Mt. Ascutney Hospital and Health Center and Our Accountable Community For Health

10/31/18

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

MISSION

To improve the lives of those we serve.

VISION

Mt. Ascutney Hospital and Health Center will provide the highest quality care, patient satisfaction, and value through:

Development of programs based on community need and sustainability

Multi-disciplinary and regional cooperation

Involvement of patients in their own care decisions

Empowerment of and respect for our staff

Fiscal responsibility

Our success will be measured by the improvement of the health, wellness, and comfort of those we serve.

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2019 Priority Goals

(How we will achieve our Vision)

Critical Issue	Goals
Employee Wellness	We will direct efforts to improve the physical and emotional well-being of our employees through active engagement and support that is both financial and biopsychosocial.
Patient Care and Customer Service	We will provide distinguished service, treating each patient and family member with respect and dignity, achieving measurably higher outcomes.
Quality / Safety/ Compliance	We will deliver the highest quality care through evidenced based practice and coordination efforts at the D-HH system level. All clinical and administrative actions will be compliant with CMS conditions of participation and payment.
Finance and Operations	We will achieve financial sustainability in partnership with the entire D-HH system, obtaining economies of scale and improved value for our patients. We will maintain and improve the mechanical systems of our physical plant and optimize information technology infrastructure and security
Clinical Integration within D-HH	We will coordinate our programs and services with the D-HH system, identifying appropriate core and specialty services for MAHHC across the continuum of care.
Governance	The Board of Trustees will steward our assets (finances, brand, people), to meet both the MAHHC and D-HH strategic goals
Public Health and Community Engagement	We will have meaningful dialogue with our community about our programs, services, and regional relationships, including seeking their support.

Our move toward Alternative Payment Reform and High Value Care

- 2018- Vermont Medicaid Next Generation ACO
- 1100 Lives, 80K of risk

- 2019- Medicare, Medicaid and Exchanges
- Almost 6000 lives and 1.5 million of Risk

- Daunting, considering our approved break-even budget

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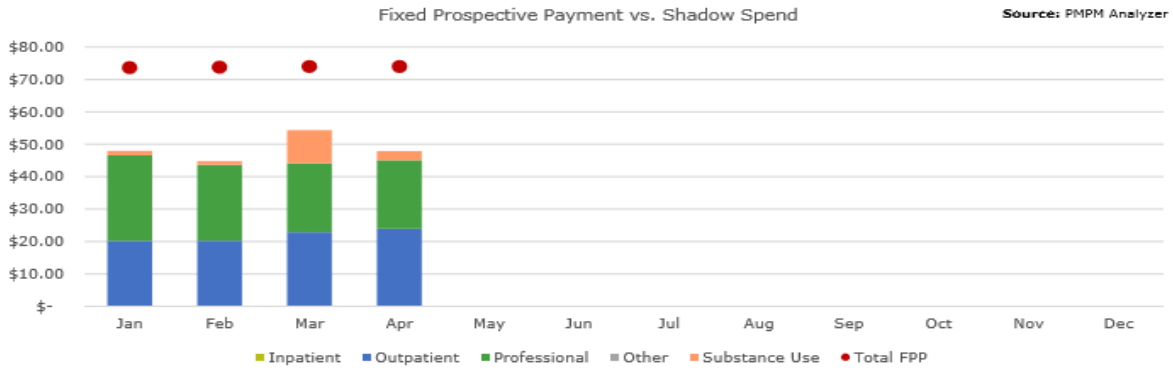
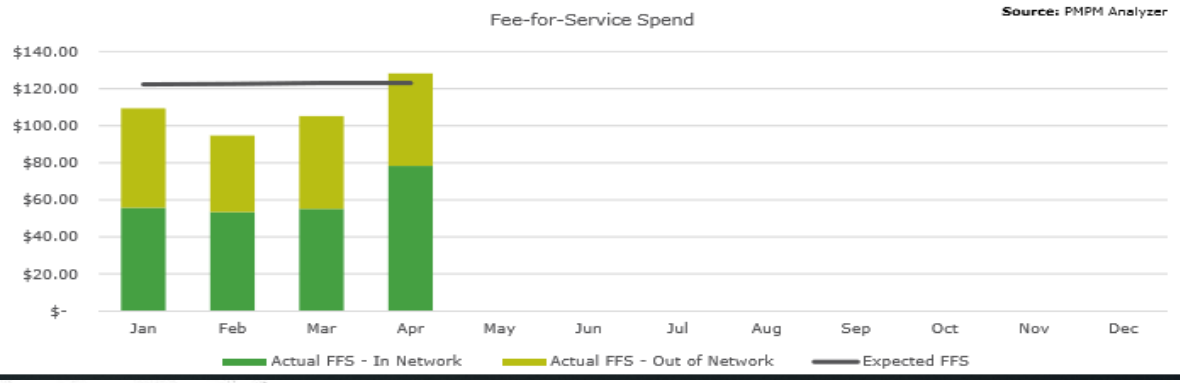
2018 Medicaid performance YTD

