct regular screening of school-age children and found a concerning number of students with high anxiety, low optimism and low resilience. During the data meeting small group discussions, the universal/prevention group focused their entire conversation on the issue of building resilience and how to move forward with a community-wide resilience campaign.

Prevention Change Packets:

The Prevention Change Packets were developed by the Vermont Department of Health and include evidence-based strategies for health measures identified by Vermont's Accountable Care Organizations. The intent of the Prevention Change Packets is to help health care providers address the social determinants of health and to increase their focus on prevention. According to Healthy People 2020, social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

We spent time at several combined steering committee meetings during the winter of 2018 reviewing and discussing the Prevention Change Packets. Vermont Department of Health Middlebury staff with assistance from a health department statistician, reviewed health department and Blueprint for Health data to identify priorities areas for Addison County from the Prevention Change Packet health measures.

We acknowledge that there are some limitations with our data and that further investigation about how local health care providers may already be addressing these issues is needed. However, based on our Addison County data, the following health measures were deemed as areas for improvement:

- Increasing percentage of Addison County adolescents receiving well-child visits
- Increasing adult BMI screening
- Improving adult type 2 diabetes control
- Improving pediatric weight assessment and control
- Improving practices for antibiotic prescribing

(See Appendix C for identified Prevention Change Packet health measures and Addison County data.)

As a follow up to the Prevention Change Packets data review, the Vermont Department of Health Middlebury office is planning an Addison County nutrition resources event for fall 2018. This is a first step to address pediatric and adult weight screening and type 2 diabetes control. Our plan is to bring together local nutrition resources including the Blueprint Community Health Team Dietitians, Expanded Food and Nutrition Education Program (EFNEP), and coordinators of gleaning programs and community cooking classes to share their resources and referral information with health, education and human service practitioners.

4. Community Survey Findings

During the spring of 2018, we launched a community survey via Survey Monkey to assess the top health and social needs of our community. 594 Addison County residents completed the survey and we received at least one response from residents in every town in the county. While we feel this was an excellent response to our survey, it is important to acknowledge the limitations of our data. 158 respondents did not provide their age but of those who did, a majority (62%) were women over the age of 50. In addition, 176 respondents did not provide their income but of the respondents who did, a majority (51%) earned more than $50,000 per year. We are concerned that we did not hear from many younger residents, lower-income residents or men of all ages. We'll share in the implementation section of this report how we plan to dig deeper into the community survey data at our next annual data meeting and hope to develop a plan to garner additional input from these specific populations.

Despite some limitations with our survey data, we were able to glean useful information from the responses. In general, the survey responses confirmed community challenges that had previously been identified by our health, education and human service partners at our December 2016 CHAT strategic planning session. Survey respondents identified affordable housing as the most concerning social challenge in our community and substance use disorder was identified by survey respondents as the most concerning health issue.

Survey respondents selected the following **social and environmental challenges** as the most concerning for our community:

Top 5 Challenges	# of Respondents who selected Challenge*	% of Respondents who selected Challenge*
Affordable housing	308	52%
Lack of a livable wage	249	42%
Lack of employment opportunities	191	32%
Childcare	169	28%
Transportation	152	26%

Survey respondents selected the following **health challenges** as the most concerning for our community:

Top 5 Challenges	# of Respondents who selected Challenge*	% of Respondents who selected Challenge*
Substance use disorder (drug and alcohol misuse)	399	67%
Access to mental health services	310	52%
Overweight/obesity	275	46%
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke)	183	31%
Access to healthcare services	172	29%

*Note: Respondents were asked to pick up to 5 challenges which why the number of responses equals more than the number of surveys received and why the percentage equals more than 100%

We also asked survey respondents about challenges they or family members have experienced in the last year. Survey respondents or their family members had experienced an average of 2.1 social/environmental and health challenges in the last year.

Survey respondents or their family members have experienced the following **social and environmental challenges** in the last year:

Challenges Experienced	# of Respondents who Experienced Challenge	% of Respondents who Experienced Challenge
Lack of a livable wage	142	24%
Affordable housing	122	21%
Lack of employment opportunities	108	18%
Street safety (crosswalks, shoulders, bike lanes, traffic control)	92	16%
Climate change	90	15%

Survey respondents or their family members have experienced the following **health challenges** in the last year:

Challenges Experienced	# of Respondents who Experienced Challenge	% of Respondents who Experienced Challenge
Overweight/obesity	202	34%
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke)	168	28%
Aging problems	129	21%
Physical activity	114	19%
Access to mental health	97	16%

We then asked survey respondents to rank social/environmental and health issues in order of importance. Affordable housing and mental health were ranked as the most important issues for our community. However, the average for the rankings of the important social/environmental and health issues were very close.

While not statistically significant because the number of respondents was low for younger age groups, it is interesting to note that our youngest respondents, the 18-24-year-old age group, reported experiencing twice as many (an average of 4.3) social and environmental challenges.

For this 18-24-year-old group, affordable housing was identified as the most important issue. Again, while not statistically significant, childcare was identified as the most important issue for 18-34-year-old respondents.

(Additional summary charts of our community survey data are included in Appendix D and the survey questions are included in Appendix E.)

5. Implementation Plan

Addressing Community Survey Results:

Addison County's health and human service partners are working to address three (affordable housing, childcare and transportation) of the top five social and environmental challenges identified by community survey respondents.

Housing: See housing section of the implementation plan on page 16.

Childcare: Addison County Building Bright Futures hosted in a childcare summit in October 2017 to discuss ways to increase access to high quality early education in the county. BBF is continuing to follow up on action items from the summit. In the meantime, Mary Johnson Children's Center just announced that they received grant funding to increase the number of infant childcare slots in the county.

Transportation: Addison County Transit Resources is a member of CHAT. ACTR staff also attended a combined steering committee meeting this spring to brainstorm strategies to increase the number of riders who receive rides through Medicaid. Addressing transportation needs is an ongoing conversation with health, human service and education partners.

Addison County health and human service partners are working to address all five of the top health concerns identified by community survey respondents:

Substance Use Disorder: See Treatment for Substance Use Disorder on page 17.

Access to mental health supports: Since implementing IFS, Counseling Service of Addison County has been able to serve more children and young adults and the number of crisis calls CSAC receives has decreased. The Blueprint for Health has imbedded CSAC mental health clinicians in local healthcare provider offices making it easier for providers to make mental health referrals and for patients to access mental health services. Unfortunately, there is a still a waiting list for adult mental health services at CSAC. CSAC has had job openings for mental health clinicians but has struggled to recruit qualified candidates.

Overweight/obesity and chronic disease: The Vermont Department of Health Middlebury Office received a grant last year to fund activities related to the 3-4-50 campaign. 3-4-50 stands for three behaviors (tobacco use, lack of physical activity and poor nutrition) that lead to four chronic conditions (cancer, heart disease, lung disease and diabetes) that result in 50% of the deaths in Vermont. Through this funding, VDH Middlebury funded a winter passport to get kids and families more physically active in the winter. VDH also funded a vegetable prescription program at Mountain Health Center in Bristol. Mountain Health staff identified and recruited pre-diabetic patients to receive a free CSA vegetable share last fall and again this spring. VDH Middlebury partnered with Middlebury Union High School Alternative Education students to build raised garden beds at the homes of local WIC participants. (WIC stands for Special Supplemental Nutrition Program for Women, Infants and Children.) Finally, the grant purchased sports equipment for May Johnson Children's Center's Rural Fun Delivery Program. Rural Fun Delivery is a summer program that provides lunches and fun activities for children in Starksboro.

University of Vermont Health Network Porter Medical Center will be partnering with Rise VT in Addison County. Rise VT was developed in Franklin County and is an evidenced-based program focused on reducing BMIs. The Blueprint for Health provides self-management programs in Addison County to help those who have been diagnosed with a chronic illness learn more about how to care for themselves and improve their health.

Access to healthcare services: To address healthcare access, University of Vermont Health Network Porter Medical Center opened Porter ExpressCare last June. Porter ExpressCare is a walk-in care clinic for adults and children over age 2 with minor illnesses or injuries who are unable to get an immediate appointment with their primary care provider.

Addressing CHAT and Prevention Change Packet Priorities:

Community Resilience Campaign: Following the CHAT data meeting, we continued conversations about developing a resilience campaign. In March and June 2018, we hosted IFS Council meetings to help prioritize campaign activities. Vermont Department of Health Middlebury District Office hosted a series of brown bag lunches on resilience. The Addison County Parent Child Center provided training to their staff on resilience. Counseling Service of Addison (CSAC) held a staff retreat this spring focused on resilience building. Finally, CSAC also hosted a May 2018 meeting of local Executive Directors and their Board Chairs to share more information about the work of CHAT and our proposed resilience campaign.

CSAC has hired a local marketing contractor to help us develop our brand and tag lines for the resilience campaign. We will continue to meet over the summer to flesh out campaign components and plan to launch a county-wide resilience campaign in the fall of 2018.

Nutrition resources event: As previously stated, the Vermont Department of Health Middlebury office is planning to host a nutrition resources event in this fall so partners can learn more about the nutrition resources in Addison County.

Coordinated Care: Blueprint for Health Middlebury staff are facilitating several initiatives to improve care coordination and communication among healthcare and human service providers. The Complex Care Coordination team includes staff from Porter Medical Center, local healthcare provider offices, CSAC, Addison County Home Health and Hospice, Bayada Home Health Care and One Care Vermont. The team meets monthly to discuss the needs of and resources for patients with complex medical needs. The Women's Health Initiative is providing enhanced health and psychosocial screenings and referrals, comprehensive family planning counseling and access to long acting reversible contraception. The Women's Health Initiative is being implemented in Addison County at Porter's Women's Health Center and the Planned Parenthood Middlebury Health Center. Finally, local Medication Assisted Treatment (MAT) providers are working with Porter's Women's Health Center, local pediatricians and human service organizations to provide substance use treatment to pregnant women in Addison County. This initiative is just starting so the group is working on consent forms and determining the best modes of communication.

Housing**:** As soon as our combined steering committee started meeting regularly, the issue of housing became a primary topic. According to data from the Vermont Agency of Human Services, the current vacancy rate for housing in Addison County is 0.2%. A typical housing market is considered balanced and healthy when vacancies remain between 4% and 6%. 45% of Addison County renter households spend more than 30% of their incomes on rent and 22% of Addison County renters pay more than half of their incomes toward rent. Approximately 100 individuals in Addison County are homeless on any given night. Finally, it is estimated that

Addison County needs about 1,200 additional rental units to serve households earning less than the area median income.