Attribution: Members by Month												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Windsor	1,071	1,068	1,056	1,041	-	-	-	-	-	-	-	-





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Transforming Healthcare Delivery

- Adding nursing, social work, and care management resources to our outpatient clinics
- Closer collaboration with community partners on an effort to keep patients in lower cost environments
- Optimizing IT
  - Dynamic worklists for providers
  - Registry building
  - Quality Dashboards
  - Care navigator

Our Challenges

- Workforce, workforce, workforce
- Balancing responsibilities to payers, patients, and partners
  - Stress of different metrics for all stakeholders: D-HH, Blueprint, ACO, providers, Federal
- Border hospital location- threat and opportunity
- Mental health and Nursing home capacity (refusal to take patients on Medicaid). Currently 9 boarders and 30+ months of inpatient stay
- Workforce…

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Goal

Create an Accountable Community for Health (ACH) and medical neighborhood that will promote the health and well-being of our community through a network of health and human service partners.

The Windsor Health Services Area (HSA) Community Collaborative adopted a new charter based on the nine core components of an Accountable Community for Health (ACH).

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Strategic Plan

Goals and Objectives for Community Health were established based on Healthy People 2020

- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death.
- Achieve health equity, eliminate disparities and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

Population/Community Health at MAHHC
Building an Accountable Community for Health

- **Community Health is embedded in our Mission and Strategic Plan**

- **We have built an infrastructure to operationalize our commitment**
  - Community Health Board Subcommittee
  - Director of Community Health
  - Mt. Ascutney Prevention Partnership

- **Leadership role in building community networks**
  - Windsor HSA Community Collaborative
  - Windsor Area Community Partnership
  - Windsor Connection Resource Center and PATCH Team
  - OneCare VT and Blueprint for Health
  - Windsor Area Drug Task Force

- **Continuum of care from prevention to chronic care management.**

- **Cost - $109,500**
  MAHHC $107,000
  Grants $2,500

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Vermont Next Generation:
A Partnership of OneCare VT with MAHHC

Developing a system and infrastructure-

- One Care Vermont
- HSA level Core Leadership Teams
- Education and Training for Core Skills and Care Navigator
- Working with Community Partners

Strategic Planning-

- Community Assessment
- Communication and Engagement Plan

Components of the system at the individual level-

- Placement of the patient in the appropriate quadrant of care with care appropriate to the needs of the individual, ie, prevention vs. intervention

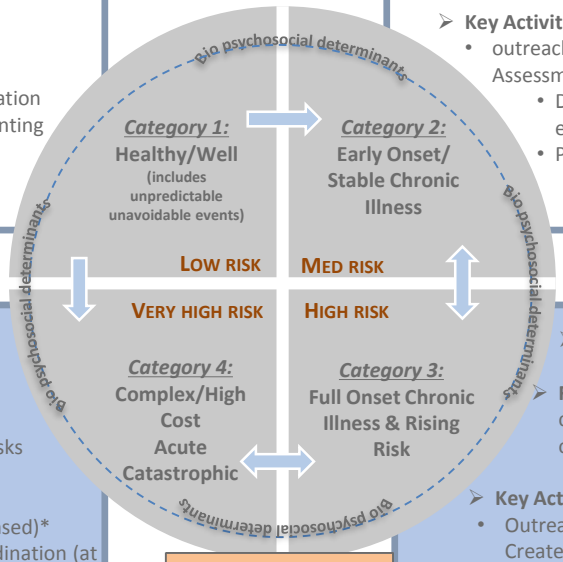
Components of the System

- Identification of high risk and very high risk through the Johns Hopkins algorithm and professional judgments
- Chart review
- Eco maps
- Self Sufficiency index
- Patient consent for work with community partners
- Lead Care Coordination conferencing
- Shared Care plan with patient-centered goals
- Care Coordination to each goal and health outcomes with Community Partners