We focused the November 2017 CHAT Council meeting on housing issues. Following the November meeting, Addison County Regional Planning Commission (ACRPC) developed and disseminated a survey to area non-profits to assess local housing assets and potential resources that could be dedicated to addressing housing needs in the county. ACRPC led a housing subcommittee of CHAT and by the spring of 2018, the subcommittee developed a four-component proposal that focuses on creating more middle-income workforce housing, lower-income workforce housing, permanent supportive housing and dispersed elderly single room occupancy units. We then created three committees to take on these four housing initiatives. (We combined the lower-income workforce housing and permanent supportive housing into one committee since there was so much overlap in the organizations involved in these projects.) The three committees are now working on projects and seeking grant funds to help move these housing initiatives forward. Vermont HomeShare will present at our September 2018 combined steering committee meeting so we can learn more about their work in housing older Vermonters. These projects won't solve all of the housing needs in Addison County but we feel this is a good start. (Appendix F: Housing Proposal)

Treatment for Substance Use Disorder: The Addison County Substance Use and Prevention Committee was formed in 2014. The initial focus of the group was to address the lack of treatment providers in Addison County for opioid misuse. In 2014, there were no healthcare providers providing mediation assisted treatment. Thanks to the efforts of Porter Medical Center, CSAC, Mountain Health Center and the providers themselves, there are now seven Addison County healthcare providers providing medication assisted treatment along with counseling to individuals struggling with substance use disorder.

More recently, the Addison County Substance Use and Prevention Committee has shifted its focus to prevention and promotion of recovery resources including programming at the Turning Point Center of Addison County. The Addison County Substance Use and Prevention Committee worked with the Regional Prevention Partnership to host a successful community book read of *The Seventh Wish* with a presentation by the author, Kate Messner. The Committee has developed a website, www.addictionhelpvt.com, and provides school and community presentations. The Substance Use and Prevention Committee will be sharing resources at upcoming community events including Vergennes Day and the Bristol Harvest Festival.

Finally, the United Way of Addison County has developed a very successful program called HELP. HELP stands for Heroin Epidemic Learning Program. HELP teaches high school students filmmaking skills and provides information about opioid use disorder. Volunteer experts in filmmaking as well as law enforcement, first responders and individuals impacted by substance use disorder teach students about both filmmaking and the impacts of drug use. Students use their new knowledge to create public service announcements (PSAs). The program culminates in a public screening of the PSAs and awards for the best student-made films. HELP has become well-known in the state and other regions are asking to replicate the program in their communities.

Getting Additional Input from the Community:

As previously stated, we are concerned that we did not receive many community survey responses from younger residents, lower-income residents or men of all ages. We will spend time at our next annual CHAT data meeting reviewing our survey data and brainstorming ways

to get additional information about the health needs of these specific populations and what additional action steps might be required to address priority areas of these groups.

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Appendix A

Addison County Community Health Action Team (CHAT) CHARTER

BACKGROUND & HISTORY:

Addison County's Community Health Action Team (CHAT) formed in 2014. CHAT initially met monthly to discuss a variety of health and healthcare topics as part of the Community Collaborative (CC) that originated from the Vermont Health Care Improvement Project (VHIP).

CHAT is a community collaborative that promotes the cohesive integration of health and human services addressing both the medical and non-medical needs that impact measurement results and outcomes, including social, economic and behavioral factors. The structure, with administrative support locally from the Blueprint and the ACOs will result in more effective health services as measured by improved results in quality, health status, utilization and experience of care.

In 2016, CHAT applied to be part of the Vermont Accountable Communities for Health (ACH) Peer to Peer Learning Lab. A committee of CHAT members participated in the ACH Learning Lab sessions, which gave the CHAT representatives opportunities to brainstorm how to strengthen CHAT meetings and prioritize our work going forward. We decided to build on the model used for Addison County's Integrating Family Services (IFS) initiative which strives to enhance services for our prenatal through age 22-year-old population (model below).

Addison County's IFS uses a triangle model with universal/prevention on the bottom, at-risk in the middle and high-risk at the top. The intent is to drive more interventions, services, and programming down to the universal level (or at least from high-risk to at-risk), so that all children and young adults get what they need as soon as possible to be healthy, vibrant members of community.

In December 2016, we hosted a strategic planning meeting for CHAT with more than 50 community members in attendance. Using the IFS model, we asked community members to prioritize the needs for the Addison County adult population age 23 and older.

We discussed many different topics during our December 2016 meeting and then narrowed our priorities to the following:

For the Universal/Prevention level, we prioritized:

- Mental health/empowerment
- Parenting supports/family services
- Community-wide programming and education

For the At-Risk level, we prioritized:

- Care coordination and communication
- Person-centered approaches
- Screening and proactive treatment of chronic diseases

For the High-Risk level, we prioritized:

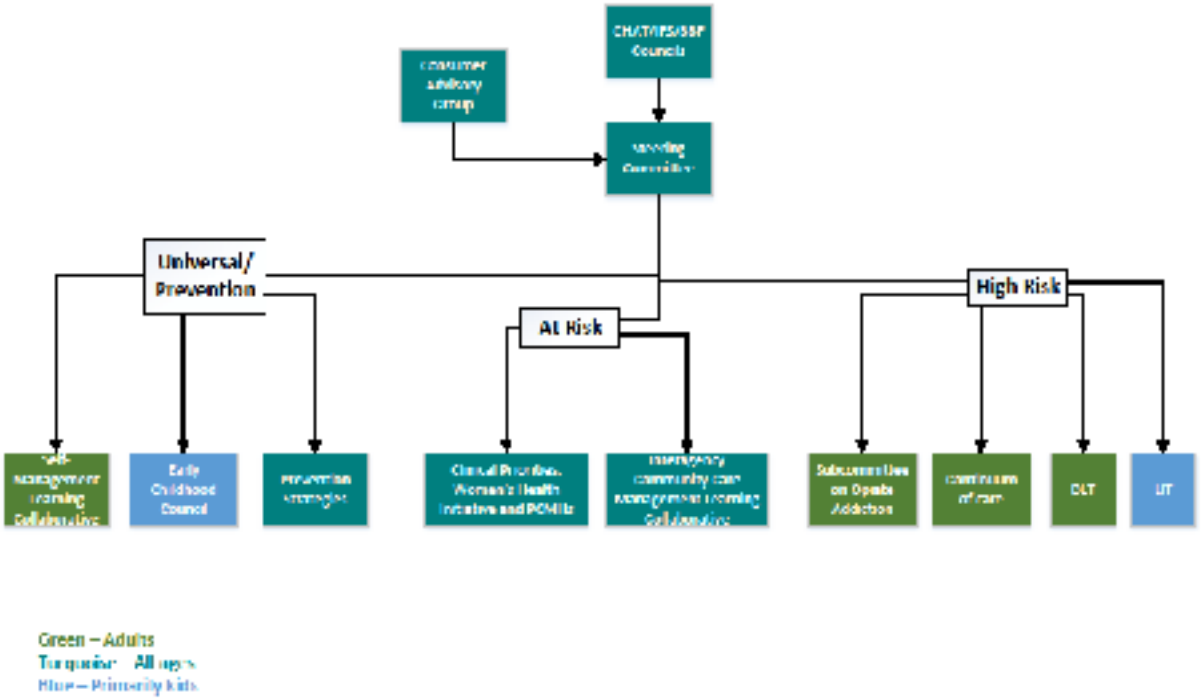
- Housing
- Medication-assisted treatment for opioid addiction
- Access to care

Since the December 2016 CHAT meeting, we have formed new committees or have engaged existing committees to work on these priority areas.

MERGING BBF, IFS, AND CHAT:

In 2014, Addison County Building Bright Futures (BBF) merged with Addison County IFS to create one strategic plan with a single steering committee. Given that all of these groups are focused on improving the health and wellbeing of Addison County residents, it made sense to combine IFS and BBF with CHAT.

Over the winter of 2017, we created an organizational chart that combined the work of IFS, BBF and CHAT (organizational chart below). We felt this was important to identify and agree upon shared priorities, reduce duplicative meetings, and improve communication. The proposed organizational chart was put before the larger BBF/IFS and CHAT councils and received approval.



Green – Adults

ROLES OF THE STEERING COMMITTEE:

The combined steering committee will:

- Establish agendas for our larger community meetings
- Facilitate communication between existing committees and teams
- Plan and host interagency trainings
- Share and review data
- Seek input from larger CHAT, IFS and BBF meeting participants to set shared regional priorities
- Make funding decisions and oversee management of funds
- Identify individuals to connect with the statewide ACH efforts, including attending meetings and sharing information to and from the statewide groups

MEETINGS:

As reflected in the organizational chart, we are organizing ourselves by intervention level (universal/prevention, at-risk, high-risk) yet, the three initiatives (BBF, IFS and CHAT) each

has their own membership/partners and reporting requirements. Therefore, we decided each group should meet twice per year with an additional meeting focused on reviewing and discussing local data.

Large Group meeting schedule:

- IFS will meet in September and March
- BBF will meet in October and April
- CHAT will meet in November and May
- The annual data meeting will take place in December

As of the drafting of this charter, the combined steering committee has agreed to meet on the 4th Thursday of the month from 9:00 – 11:00am.

The IFS/BBF combined steering committee will continue to meet monthly on the 2nd Monday of the month from 10:00am – 11:30am to address the programmatic and systems needs of children and young adults up to age 22-years. Addison Building Bright Futures will act as a sub-committee of the greater IFS/BBF council, and will meet monthly (2nd Friday of the month from 9:00-12:00) to focus on early childhood related systems issues of the IFS/BBF strategic plan.

Finally, because we will not have healthcare represented at the IFS/BBF steering committee meetings due to scheduling conflicts, we have agreed that all healthcare related issues for children and young adults will be tabled and discussed at the combined steering committee meetings.

FACILITATION:

Planning and facilitation of the large group meetings will be a team effort of members from the combined steering committee. Outside facilitation can be utilized as appropriate particularly if there are challenging decisions to work through.

The monthly combined steering committee meetings will be planned and facilitated by Moira Cook.

Cheryl Huntley and Dana Anderson will continue to facilitate the IFS and BBF steering committee meetings.

STEERING COMMITTEE MEMBERSHIP:

Background: The initial steering committee members were those who participated in the ACH Peer-to-Peer Learning Lab. Once we realized it made sense to combine the IFS/BBF steering committee with the CHAT steering committee, the IFS/BBF steering committee were included in the combined steering committee. However, after we set our priorities and developed the organizational chart, we knew the steering committee membership had to be expanded to better represent various sectors of our community.

We agree that organizations/businesses will serve as members of the CHAT steering committee, not the individual staff members listed below. When there is staff turnover, the organization will remain on the steering committee and must assign a new designee to serve on the combined steering committee. There will be an annual review of this charter and the composition of the combined steering committee. (See page 8.)

The proposed combined steering committee members are:

- Vermont Blueprint for Health Middlebury Staff – Susan Bruce, Project Manager
- Building Bright Futures – vacant, Regional Coordinator for Addison and Rutland Counties
- Agency of Human Services – Adam Sancic, Field Director
- Counseling Service of Addison County – Cheryl Huntley, Operations Director
- Department of Children and Families, Family Services – Andrea Grimm, District Director
- Department of Children and Families, Economic Services - Robyn Stattel, District Director
- Parent Child Center of Addison County – Donna Bailey, Co-Director
- Vermont Department of Health – Moira Cook, District Director
- Addison County Community Trust – Elise Shanbacker, Executive Director
- Middlebury College – Dave Donahue, Special Assistant to the President and Community Relations
- Porter Hospital – Carrie Wulfman, Chief Medical Officer
- One Care – Trevor Hanbridge, ACO Clinical Consultant
- Elderly Services – Jen Stewart, Licensed Clinical Social Worker
- Mountain Health Center – Martha Halnon, Chief Executive Officer
- Addison County Home Health and Hospice – Tim Brownell, Executive Director
- United Way of Addison County – Kate McGowan, Executive Director
- Addison County Regional Planning Commission – Adam Lougee, Executive Director, or Claire Tebbs, Senior Planner
- School Representative, Addison County's three school districts have designated one person to participate on their behalf – Susan Bruhl, Special Education Coordinator, Addison Northeast Supervisory Union
- Business Community Representative – to be determined

OPERATING PRINCIPLES:

The combined steering committee will utilize the following operating principles to guide their work:

Collaboration: Promote cross-sector participation throughout Addison County.

Equality: All combined steering committee members have equal standing regardless of their organizational size and resources.

Consensus: Decisions are made by consensus. We work through an issue until everyone can support it.

Shared Learning: Focus on exploring and sharing opportunities for innovation.

DECISION MAKING:

1. **We aim for consensus.**

   The combined steering committee aims to reach consensus on key decisions. Consensus in this context does not necessarily mean 100% agreement on all parts of every issue, but rather that all members review a decision in its entirety and can say "I can live with that."

   The combined steering committee will work to understand and integrate perspectives until a solution is identified that is acceptable to everyone.

   We use a "thumbs up/thumbs down" signal as a way of gauging members' positions:

   - Thumbs up – supports the decision
   - Thumbs middle – neutral, can live with the decision
   - Thumbs down – deal breaker, suspends the decision until further discussion

   In the event of a thumbs down vote, we attempt to resolve the issue through further discussion in a reasonable amount of time. In the event that's not doable, a sub-team of the council will convene separately and come back with recommendations.

2. **We act as team players.**
   As combined steering committee members, we acknowledge and are explicit about our organizational or sector-specific self-interests **but also participate in service to the collective, common agenda.** As such, we are conscientious about invoking our veto power (thumbs down vote) and ask ourselves first, "is this issue or decision fundamental to my participation in the combined steering committee?" We also expect combined steering committee members to actively reach out to clients, colleagues, and community partners to help inform the steering committee's decisions.

3. **A quorum is required.**
   A quorum of the majority of combined steering committee members is required for a decision to be considered valid. We will solicit input from any organization/business or interested parties, with adequate warning, prior to voting. Any interested party can participate in a combined steering committee meeting however, only the members listed above, their designee, or their dually appointed successor can vote.

4. **One must be present to win.**
   Members or their designees must be present to vote on decisions. Each organization/ business has one vote only. If more than one staff member from an organization/ business is present, they must determine who will vote on behalf of their organization.

If a member is unable to attend a combined steering committee meeting, they agree to communicate their views to the entire steering committee via email in advance of the meeting. However, combined steering committee members must make every effort to regularly attend meetings or send a designee.

5. **Once it's done, it's done.**
   We revisit previous decisions by the combined steering committee only if the members collectively agree to re-open and issue.

EXECUTIVE COMMITTEE:

The Executive Committee shall consist of 4-7 members of the combined steering committee to set agendas for the monthly steering committee meetings and for the larger community meetings. The Executive Committee will also develop recommendations for consideration by the combined steering committee. While the Executive Committee prepares important decisions for the combined steering committee, it does not have the authority to make binding decisions on behalf of the combined steering committee unless so authorized to do so by the combined steering committee.

AD HOC WORK GROUPS:

Ad hoc work groups will be created as needed to provide temporary assistance on issues outside the combined steering committee's or executive committee's roles when additional time is needed to develop work products.

CONFLICT OF INTEREST POLICY:

1. **Purpose**

   The purpose of this policy is to help inform the combined steering committee about what constitutes a conflict of interest, and assist the combined steering committee in identifying and disclosing actual and potential conflicts. The combined steering committee is a collaborative of interested parties and it is acknowledged that combined steering committee members will have organizational and/or sector-specific self-interests. Conflicts of interests happen all the time. In fact, they are inevitable. The key therefore is not to try to avoid all possible conflict-of-interest situations, which would be impossible, rather the combined steering committee needs to identify and follow a process for handling them effectively.

2. **What is a real or potential conflict of interest?**

   A real conflict of interest is present when a combined steering committee member's stake in a decision is such that it clearly reduces the likelihood that the combined steering committee member's influence can be exercised impartially in the best interest of this collaborative. A potential conflict of interest exists when there is either the appearance of a real conflict of interest, even if a real conflict doesn't exist, or the decision contemplated by the combined steering committee could possibly involve a real conflict of interest for one or more combined steering committee members.

Of particular concern are personal conflicts of interest. A personal conflict of interest exists when a combined steering committee is in a position to influence a decision that may result in personal gain, or gain for a relative as a result of the collaborative' s business dealings. For this this policy, a relative is any person is related by blood or marriage or domestic partnership.

In the case of this collaborative, special attention needs to be paid to situations where organizational conflicts of interest could result in personal gain. Such conflicts are to be considered as equivalent to personal conflicts of interest and should be handled as such.

3. How to manage a real or potential conflict of interest?

A combined steering committee member who has a real or potential conflict of interest must do the following:

A. Duty to Disclose

Each combined steering committee member shall disclose all material facts regarding his or her interest in the decision under consideration promptly upon learning of the proposed decision. It will not be necessary to excuse oneself from participating in the related discussions or in the voting process as long as the conflict is not a personal conflict or an organizational conflict that could result in personal gain and has not been disclosed. In the case of a personal conflict or an organizational conflict that could result in personal gain, combined steering committee members will excuse themselves from the voting process.

B. Determining Whether a Conflict of Interest Exists

If necessary, the combined steering committee may determine if a personal conflict of interest or an organizational conflict that could result in a personal gain for a combined steering committee member. The combined steering committee member(s) and any other interested person(s) involved in with the decision need not be present during the combined steering committee's discussion or determination of whether a personal conflict of interest exists or an organizational conflict that could result in personal gain.

C. Procedures for Addressing a Conflict of Interest

1. The combined steering committee may ask questions of and receive presentation(s) from the combined steering committee member(s) and any other interested person(s) that have a personal conflict of interest, but shall vote on the decision in their absence.
2. The combined steering committee shall ascertain that all material facts regarding the decision and the insider's conflict of interest have been disclosed to the combined steering committee.

3. After exercising due diligence, which may include investigating alternatives that present no conflict, the combined steering committee shall determine whether the decision is in the collaborative's best interest, for its own benefit, and whether it is fair and reasonable to the collaborative; the remaining combined steering committee members may approve the decision.

ANNUAL REVIEW OF CHARTER AND STEERING COMMITTEE COMPOSITION:

On an annual basis, the combined steering committee will review this charter and the combined steering committee composition. The combined steering committee will either affirm the accuracy of this document and the current composition of the steering committee or make adjustments as issues and gaps emerge over time. Adjustments or the affirmation will be documented.

In 2018, the combined steering committee will review the functionality of the Executive Committee and will revisit the idea of forming a Finance Committee.

CHARTER ADOPTION:

This Charter was adopted by consensus vote on September 28, 2017. This Charter should be reviewed in September 2018.

Appendix B

Notes from Dec 7th, 2017
Addison CHAT Data Meeting - Breakout Session

Prevention/Universal

Sticky notes: sources of data that were of interest or of note to participants:

CSAC serving 100 more children under age 12 in the last five years.

50% of Addison County female high school students and 57% of Addison County male high school students agree that in their community, they feel like they matter to people. (52% of MUHS females and 58% of MUHS males agree that in their community they feel like they matter.)

48% of Addison County female high school students and 45% of Addison County male high school students agree that students help decide what goes on in school. (46% of MUHS students agree that students help decide what goes on in school.)

62% of MUHS females and 64% of MUHS males agree that teachers really care about them and give them lots of encouragement.

79% of MUHS students who spoke to their parents at least weekly about school

In early childhood, one million new brain cell connections form each and every second . . . if conditions are right. (E,g, safe stable, nurturing, interactive environment)

48 high-quality infant/toddler center-based childcare slots. 300+ infants and toddlers in Addison County. 80% of kids lack quality childcare.

56.8% of 13-18-year -olds are up to date with HPV vaccine

Physical design of the community has huge impacts on health and well-being (sidewalks, bike lanes)

Express Care: June – November 3,191 visits, mostly 25-40-year-olds

3-4-50: 3 behaviors (poor nutrition, lack of physical activity, tobacco use) leads to 4 diseases (heart disease, cancer, diabetes and lung diseases) that result in more than 50% of the deaths in Addison County

The World Health Organization (WHO) estimates that 90% of our physical and mental health conditions are due to stress (worry, anxiety, ACEs, etc)

SASH serves seniors: 93 participants in the Vergennes area. ACCT sponsors 3 SASH sites thought only 26 of the 93 participants are in ACCT housing.

At-Risk

Sticky notes: sources of data that were of interest or of note to participants:

YRBS school connectedness predicts adolescent substance use

% of students receiving free or reduced lunch has doubled in ACSD

There are 21 towns in Addison County, most have less than 1% growth, none have answers to local childcare needs, none have answers to affordable housing needs

25% of dental patients are using sliding scale payments

Research by the American Geriatric Society demonstrated a correlation between higher Medicare expenditures for Medicare recipients and caregiver fatigue. The cost increase was $322.84 per month for each Medicare recipient when their caregiver experienced severe fatigue from their caregiver role.