Population Health Approach: A game plan for every person

- **44% of the population**
- **Focus:** Maintain health through preventive care and community-based wellness activities
- **Key Activities:**
  - Preventive care (e.g. wellness exams, immunizations, health screenings)
  - Wellness campaigns (e.g. health education and resources, wellness classes, parenting education)
  - RiseVT

- **40% of the population**
- **Focus:** Optimize health and self-management of chronic disease
- **Key Activities:** Category 1 plus
  - outreach for annual Comprehensive Health Assessment (i.e. physical, mental, social needs)
    - Disease & self-management support* (i.e. education, referrals, reminders)
    - Pregnancy education



- **6% of the population**
- **Focus:** Address complex medical & social challenges by clarifying goals of care, developing action plans, & prioritizing tasks
- **Key Activities:** Category 3 plus
  - Designate lead care coordinator (licensed)*
  - Outreach & engagement in care coordination (at least monthly)*
  - Coordinate among care team members*
  - Assess palliative & hospice care needs*
  - Facilitate regular care conferences *

- **10% of the population**
- **Focus:** Active skill-building for chronic condition management; address co-occurring social needs
- **Key Activities:** Category 2 plus
  - Outreach & engagement in care coordination Create & maintain shared care plan*
  - Coordinate among care team members*
  - Emphasize safe & timely transitions of care

16% Lives
40% Spending
89% Multiple Chronic
67% MH Condition

* Activities coordinated via Care Navigator software platform

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Components of a System for Population Health

Quadrant One – Prevention

- Mt. Ascutney Prevention Partnership utilizes programs and environmental strategies to prevent high-risk behaviors such as substance misuse
- 3-4-50 and RISE Vermont
- Family Wellness Program embedded in pediatric clinic, our schools and the community
- Promise Community Initiative to maximize social and emotional competence in children and families and promote kindergarten readiness. A five pronged campaign has been developed to build capacity within daycares, institute a social marketing campaign aimed at Read, Play and Grow, decrease social isolation through renovation of space and creation of programs at the Windsor Connection Resource Center, authentic family engagement and maximizing resources.

Quadrant Two- Optimize Health and Self-management of Chronic Disease

- Annual Wellness Exam within Patient Centered Medical Home.

- Self-Management programs for tobacco cessation, chronic pain, wellness action and recovery program for mental health, healthy living. Diabetes prevention are offered on an ongoing basis.

- Referrals to community health team and collaborative care nurses for patient education with early diagnosis and as needed throughout the trajectory of a chronic disease

Quadrant Three and Four- Care Coordination

- Proactive identification of high risk and very high risk patients through John Hopkins algorithm and professional judgment
- Outreach to high risk and very high risk patients not currently followed by the team
- Assessment through Echo mapping, Camden cards and self-sufficiency index
- Chart Review
- Patient Centered Care Planning and Conferencing
- Selection of a Lead Care Coordinator
- Development of a Shared Care Plan
- Communication and Engagement of the Team through Care Navigator
- Implementation of the shared care plan and addressing social determinants of care and barriers to health

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Community Health Improvement Process

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Comparison of CHNA priorities 2015 to 2018

Issue	Placement in 2015	Increasing or Decreasing Priority
1. Access to mental health services	#2	⬆
2. Alcohol & drug misuse, prevention, treatment, & recovery	#1	⬇
3. Access to affordable health insurance, health care services, & prescription drugs	#4	⬆
4. Family strengthening, including poverty and childhood trauma	#7	⬆
5. Availability of primary care services	#9	⬆
6. Healthcare for seniors	#10	⬆
7. Affordable housing	Not on list	
8. Availability of affordable adult dental care	#3*	⬇

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*2015 included children and adults

Objective #1 ~ Alcohol & Drug Misuse *(including Heroin and Use of Pain Medications)*