#1 protective factor for youth at-risk: have an adult that cares about them no matter what!

At- Risk Discussion:

- The group was very concerned about the lack of resources for our youngest and oldest Addison County residents. The lack of childcare is very difficult for working families and impacts employers. There is a lack of appropriate/safe housing for our older Addison County residents.
- Hunger among school-age children has seen a slight decrease in Vermont but hunger is increasing among older Vermonters.
- The demographics of Middlebury have changed in the last 20 years. More children living in poverty.

High Risk

Sticky notes: sources of data that were of interest or of note to participants:

Infusions: FY16 – 570 visits, FY17 – 1055 visits

574 high risk and very high-risk Medicaid patients.

# of children who have a consult at the state interagency team.

Addiction recovery Housing: 120 in MAT and growing. Many of these have no money left.

38% of Addison County callers/ texters to VT 211 are related to basic needs of food, housing and utilities. And 75% of these are related to housing.

The # of kids in DCF custody have gone down, but the number of kids in state level residential have gone up. And, the # of available foster home placements in Addison have gone down.

ACTR data – 20 unique people received rides to clinics; however, for those 20 people: there were 1165 trips in August, 1140 trips in September, and 1141 trips in October.

ACCT – Approximately 35 formerly homeless households in their apartments. Five were new this year; 16 were denied this year; and 13 received case management. No health data information is linked to this ACCT data.

High Risk Discussion:

- People were shocked that 20 people consumed that many rides in such a brief span of time.
- Opportunities for communicating / aligning service opportunities for those on infusion
- HOUSING → 211 – we know this is the case, but it is still significant and shocking
- The increase in the # of kids in residential was discussed. What do we need to do to here in Addison to keep the kids here? What needs to occur to stop them from leaving? Further examination of the causes of this are needed – a deeper dive. What about wrap around services? Are they meeting the need?
- There are 120+ in MAT – there are significant housing needs for this population. We need to better understand:
    - Issues surrounding post-incarceration housing and services
    - available sources of funding
    - how zoning for this kind of housing works
    - the community culture around the geographic placement of such housing ("I'm supportive, but just not in my backyard", public vs. behind closed door attitudes, etc.)
    - Feasibility of using funding from different pots/sources to braid services in one location. Three major components are needed: i) rent support; ii) physical space (the actual housing); iii) support services for the residents

Appendix C

Prevention Change Packets Priorities for Addison County

Organization of this document:

Moira Cook, District Director for the Vermont Department of Health Middlebury District Office, reviewed Healthy Vermonters 2020 data, the Middlebury District Office Profile data and Blueprint for Health data for the Middlebury Health Service area for the strategies listed in the Prevention Change Packets. With the help of a Vermont Department of Health Statistian, we determined which prevention change packet strategies were highest priority for Addison County. Please note that there are limitations to this data. Some of the data provided is older and local health care providers may be doing work in their practices to address these issues.

Below are priority prevention change packet strategies for Addison County and our rationale for including them:

- Adolescent Well-Child Visits: The School Nurse Report indicates that we have the lowest percentage of students in the state receiving a well-child visit in the last 12 months. As discussed at a combined steering committee, local pediatric practices may be providing more adolescent well-child visits than the Health Department data indicates.

- Adult BMI screening: Addison County adult BMI is the same as the state overall but 30% of Addison County adults are obese and our type 2 diabetes prevelance is increasing.

- Adult Type 2 Diabetes Control: Addison County has a slightly higher, though not statisically significant, diabetes prevelance and our A1c testing is one of the lowest in the state.

- Pediatric Weight Assessment and Counseling: This is included because kids who are obese are more likely to become obese adults. Addison County's YRBS obesity data is the same as the rest of the state. The percentage of Addison County's pediatric WIC participants who are obese is the lowest in the state but in a healthy, well-nourished society, you would expect 5% of young children to be obese. 11% of Addison County's pediatric WIC participants are obese.

- Antibiotic Prescribing: We are doing worse than the state overall for antibiotic avoidance for bronchitis.

The following pages include screenshots of:

- Identified prevention change packet strategies
- Healthy Vermont 2020 data

- Blueprint for Health Middlebury Health Service Area data for antibiotic prescribing and diabetes only

VERMONT
DEPARTMENT OF HEALTH

Clinical & Community Strategies to Improve Adolescent Well-Care Visits

The following table highlights evidence-based strategies to improve adolescent well-care visits in clinical and community settings.

ACO Measure Cluster (NCQA HEDIS): Adolescent Well-Care Visit (AWC)
The percentage of attributed members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Increase insurance access • Promote use of Vermont Health Connect resources including website, phone number, and local navigators, brokers, and certified application counselors • Assist adolescents and families to understand insurance benefits and address perceived barriers to care (e.g., AWCV frequency, ECB descriptions, etc.) Accept current Bright Futures guidelines for health supervision • Adopt *Bright Futures* core tools (i.e. pre-visit questionnaires, documentation, education handouts) • Educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits • Adopt evidence-based screening tools • Ensure all practice staff are aware of annual recommendations (including systems for scheduling and reminder-recall) Provide adolescent-centered and informed care • Ensure the clinical space is welcoming and age appropriate for adolescents	Use mobile devices, e-mail, and social networking sites as primary prevention education and services; new media vehicles offer low cost avenues to develop and distribute tailored health care messages • Use social networking to reach adolescents and caregivers • Use texting to reach adolescents and caregivers Develop partnerships with key community stakeholders • Work with school-based and community health centers • Work with partners to explore alternate funding sources • Partner with Title V (maternal and child health) agencies • Engage key community stakeholders • Pediatric and Family practice providers can establish relationships to assist with transition of care from adolescence into young adulthood • Partner with the Health Department/ Office of Local Health designees and local schools • Review local Youth Risk Behavior Survey data to understand current risk behaviors	Office of Local Health designees, Agency of Human Services departments, ACOs, and healthcare quality improvement focused organizations should make state-adopted periodicity schedules well known to all clinical and community providers (Bright Futures is Vermont's Early and Periodic Screening, Diagnosis, and Treatment periodicity schedule) Providers and community partners (such as the Office of Local Health, schools, designated agencies, etc.) should educate families and adolescents on annual AWCV recommendation (including guidelines outlined in the periodicity schedule) and the benefits of these visits Providers and community partners should encourage their local school athletic that sports physicals be completed during, or within a reasonable timeframe (as determined by the provider) of a recent AWCV. Athletic directors and coaches can remind parents and caregivers that sports physicals should not replace recommended AWCVs.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Provide training and tools to ensure all practitioners are adolescent-friendly • Use or create adolescent friendly materials; test materials with adolescents • Consider strategies to ensure continuity of provider care • Communicate the confidential nature of visits and billing to adolescents and parents/caregivers, and ensure private consultation time with patients • Expand or tailor office hours to fit adolescent lives (i.e. school, sports, and work) • Hold specific slots for AWCVs • Consider ways to evaluate satisfaction with care, privacy and confidentiality Improve quality of adolescent care • Ensure providers are well-trained to understand adolescent needs • Ensure providers and office staff adopt the *Bright Futures* guidelines • Adopt the use of a strengths-based approach as described in *Bright Futures* Leverage missed opportunities to increase well-care visits • Maximize other patient encounter opportunities to schedule AWCVs (e.g. episodic, acute care, sports physicals, sexual health services, immunizations) Inform caregivers on the importance of AWCVs	• Partner with School Nurses to ensure all students are receiving AWCVs and improve communication between schools and provider offices • Partner with supervisory union or school district's Whole School, Whole Community, Whole Child wellness teams	

School Age Health

Percent of Students Age 10 17 who have had a Wellness Exam in Past 12 Months; School Nurse Report, 2014 2015

*This is a Healthy Vermonters 2020 objective

Percent of Students Age 10-17 who have had a Wellness Exam in Past 12 Months; School Nurse Report, 2...

District Offices (2014-2015)	Indicator Value	Statistically Compared to State
Barre	63.0	N/A
Bennington	65.0	N/A
Brattleboro	62.0	N/A
Burlington	62.0	N/A
Middlebury	56.0	N/A
Morrisville	63.0	N/A
Newport	67.0	N/A
Rutland	60.0	N/A
Springfield	71.0	N/A
St. Albans	59.0	N/A
St. Johnsbury	80.0	N/A
White River Junction	63.0	N/A

Please note: We presented this data at the December 7 CHAT data meeting and there is some issue with the accuracy of the school nurse reports. Also, as we discussed at the CHAT steering committee in January, how well-child visits are coded can impact the data.

Clinical & Community Strategies to Improve Adult BMI Screening and Follow Up

The following table highlights evidence based strategies to improve adult BMI screening rates and follow up in clinical and community settings.

ACO Measure: Core-20: Adult Weight Screening and Follow-Up
Screen for obesity in adults 18 years or older. Patients with body mass index (BMI) of 30 or higher should be offered or referred to intensive, multicomponent behavioral interventions. Those with BMI of 25-30 should also be referred for nutrition and physical activity interventions.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Screen all adults for overweight or obesity. • Calculate BMI using BMI calculator (available online) • Use motivational interviewing to discuss BMI findings with patient For obese patients: intensive, multicomponent behavioral interventions include the following: • Behavioral management activities, such as setting weight-loss goals • Improving diet or nutrition and increasing physical activity • Addressing barriers to change • Self-monitoring • Strategizing about how to maintain a lifestyle change For overweight patients: Learn about current diet and physical activity patterns and counsel on changes to encourage weight loss • Offer nutrition counseling to increase the daily recommended servings of fruits and vegetables. • Screen for physical activity habits and offer	Use motivational interviewing: Providers should be trained in these techniques to best assist patients. Provide referrals to community-based Small Diabetes Prevention Programs or one of the other self-management programs: MyHealthyVT.org Adopt technology-supported multicomponent coaching or counseling intervention intended to reduce weight such as: • apps to track food intake and physical activity • supportive texts • online/secure counseling • tracking of food intake and physical activity. Create or refer patients to social support interventions in community settings: • Weight Watchers • Curves • TOPS (Taking off Pounds Sensibly) Distribute fruit and vegetable prescriptions to encourage patients to eat more fruits and vegetables. Provide gym prescriptions to encourage patients to be more physically active.	Support Healthy community design and food access projects that support physical activity and healthy eating. Promote increased healthy eating and physical activity options in worksites including: • Use the Vermont Department of Health's "Creating a Healthier Workplace" resource to implement policies such as: • health insurance coverage with no or low out-of-pocket costs for medications • Healthy food policies for meetings • Increased healthy eating and physical activity options at worksites • Worksite gardens • Flex time for physical activity • Paid time off for preventive screening • Healthy food incentives (3 smoothie day, veggie platter) • Aim for at least 30% healthy items in vending machines • Include healthy choices at snack bars, cafeterias and events Encourage increased availability of healthy foods and beverages at public service venues and in vending machines.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
counseling to maintain or improve habits For patients at a healthy weight: learn about current diet and physical activity patterns and encourage continuation.	Offer gym membership through the Ladies First program that provides funding for lifestyle programs and gym memberships to women meeting insurer thresholds. Arrange for health coaching that will continue the conversation with patients and encourage them to take the talking next steps to healthy eating and increasing physical activity.	Support primary prevention activities aimed at children and youth to build healthy habits in physical activity and food choices.

Nutrition & Weight Status

Percent of adults age 20 and older who are obese; BRFSS, 2015-2016

"This is a Healthy Vermonters 2020 objective

Percent of adults age 20 and older who are obese; BRFSS,		
Counties (2015, 2016)	Indicator Value	Statistically Compared to State
ADDISON	30	Same
BENNINGTON	32	Same
CALEDONIA	32	Same
CHITTENDEN	20	Better
ESSEX	20	Same
FRANKLIN	33	Worse
GRAND ISLE	27	Same
LAMOILLE	23	Same
ORANGE	32	Same
ORLEANS	31	Same
RUTLAND	34	Worse
WASHINGTON	26	Same
WINDHAM	25	Same
WINDSOR	28	Same

Clinical & Community Strategies to Improve Adult Type 2 Diabetes Control

The following table highlights evidence based strategies to reduce poor A1C control in clinical and community settings.

ACO Measure: Core 17: Diabetes Mellitus: Hemoglobin A1C Poor Control >9%

A1C testing is recommended quarterly for adults who do not meet treatment goals. Performance measures apply to adults 18 – 75 years of age. Patients with an A1C greater than 9 percent should be offered multicomponent interventions to improve blood glucose control.

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Implement a standardized diabetes treatment protocol using evidence-based clinical practice recommendations–Diabetes Care Clinical Practice Recommendations[2]: • Diabetes self-management education/support (DSME/S) • Medical nutrition therapy (MNT) • Education on physical activity • Guidance on routine immunizations • Psychosocial care is a critical component of diabetes management Use motivational interviewing techniques to discuss behavior change goals and action plans. For patients with A1C greater than 9 percent, offer multicomponent behavioral interventions to include the following: • Achieving a realistic body weight • Improving nutrition and increasing physical activity • Achieving blood pressure control • Scoring diabetes distress and reducing it • Treating depression	Motivational Interviewing: Train providers in these techniques to best assist patients. Provide referrals to self-management programs: • Healthier Living Workshop – Diabetes: for problem solving and action planning; healthy eating; exercise; monitoring blood sugar; managing stress; using good foot care; and handling sick days • Diabetes Self Management Education (DSME) Programs provided by Certified Diabetes Educators in all local health service areas Use of Registered Dietitians who provide medical nutrition therapy (MNT) available through the local Vermont Blueprint for Health Community Health Teams (CHTs) and ambulatory services at all Vermont Hospitals See Clinical & Community Strategies to Improve Adult BMI Screening and Follow-up. See Clinical & Community Strategies to Reduce Tobacco Use	Community-based National Diabetes Prevention Program to reduce diabetes risk See Clinical & Community Strategies to Improve Adult BMI Screening and Follow-up. Policy and Regulatory Approaches • Advocate lowering of sugar content in processed foods and beverages • Use new Nutrition Facts labels starting in July 2018 to note "added sugars" • Promote population level oral health by supporting community water fluoridation See Clinical & Community Strategies to Reduce Tobacco Use

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
• Establishing realistic priorities for lifestyle improvement • Adjusting diabetes medications • Adjusting plans for self-monitoring of blood glucose For self-management support: • Encourage use of patient portals • Community-based programs and services • Consumer support group Provide patients with information and resources available in the local health service areas and statewide including: • Learning to Live Well with Diabetes • Single Page Guide For Diabetes Care • DASH Eating Plan • A1C…what's Your Number? See Clinical & Community Strategies to Reduce Tobacco Use See Clinical & Community Strategies to Improve Adult BMI Screening and Follow-up.	Oral Health Having diabetes increases a person's risk for having oral disease; untreated oral disease makes it more difficult to control A1C levels.[3] Integrate messages about the importance of oral health to overall health using the Quick Guide for Implementing Oral Health Strategies and refer patients to a local source for dental care as you would make a referral to any other specialist.	

Adult diabetes prevalence: 10% for Addison County, 8% for Vermont (source: Middlebury District Office data profile)

Diabetes & Chronic Kidney Disease

Rate of new cases of end-stage renal disease (ESRD) per million population; US Renal Data System, 2012-2014

* This is a Healthy Vermonters 2020 objective

Rate of new cases of end stage renal disease (ESRD) per million population; US Renal Data System,		
Counties (2012-2014)	Indicator Value	Statistically Compared to State
ADDISON	153.0	Same
BENNINGTON	191.3	Same
CALEDONIA	241.6	Same
CHITTENDEN	144.2	Same
ESSEX	No data available	Same
FRANKLIN	268.7	Same
GRAND ISLE	No data available	Same
LAMOILLE	452.7	Worse
ORANGE	126.9	Same
ORLEANS	221.2	Same
RUTLAND	225.0	Same
WASHINGTON	210.1	Same
WINDHAM	167.2	Same
WINDSOR	130.7	Same

Diabetes & Chronic Kidney Disease

Percent of adults with diagnosed diabetes who had diabetes education; BRFSS, 2012, 2015

*This is a Healthy Vermonters 2020 objective

Percent of adults with diagnosed diabetes who had diabetes education; BRFSS,		
Counties (2012, 2015)	Indicator Value	Statistically Compared to State
ADDISON	44	Same
BENNINGTON	43	Same
CALEDONIA	38	Same
CHITTENDEN	48	Same
ESSEX	No data available	N/A
FRANKLIN	50	Same
GRAND ISLE	No data available	N/A
LAMOILLE	58	Same
ORANGE	57	Same
ORLEANS	43	Same
RUTLAND	58	Same
WASHINGTON	74	Better
WINDHAM	19	Worse
WINDSOR	57	Same

Diabetes: HbA1c Testing

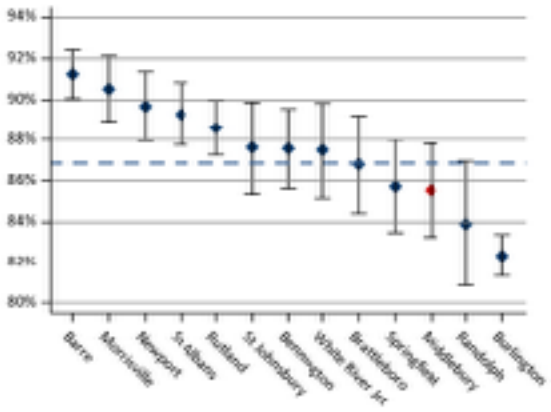


Figure 9: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, that received a hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Diabetes: HbA1c Not in Control (Core-17, MSSP-27)

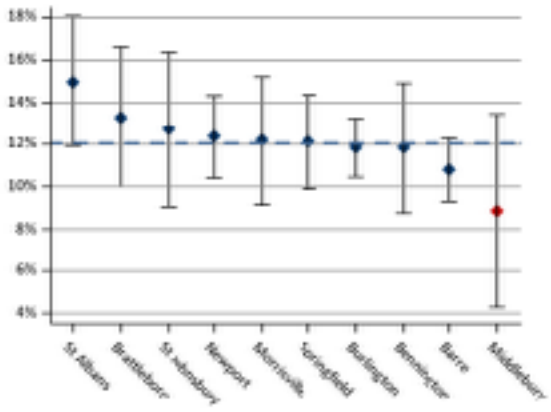


Figure 10: Present the proportion, including 95% confidence intervals, of continuously enrolled members withdiabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Blueprint clinical data registry was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with clinicalresults for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Clinical & Community Strategies to Improve Pediatric Weight Assessment and Counseling

BCD Measure: Core-15 (BCCH, HEDIS, NQF 0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Provider Tools • Use Promoting Healthier Weight in Pediatrics toolkit • Adopt Bright Futures Guidelines (i.e. pre-visit questionnaires, documentation, education) Validated screening tool and protocol • Assess all children for obesity at well care visits 2-18 years. • Annually assess behaviors and attitudes, diet and physical activity behaviors, and medical risks through physical exam and family history • Use Body Mass Index (BMI) to screen for obesity, record percentile, and diagnosis • Use motivational interviewing to discuss BMI findings with patient and family • Integrate oral health risk assessments, and fluoride varnish applications in well-care visits using Vermont's From the First Tooth Program. For patients with healthy weight: • Reinforce healthy habits of patient and family; re-evaluate at next visit For overweight and obese patients: • Order appropriate laboratory tests • Review signs/symptoms associated with	Parent/Family resources • Provide resources to parent/caregivers regarding healthy eating and physical activity practices for appropriate age level • Provide VDH resource on screen time • Provide parents/caregivers with 2-1-1 phone number and encourage outreach to Help Me Grow • Provide information on community based resources and education for physical activity and healthy nutrition (Parks and Recreation, Cooking for Life, etc.) • Provide information to 802Quits for information on smoking cessation • Integrate messages about the importance of oral health to overall health using the Quality Guide for Implementing Oral Health Integration, and refer patients to a local source for dental care Partnership building/referral resources • Promote educational resources and materials with providers and partners (e.g. Promoting Healthier Weight toolkit, Bright Futures). • Outreach to community stakeholders (e.g. schools, early education providers, childcare) • Connect with local Parent Child Center	School strategies • Educate families, children and adolescents on the benefits of having a well-care visit each year, as outlined by Bright Futures • Promote activities aimed at children and youth to build healthy habits including: • Participating in the Whole School, Whole Community, Whole Child Framework • Implementing local wellness policies for both early childhood education programs and K-12 schools that include adherence to the federal school nutrition standards, physical activity during the school day, and nutrition education in each grade. • Supporting schools and municipalities for Safe Routes to School, so that students can walk or ride their bike to school • Integrating and supporting Farm to School activities Community leaders including VDH staff, local business, regional councils, health care providers • Create or enhance access to healthy eating and physical activity by increasing sidewalks, bike paths, farmers' markets, community gardens