- Revision and distribution of *Substance Use Treatment Guide*
- SBIRT (Screening, brief intervention and referral to treatment)
- Gov. Summit for Substance Misuse Workforce and Workshop
- Windsor County Drug Take-Back Days
- Youth Summit
- "Be Aware, Don't Share" and "VT's most dangerous Leftovers"
- Vermont Prescription Monitoring System education and outreach to providers
- Medication Assisted Therapy
- Pediatrics, Primary Care & specialty addiction services
- Training and implementation of new state prescribing regulations for providers
- Multi-disciplinary pain consult team implemented for chronic pain patients

- Windsor County wide school needs assessment to link prevention resources to identified needs.
- Supported creation and $ support for a Student Assistance Professional in the WCSU School district.
- Worked with Two Rivers Ottauquechee Regional Commission (TRORC) to assess 30-town region of existing "adult only" policies related to outlet density/location, outdoor events, and restricting advertising.
- Conducted Health Readiness Assessment interviews in 3 towns to serve as catalyst to concept of town health and wellness committees.
- Disseminated *Supporting Healthy Communities.*

Funding Supports:

- MAHHC ($81,500), Regional Prevention Partnership grant ($135K), Prevention infrastructure grant ($60K), SBIRT grant ($112.5K), Blueprint for Health grant ($129K), Blueprint Spoke grant ($459.7K), MAPP Sustainability ($14.5K), Foster McGaw prize ($6.6K)

Partners and Resources:

- Windsor County Prevention Partners
- Two Rivers Ottauquechee Regional Commission
- Ottauquechee Community Partnership
- Windsor Southeast Supervisory Union
- SBIRT Vermont, www.sbirt.vermont.gov
- Vermont Department of Health
  - Parent Up, www.parentupvt.org (talk to kids about drugs)
- Woodstock Police Department
  - "Text-a-tip", report underage drinking parties before they happen! (802) 296 - 1746
- Towns of Weathersfield, Woodstock, and Windsor
- Healthcare and Rehabilitative Services (HCRS, behavioral health clinician in primary care clinics)
- Junction Youth Center
- Windsor County Sherriff & DEA for drug take back
- Healthcare and Rehabilitative Services (HCRS)
- Windsor County Prevention Partners
- Ottauquechee Community Partnership
- CT Valley Recover Services
- Bradford Psychiatric Associates
- Blue Cross and Blue Shield
- White River Family Practice
- Windsor Police Department
- Windsor Connection Resource Center
- Vermont Department of Health, http://www.healthvermont.gov/alcohol-drugs/reports/data-and-reports
- Vermont Prescription Monitoring
- Dartmouth Hitchcock Medical Center, www.twinstatesafemeds.org
- Support and Services at Home (SASH)
- Turning Point Recovery Center (Springfield and Hartford)
- UVM and VT Medical Society
- SBIRT Vermont, http://sbirt.vermont.gov

Substance Use Treatment Guide:
http://www.mtascutneyhospital.org/sites/default/files/content/documents/ConsumersGuideforSubstanceUseTreatmentinUpperValley2017.pdf

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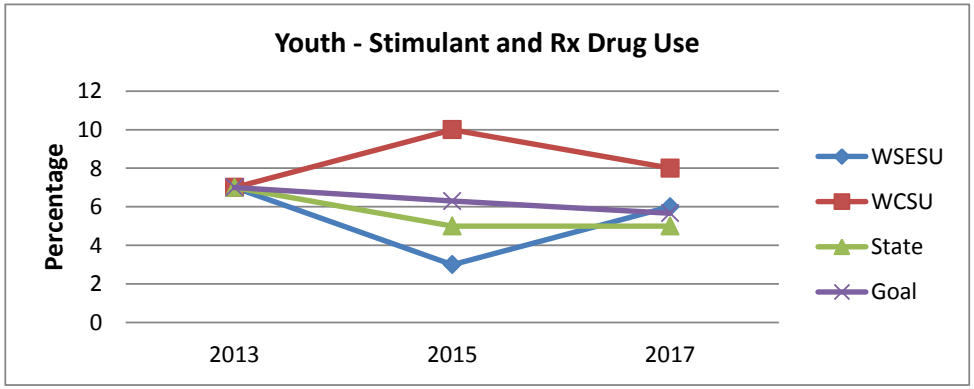
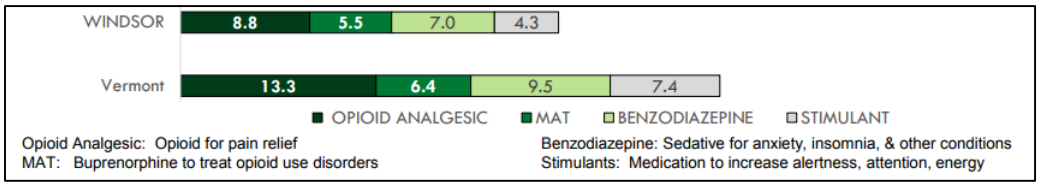
Outcomes: Rx Drug Use