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
besity • Learn about current diet and physical activity patterns and counsel on changes • Assess readiness to change • Work with patient/family to set achievable goals for nutrition and activity • Promote self-management skill development Referrals • Identify children in need of referral to appropriate care (Registered Dietitian, Nutritionist, Endocrinology, etc.) • Initiate referrals and track progress until completion; ensure receipt of referral report Training and roles • Ensure practitioners and staff are trained on accurate administration of BMI screening tool • Train practitioners and staff in strength-based communication strategies with children, youth, and families Documentation and tracking • Determine a consistent location where screening results will be documented • Track overweight and obese screening rates • Develop recall/reminder systems to ensure follow-up visits and referrals happen Create a process flow map to identify barriers to BMI screening and follow-up counseling	• Participate in community coalitions or partnerships to address obesity Provide fruit and vegetable prescriptions to encourage patients to eat more fruits and vegetables. Provide park prescriptions to encourage patients to be more physically active.	• Provide incentives to food retailers to locate in underserved areas and to offer healthier food and beverage choices • Promote population-level oral health by supporting community water fluoridation Promote increased healthy eating and physical activity options at worksites. • Worksite gardens • Flex time for physical activity • Healthy food incentives • Engage municipal governments, employers, schools, and health care providers to develop community-wide strategies to address physical activity and nutrition

Nutrition & Weight Status

Percent of children age 2-5 (in WIC) who are obese; PedNSS / WIC, 2014

*This is a Healthy Vermonters 2020 objective

Percent of children age 2-5 (in WIC) who are obese; PedNSS / WIC,		
District Offices (2014)	Indicator Value	Statistically Compared to State
Barre	17	N/A
Bennington	14	N/A
Brattleboro	14	N/A
Burlington	12	N/A
Middlebury	11	N/A
Morrisville	15	N/A
Newport	12	N/A
Rutland	13	N/A
Springfield	14	N/A
St. Albans	14	N/A
St. Johnsbury	12	N/A
White River Junction	11	N/A

Nutrition & Weight Status

Percent of adolescents in grades 9-12 who are obese; YRBS, 2015

*This is a Healthy Vermonters 2020 objective

Percent of adolescents in grades 9-12 who are obese; YRBS,		
District Offices (2015)	Indicator Value	Statistically Compared to State
Barre	11	Same
Bennington	12	Same
Brattleboro	12	Same
Burlington	10	Better
Middlebury	13	Same
Morrisville	13	Same
Newport	19	Worse
Rutland	19	Worse
Springfield	17	Worse
St. Albans	16	Worse
St. Johnsbury	12	Same
White River Junction	11	Same

Clinical & Community Strategies to Improve Outpatient Antibiotic Prescribing

The following table highlights evidence based strategies and best practices to improve outpatient antibiotic prescribing in clinical and community settings.

ACO Measures:

Core-5: Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Core-13: Appropriate Testing for Children with Pharyngitis

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Clinical Approaches	Innovative Patient-Centered Care and/or Community Linkages	Community Wide Prevention Strategies
Provider education & training • Offer clinician education (interactive educational meetings may be more effective than didactic lectures) • Conduct audit and performance feedback[1] • Arrange for peer group academic detailing to reinforce or change prescribing behavior[2] Provide tools • Invest in clinical decision support tools to facilitate accurate diagnoses and treatment[3]	Patient education & tools • Provide printed educational materials in the provider office • Use prescription bag insert educational materials to enhance adherence • Display appropriate antibiotic use posters in the clinical setting to educate patients, to reduce patient expectations for antibiotics, and to demonstrate clinician commitment to judicious prescribing[3] Care planning[3] • Use delayed prescriptions when antibiotics are not immediately indicated • Write post-dated prescription • Re-contact patient after clinic visit • Give verbal order to fill prescription after a predetermined length of time if symptoms do not improve • Consider alternative management strategy if symptoms worsen after 48–72 hours of initial empiric antimicrobial therapy or fail to improve despite 3–5 days of initial empiric antimicrobial therapy	Public education • Educate the public through a variety of venues and formats, including social media, on the importance of appropriate antibiotic use Improvements to the system of care • Integrate clinical decision support with electronic medical records[4] Establish retail clinics, which appear to provide care equal in quality to traditional clinics[5]

Avoidance of Antibiotic Treatment, Acute Bronchitis (Core-6)

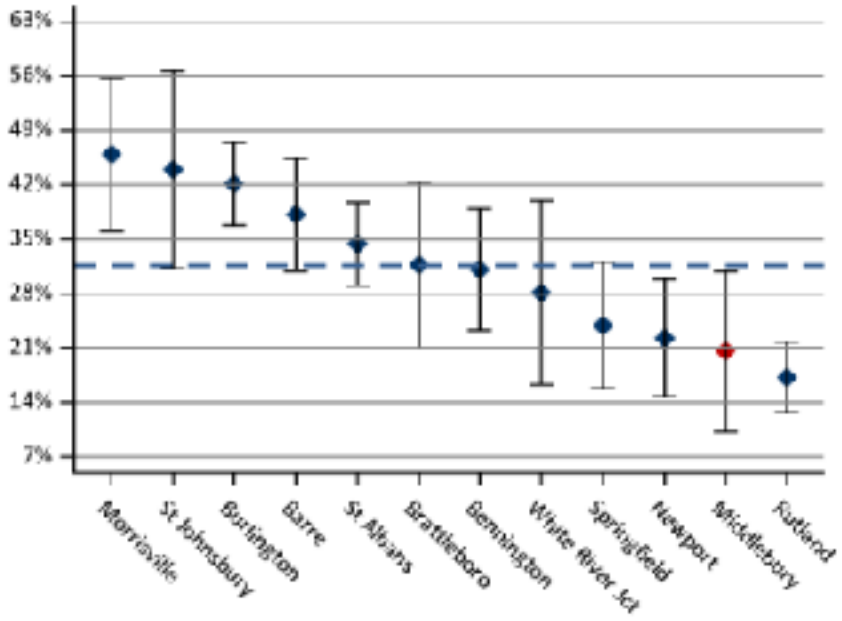


Figure 31: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 18–64 years, that received a diagnosis of acute bronchitis but was not dispensed an antibiotic prescription. The blue dashed line indicates the statewide average.

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Appendix D: CHNA Survey Data

Survey respondents were asked *In the last year, what social or environmental and health challenges have you or a family member experienced?* The top challenges faced were included in the body of the report. The following tables show the average number of challenges based on demographic information.

Challenges Experienced by Town

Town	# of Responses by Town	% of Total Responses	Average of Social/Environmental Challenges Experienced	Average of Health Challenges Experienced
Addison	22	3.70%	1.95	2.9
Bridport	26	4.38%	2.81	2.7
Bristol	85	14.31%	2.27	2.4
Cornwall	14	2.36%	1.57	1.6
Ferrisburgh	29	4.88%	1.52	1.8
Goshen	2	0.34%	0.50	2.0
Granville	1	0.17%	0.00	0.0
Hancock	1	0.17%	3.00	4.0
Leicester	7	1.18%	2.86	2.9
Lincoln	30	5.05%	2.17	1.7
Middlebury	111	18.69%	2.18	2.3
Monkton	24	4.04%	1.96	2.1
New Haven	41	6.90%	1.66	1.8
Orwell	12	2.02%	1.92	1.3
Panton	10	1.68%	1.70	2.0
Ripton	4	0.67%	3.00	1.8
Salisbury	13	2.19%	2.08	2.1
Shoreham	14	2.36%	3.93	2.9
Starksboro	29	4.88%	1.69	1.3
Vergennes	40	6.73%	3.03	2.5
Waltham	7	1.18%	0.71	1.9
Weybridge	6	1.01%	1.67	1.0
Whiting	6	1.01%	1.67	1.0
#N/A	60	10.10%	1.65	1.5
Grand Total	594		2.10	2.1

Challenges Experienced by Age

Age	# of Responses by Age	% of Responses by Age	Average of Social/Environmental Challenges Experienced	Average of Health Challenges Experienced
#N/A	158	27%	1.14	1.1
18-24 years	10	2%	4.80	4.3
25-29 years	22	4%	2.86	2.4
30-34 years	38	6%	2.68	2.1
35-39 years	37	6%	1.81	2.4
40-44 years	33	6%	1.76	2.2
45-49 years	32	5%	2.22	2.2
50-54 years	68	11%	3.38	2.9
55-59 years	56	9%	2.16	2.1
60-64 years	51	9%	2.57	2.6
65-69 years	48	8%	2.02	2.1
70-74 years	28	5%	1.89	2.5
75-79 years	9	2%	2.00	2.4
80 years or older	4	1%	2.50	3.8
Grand Total	594		2.10	2.1

Challenges Experienced by Income

Row Labels	# of Responses by Income	% of Responses by Income	Social/Environmental Challenges Experienced	Average of Health Challenges Experienced
#N/A	176	29.63%	1.26	1.1
$10,000 - $24,999	22	3.70%	4.09	3.2
$100,000 - $149,999	84	14.14%	1.48	2.0
$150,000 or more	53	8.92%	1.21	1.9
$25,000 - $49,999	85	14.31%	2.91	2.5
$50,000 - $99,999	169	28.45%	2.83	2.8
Less than $10,000	5	0.84%	5.00	2.8
Grand Total	594		2.10	2.1

Survey respondents were asked to *Please rank the categories below based on how important it is to address them in your community, with "1" being the most important, "2" being the next most important, and so on.* The following are the average responses based on demographics.

Average Rank of Categories by Town

Town	# of Responses by Town	Average of Services for children and families (Rank)	Average of Hunger and nutrition (Rank)	Average of Healthcare (Rank)	Average of Substance use disorder (Rank)	Average of Services for seniors (Rank)	Average of Mental health (Rank)
Addison	22	3.31	4.00	3.25	3.38	4.31	2.88
Bridport	26	3.00	3.94	3.17	3.11	4.10	2.60
Bristol	85	2.75	3.87	3.21	3.31	4.29	3.38
Cornwall	14	3.67	3.73	3.20	2.70	4.90	2.36
Ferrisburgh	29	3.18	4.47	3.25	2.94	3.71	3.29
Goshen	2	3.50	3.00	3.50	3.50	4.00	3.50
Granville	1	4.00	6.00	3.00	1.00	5.00	2.00
Hancock	1	6.00	1.00	2.00	5.00	3.00	4.00
Leicester	7	3.00	5.00	3.17	2.86	4.17	2.43
Lincoln	30	3.42	3.74	2.70	3.79	4.30	3.05
Middlebury	111	3.04	3.95	3.20	3.36	4.31	2.73
Monkton	24	3.17	4.21	2.94	3.61	4.16	2.74
New Haven	41	2.70	3.41	3.04	3.65	4.16	3.25
Orwell	12	2.67	4.33	3.86	2.57	3.86	2.57
Panton	10	3.00	3.40	3.00	2.80	3.50	3.33
Ripton	4	4.33	4.33	5.00	2.67	3.33	1.33
Salisbury	13	3.00	3.83	3.29	2.75	4.29	2.50
Shoreham	14	2.73	4.00	2.75	3.67	3.83	3.75
Starksboro	29	3.47	3.69	2.65	3.13	4.50	3.38
Vergennes	40	2.75	3.57	3.42	3.48	4.31	2.81
Waltham	7	4.00	3.80	4.00	2.60	3.20	3.00
Weybridge	6	2.80	5.20	2.80	4.00	4.00	2.80
Whiting	6	4.00	3.50	2.25	4.00	5.00	2.25
#N/A	60	3.48	3.88	3.59	3.03	3.85	2.82
Grand Total	**594**	**3.08**	**3.90**	**3.18**	**3.29**	**4.18**	**2.95**

Average Rank of Categories by Age

Age Range	# of Respondents by Age	Average of Services for children and families (Rank)	Average of Hunger and nutrition (Rank)	Average of Healthcare (Rank)	Average of Substance use disorder (Rank)	Average of Services for seniors (Rank)	Average of Mental health (Rank)
N/A	158	3.00	3.00	3.00	2.50	6.00	3.50
18-24 years	10	2.00	3.50	3.33	3.40	3.67	3.90
25-29 years	22	2.58	3.37	3.10	3.79	4.39	3.37
30-34 years	38	2.61	3.86	3.38	3.17	4.44	3.47
35-39 years	37	3.09	3.74	3.39	3.36	4.43	2.69
40-44 years	33	2.59	4.17	3.79	3.41	4.16	2.56
45-49 years	32	3.10	3.77	3.61	3.45	4.53	2.50
50-54 years	68	3.41	4.19	3.00	3.44	3.98	2.68
55-59 years	56	3.46	4.30	3.09	3.10	3.83	2.40
60-64 years	51	2.98	3.91	3.07	3.19	4.33	3.08
65-69 years	48	3.09	3.89	3.07	3.26	4.13	3.11
70-74 years	28	3.54	3.36	2.89	3.00	4.30	3.68
75-79 years	9	3.29	3.83	2.00	2.71	3.89	4.00
80 years or older	4	3.50	3.67	2.75	4.33	2.00	4.33
Grand Total	594	3.08	3.90	3.18	3.29	4.18	2.95

Average Rank of Categories by Income

Row Labels	# of Respondents by Income	Average of Services for children and families (Rank)	Average of Hunger and nutrition (Rank)	Average of Healthcare(Rank)	Average of Substance use disorder (Rank)	Average of Services for seniors (Rank)	Average of Mental health (Rank)
N/A	176	2.94	3.50	2.47	3.63	4.38	2.79
$10,000 - $24,999	22	3.00	3.57	3.05	3.45	4.14	3.59
$100,000 - $149,999	84	3.17	4.25	3.12	3.10	4.19	2.75
$150,000 or more	53	3.21	4.02	3.28	2.82	4.65	2.71
$25,000 - $49,999	85	3.10	3.80	3.35	3.24	4.14	2.94
$50,000 - $99,999	169	3.03	3.88	3.22	3.51	4.03	3.01
Less than $10,000	5	2.25	2.25	2.00	3.20	4.75	5.20
Grand Total	594	3.08	3.90	3.18	3.29	4.18	2.95

Survey respondents were asked to *Please rank a second set of categories below based on how important it is to address them in your community, with "1" being the most important, "2" being the next most important, and so on.* The following are the average responses based on demographics.

Average Rank of Second Set of Categories by Town

Row Labels	# of Responses by Town	Average of Pedestrian and public transportation infrastructure (Rank)	Average of Clean environment (Rank)	Average of Affordable housing/homelessness (Rank)	Average of Economic opportunities (Rank)	Average of Recreation and physical activity resources (Rank)	Average of Sense of community (Rank)
Addison	22	3.56	3.67	3.07	3.60	3.69	3.19
Bridport	26	3.47	3.22	2.15	2.29	4.50	4.60
Bristol	85	3.85	3.51	1.97	2.68	4.63	4.24
Cornwall	14	3.90	4.30	2.30	2.27	3.91	4.00
Ferrisburgh	29	4.29	3.94	1.88	2.71	4.24	3.94
Goshen	2	5.50	1.00	4.00	3.00	5.50	2.00
Granville	1	6.00	3.00	5.00	4.00	2.00	1.00
Hancock	1	1.00	6.00	3.00	2.00	5.00	4.00
Leicester	7	3.00	3.83	1.43	3.67	4.43	4.14
Lincoln	30	3.68	3.16	3.06	2.55	4.47	3.84
Middlebury	111	4.08	3.87	1.82	2.39	4.42	4.09
Monkton	24	2.82	3.39	2.79	2.89	4.41	4.67
New Haven	41	4.55	3.27	2.39	2.72	3.92	3.33
Orwell	12	3.17	4.00	3.00	2.71	3.14	4.33
Panton	10	2.33	2.50	3.60	4.25	4.50	2.33
Ripton	4	3.67	4.33	2.00	3.33	4.00	3.67
Salisbury	13	4.17	3.43	1.86	2.43	3.57	4.43
Shoreham	14	4.33	4.27	1.58	2.42	4.00	4.50
Starksboro	29	4.18	3.13	1.94	2.59	4.88	4.06
Vergennes	40	3.37	3.57	2.44	2.97	3.90	4.10
Waltham	7	3.20	3.75	2.40	2.40	4.00	4.80
Weybridge	6	3.20	3.00	2.60	3.20	3.80	5.20
Whiting	6	4.75	3.25	3.25	2.50	3.75	3.50
#N/A	60	3.76	4.16	1.76	2.26	4.36	4.53
Grand Total	**594**	**3.81**	**3.63**	**2.18**	**2.64**	**4.28**	**4.09**

Average Rank of Second Set of Categories by Age

Age Ranges	Respondents by Age	Average of Pedestrian and public transportation infrastructure (Rank)	Average of Clean environment (Rank)	Average of Affordable housing/homelessness (Rank)	Average of Economic opportunities (Rank)	Average of Recreation and physical activity resources (Rank)	Average of Sense of community (Rank)
# N/A	158	3.50	3.00	3.50	1.50	6.00	3.50
18-24 years	10	4.50	2.80	1.22	3.13	4.33	4.10
25-29 years	22	4.71	3.05	2.27	3.50	3.57	3.76
30-34 years	38	3.37	3.89	2.26	2.63	4.31	4.54
35-39 years	37	3.71	4.06	2.03	2.44	3.82	4.69
40-44 years	33	3.69	3.53	2.41	2.68	3.71	4.50
45-49 years	32	3.90	4.31	2.19	2.42	4.10	4.13
50-54 years	68	3.81	3.74	2.05	2.30	4.52	4.32
55-59 years	56	4.05	3.55	2.34	2.77	4.19	3.34
60-64 years	51	3.75	3.89	1.89	2.57	4.51	4.00
65-69 years	48	3.36	3.30	2.38	2.98	4.64	3.95
70-74 years	28	4.16	3.12	2.19	2.59	4.62	3.96
75-79 years	9	3.71	2.86	2.63	2.38	4.89	3.25
80 years or older	4	4.00	2.67	2.25	3.33	4.00	4.33
Grand Total	594	3.81	3.63	2.18	2.64	4.28	4.09

Average Rank of Second Set of Categories by Income

Row Labels	Respondents by Income	Average of Pedestrian and public transportation infrastructure (Rank)	Average of Clean environment (Rank)	Average of Affordable housing/homelessness (Rank)	Average of Economic opportunities (Rank)	Average of Recreation and physical activity resources (Rank)	Average of Sense of community (Rank)
	176	3.73	3.07	2.31	2.18	4.81	4.00
$10,000 - $24,999	22	3.75	3.60	2.15	2.86	4.30	4.19
$100,000 - $149,999	84	3.81	3.91	2.26	2.63	4.14	3.92
$150,000 or more	53	3.63	3.83	2.29	2.30	4.27	4.42
$25,000 - $49,999	85	3.99	3.25	2.04	2.82	4.35	4.20
$50,000 - $99,999	169	3.84	3.72	2.14	2.68	4.29	4.01
Less than $10,000	5	2.40	2.75	3.00	3.25	3.80	4.80
Grand Total	594	3.81	3.63	2.18	2.64	4.28	4.09

Appendix E

Community Health Needs Assessment 2018

Mountain Health Center and the University of Vermont Health Network Porter Medical Center, in collaboration with the Community Health Action Team, are conducting a survey to assess the top health and social needs of our community. We are interested in your input.

This survey will take approximately 10 minutes to complete. Results of the survey will be available later in 2018. All responses will be anonymous and confidential. Your opinions are valuable to us and we appreciate your time.

1. Do you live in Addison County?

- ☐ **Yes**
- ☐ **No**

2. Are you over the age of 18?

- ☐ **Yes**
- ☐ **No**

3. What town do you live in?

- **Addison**
- **Bridport**
- **Bristol**
- **Cornwall**
- **Ferrisburgh**
- **Goshen**
- **Granville**
- **Hancock**
- **Leicester**
- **Lincoln**
- **Middlebury**
- **Monkton**
- **New Haven**
- **Orwell**
- **Panton**
- **Ripton**
- **Salisbury**
- **Shoreham**
- **Starksboro**
- **Vergennes**
- **Waltham**
- **Weybridge**
- **Whiting**

4. When you think about social and environmental challenges in the community where you live, what are you most concerned about? (please select up to 5)

- **Availability of social supports**
- **Lack of a livable wage**
- **Lack of employment opportunities**
- **Child abuse/neglect**
- **Bullying**
- **Domestic violence**
- **Access to healthy foods**
- **Transportation**
- **Opportunities for physical activity, safe recreational areas**
- **Homelessness**
- **Hunger**
- **Elder abuse/neglect**
- **Street safety (crosswalks, shoulders, bike lanes, traffic)**
- **Access to opportunities for health for those with physical limitations or disabilities**
- **Incarceration rates**
- **Racial or cultural discrimination**
- **Crime/vandalism**
- **Lack of support for seniors**
- **Lack of support for youth**
- **Childcare**
- **Affordable housing**
- **Clean environment**
- **Clean water**
- **Climate change**
- **None of the above**
- **Other:**

5. When you think about health challenges in the community where you live, what are you most concerned about? (please select up to 5)

- **Substance abuse (drugs, alcohol)**
- **Overweight/obesity**
- **Access to mental health services**
- **Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke)**
- **Cancer**
- **Physical activity**
- **Access to healthcare services**
- **Access to dental care**
- **Tobacco use**
- **Aging problems (arthritis, hearing/ vision loss)**
- **Suicide**
- **Lung disease (asthma, COPD, etc.)**
- **Infectious disease (hepatitis A, B, C, influenza, etc.)**
- **Sexually Transmitted Infections**
- **Prenatal care/maternal and infant health**
- **Falls**
- **Immunizations**
- **Other (please specify)**

6. In the last year, what social or environmental challenges have you or a family member experienced? Click all that apply.