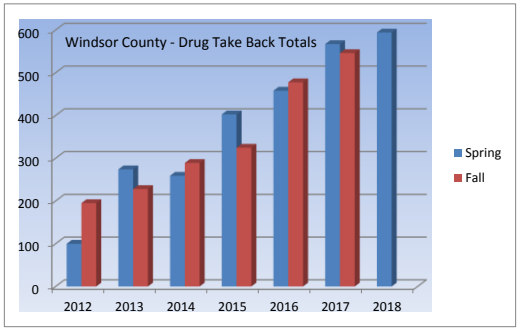
- *Goal : ↓ by 10% the percentage of students who have misused a stimulant or Rx pain reliever in the past 30 days.*



Vermont Prescription Monitoring System data shows Windsor County to be one of the lowest rate of prescriptions per 100 residents by drug class



Windsor County - # of drugs collected, take back



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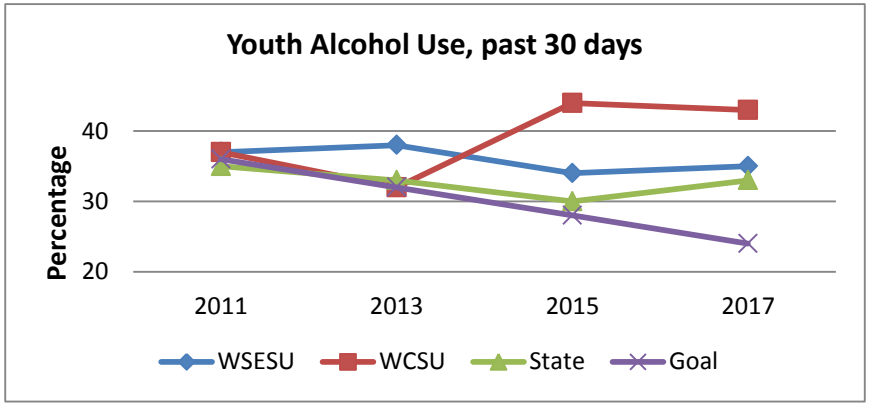
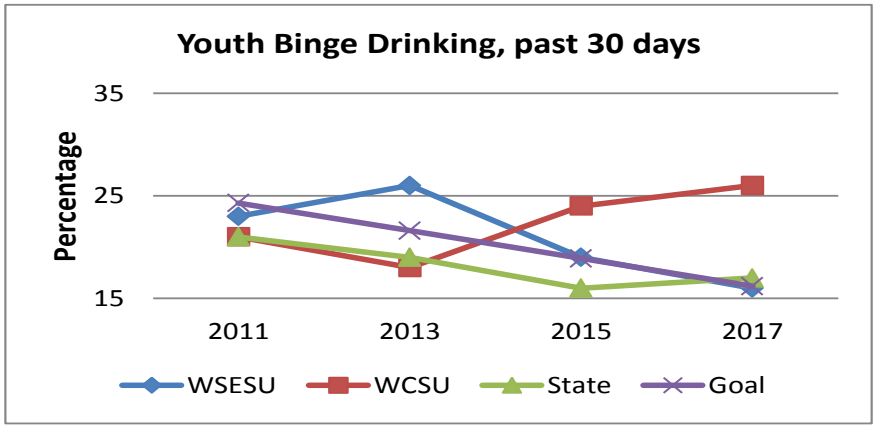
Outcomes: Alcohol Use