- **Availability of social supports**
- **Lack of a livable wage**
- **Lack of employment opportunities**
- **Child abuse/neglect**
- **Bullying**
- **Domestic violence**
- **Access to healthy foods**
- **Transportation**
- **Opportunities for physical activity, safe recreational areas**
- **Homelessness**
- **Hunger**
- **Elder abuse/neglect**
- **Street safety (crosswalks, shoulders, bike lanes, traffic)**
- **Access to opportunities for health for those with physical limitations or disabilities**
- **Incarceration**
- **Racial or cultural discrimination**
- **Crime/vandalism**
- **Lack of support for seniors**
- **Lack of support for youth**
- **Childcare**
- **Affordable housing**
- **Clean environment**
- **Clean water**
- **Climate change**
- **None of the above**
- **Other (please specify)**

7. In the last year, what health challenges have you or a family member experienced? Click all that apply.

- **Substance abuse (drugs, alcohol)**
- **Overweight/obesity**
- **Access to mental services**
- **Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke)**
- **Cancer**
- **Physical activity**
- **Access to healthcare services**
- **Access to dental care**
- **Tobacco use**

- **Aging problems (arthritis, hearing/ vision loss)**
- **Suicide**
- **Lung disease (asthma, COPD, etc.)**
- **Infectious disease (hepatitis A, B, C, influenza, etc.)**
- **Sexually Transmitted Infections**
- **Prenatal care/maternal and infant health**
- **Falls**
- **Immunizations**
- **None of the above**
- **Other (please specify)**

We are interested in learning about the needs that are not being met by available resources and services in our community. The following questions ask you about specific types of needs. Please tell us how much of a need there is for each of the following 6 areas by choosing "High Need", "Some Need", "No Need", or "Don't Know".

The categories to consider are: Healthcare, Seniors, Children and Families, Hunger and Nutrition, Substance Use and Mental Health.

*** 8. HEALTHCARE**

	High Need	Some Need	No Need	Don't Know
Access to alternative healthcare providers (acupuncture, chiropractors, etc.)				
Access to primary health care provider				
Short-term community support after hospitalization				
Affordable health care				
Affordable dental care				
Access to timely specialist care				
Access to cancer screenings and resources				

*** 9. SENIORS**

	High Need	Some Need	No Need	Don't Know
Elder housing				

	High Need	Some Need	No Need	Don't Know
Social Connections				
Adequate nutrition for seniors				
Transportation to services (healthcare, grocery, shopping)				
Access to nursing home care				
Elder day care				
Access to long term health care				
Affordable in-home services				

*** 10. CHILDREN AND FAMILIES**

	High Need	Some Need	No Need	Don't Know
Mentoring programs				
More childcare resources				
Adequate nutrition for children				
Social connections				
After school programming				
Summer programming				
Access to dental care for children				
Access to dental care for adults				
Parenting education				
Domestic abuse prevention				
Child abuse prevention support				
Good schools				
Home visits for newborns				
Housing for families				
Transportation to services (work, healthcare, school/childcare, grocery, shopping)				

*** 11. HUNGER AND NUTRITION**

	High Need	Some Need	No Need	Don't Know
Access to affordable healthy foods				
Obesity prevention programs				
Nutrition education				
Knowledge of healthy meal preparation				

*** 12. SUBSTANCE USE DISORDER**

	High Need	Some Need	No Need	Don't Know
Reduction of alcohol misuse (adults)				
Reduction of opiate/narcotic use (adults)				
Access to residential substance use disorder treatment				
Reduction of alcohol use (youth)				
Reduction of marijuana use (adults)				
Substance use prevention programs				
Reduction of marijuana use (youth)				
Access to outpatient substance use disorder treatment				

*** 13. MENTAL HEALTH**

	High Need	Some Need	No Need	Don't Know
Access to mental health services (children/ youth)				
Access to residential mental health services				
Prevention of mental health issues				
Early detection of mental health issues (children/youth)				
More mental health professionals				
Access to mental health services (adults)				

In your opinion, rank the importance of addressing each of the issues below in your community, with "1" being the most important, "2" being the next most important, and so on.

14. Please rank the categories below based on how important it is to address them in your community, with "1" being the most important, "2" being the next most important, and so on.

- **Services for children and families**
- **Hunger and nutrition**
- **Healthcare**
- **Substance use disorder**
- **Services for seniors**
- **Mental health**

15. As you did in the previous question, please rank the issues below based on how important it is to address them in your community, with "1" being the most important, "2" being the next most important, and so on.

- **Pedestrian and public transportation infrastructure**
- **Clean environment**
- **Affordable housing/homelessness**
- **Economic opportunities**
- **Recreation and physical activity resources**
- **Sense of community**

16. Please tell us a little more about the issues you ranked as most important:

Lastly, we have a few demographic questions so we can understand a little more about who you are. As a reminder, this survey is anonymous, and all of your responses are confidential.

17. What is your gender? (please select one)

- **Male**
- **Female**
- **Do not identify with male or female**

18. What is your highest level of education? (please select one)

- **Some high school (did not finish)**
- **High school diploma or GED**
- **Currently attending college**
- **Some college**
- **Associates degree**
- **Bachelor's degree**
- **Graduate degree**
- **Other (please specify)**

19. What was your household's income in 2017?

- **Less than $10,000**
- **$10,000 - $24,999**
- **$25,000 - $49,999**
- **$50,000 - $99,999**
- **$100,000 - $149,999**
- **$150,000 or more**

20. What is your race/ethnicity?

- American Indian or Eskimo
- Asian or Pacific Islander
- Black or African American
- Hispanic, Latino or Spanish origin
- White or Caucasian
- More than 1 race
- Other (please specify)

21. Do you have children under the age of 21 living in your household?

- **Yes**
- **No**

22. Do you have any elders dependent on you for care or support?

- **Yes**
- **No**

23. Which best describes your employment status?

- Employed full-time
- Employed part-time

- Full-time student
- Retired
- Unemployed
- Homemaker
- Other (please specify)

24. Do you have medical insurance?

- **Yes**
- **No**

25. Do you consider yourself a permanent resident of Vermont?

- **Yes**
- **No**

26. What age range are you in?

- 18-24 years
- 25-29 years
- 30-34 years
- 35-39 years
- 40-44 years
- 45-49 years
- 50-54 years
- 55-59 years
- 60-64 years
- 65-69 years
- 70-74 years
- 75-79 years
- 80 years old or older

Appendix F

Proposed Housing Initiatives for Addison County

Need	Description of project	Partners/Resources Status
Workforce Housing 25 market rate houses 5 subsidized "habitat" ownership units 20 market & affordable rental units	New mixed-use ownership housing, partly subsidized, duplexes/multifamily construction; Habitat homes; College land • ACCT is exploring a partnership with the College and Habitat for Humanity to build mixed-income housing on college land in Middlebury; • 25 units market housing - A private developer would deliver ownership units targeted to college workforce at ~$250k – $350K price point • ACCT would develop multifamily or duplex housing most likely along the lines of our typical (rental) housing model that serves people earning 50-80% of area median income ($25-$40k for a single earner). Habitat would provide ownership units serving families at ~70% AMI.	ACCT, Habitat, Middlebury College in exploratory discussions that are ongoing; intent to tie this into a conversation with Porter and VT Coffee. Moving forward tentatively.

Lower Income Workforce Housing 10 units	Multi-unit - Single-room occupancy housing (SRO); This would be an independent living facility but could include some level of on-site supervision. • Typically, 5-15 units at a site (Group home defined as permitted up to 10 units for zoning purposes) • Could fill 50 units according to service providers • Mainly for people who simply can't afford more than ~$400/mo. in rent; filling the gap the boarding house on Elm St used to provide Focus would be on people who did not need ongoing case management support (e.g. mental illness, substance use)	ACCT could potentially develop the units but if using traditional sources would likely need to pair this project with more units to reach economy of scale; potentially a scattered-site option with supportive housing. Would also need to find a source for rental assistance that could subsidize the units down to $300-$400/mo. Or 30% of residents' income.

Permanent Supportive Housing 5-10 Units	This project would create 5-10 units of combine housing, rental assistance, and services ("the 3-legged stool") Often cited as part of the solution to ending homelessness –serves people who have struggled with homelessness and often have multiple barriers to housing, like mental illness, substance use disorder, etc. VHCB contracted with Corporation for Supportive Housing in 2016 to produce a roadmap to end homelessness; a large focus was on permanent supportive housing; this seems to be a state priority	Possible partnership with Porter Hospital to provide operating subsidy that would support reduced rents and services on site for patients they either house in the ED or discharge back to homelessness, Charter House, substandard housing, etc. CSAC, VT Dept MH, VHCB ACCT could develop the unit under master lease agreement with CSAC or another service provider to manage/rent the units; CSAC could provide ongoing rental subsidies through the shelter + care program; JGHS also has access to project-based rental assistance. Other partners/ resources: Corrections (Ongoing rental subsidies) Limited to certain types/ numbers of offenders; Addiction Recovery (Later stages)
Dispersed Elderly SRO 20 units (one at a time)	There are a number of people in the Region that would consider adding an accessory apartment or an SRO in return for help. However, many do not know where to start. This project puts together a sub-committee to try and create disbursed units in existing structures and matching elderly homeowners with caretakers or home owners with elderly tenants	Elderly Services. CSAC, Age Well Vermont; Home Share Vermont; Contractor;