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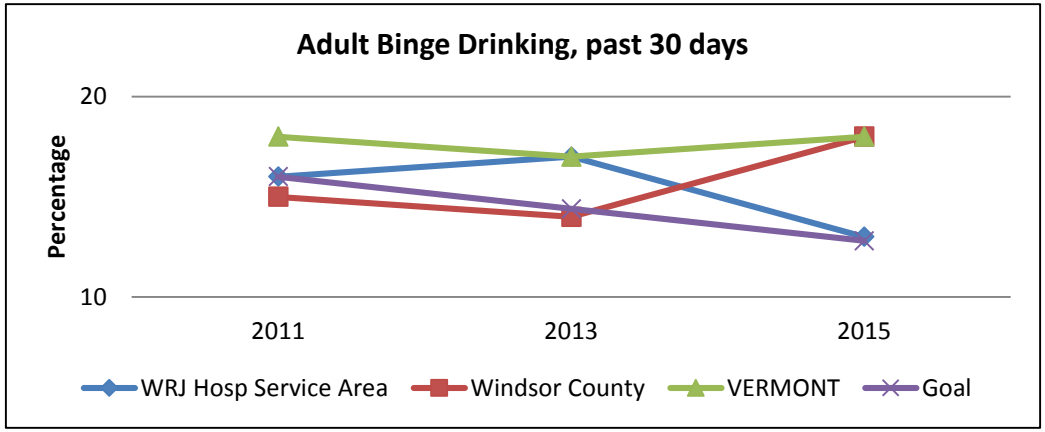
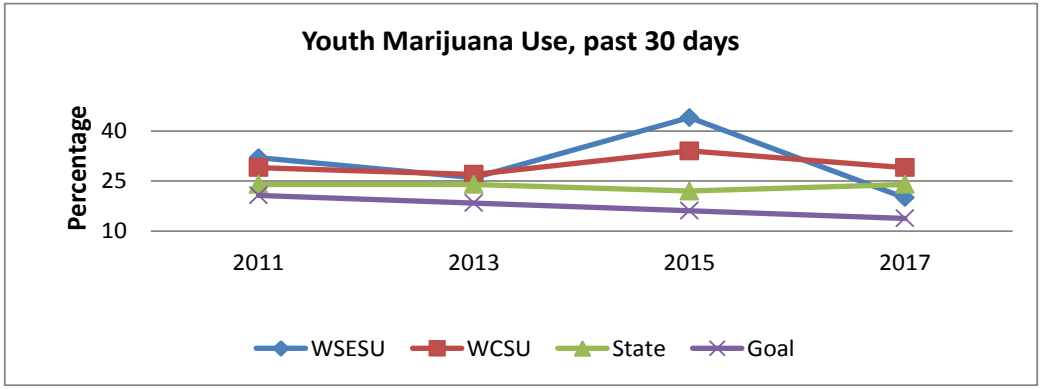
Outcomes: Marijuana Use





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Objective #2 ~ Access to Mental Health

- Distributed brochure of *Mental Health Providers* in the hospital and throughout the community.
- 3 WRAP workshops delivered for skill building and self-management support for anxiety, depression, and general mental health
- Expansion of a HCRS embedded clinician/LADAC to four days a week in Patient Centered Medical Home supported by SBIRT grant.
- Hired and Supported a psychiatrist within Patient Centered Medical Home
- Partnership for interagency care management with HCRS
- Provided Mental Health First Aid training to Hospital staff and community partners X2.
- 336 mental health counseling sessions were provided through the Windsor Connection Resource Center.

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Partners and Resources:

- Windsor Community Health Clinic
  - Wellness Recovery Action Plan, http://www.mtascutneyhospital.org/community-services/community-resources/wellness-recovery-action-plan
- Healthcare and Rehabilitative Services (HCRS)
- West Central Behavioral Health (Mental Health First Aid)
- Windsor Connection Resource Center
- Mental Health Providers brochure: http://www.mtascutneyhospital.org/sites/default/files/content/documents/MAH17_MentalHealthBrochure_Web.pdf

WEST CENTRAL BEHAVIORAL HEALTH
Adult | Child | Family

HCRS Health Care & Rehabilitation Services

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Expenditures- Mental Health

- MAHHC $290,000
- Grants $5,000 for WRAP from Blueprint

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Dental Health

- Application of fluoride in Pediatric clinics
- Outreach to recruit a local dentist
- Community Health Team, Spoke Staff, and staff of the Windsor Community Health Clinic assist patients to find dental homes*, care and financing.
- Dental clinic in the Windsor school, provided education to 252 children and their parents, provided dental screening and sealant applications to 60 children and 463 teeth in 2017.
- Windsor Community Health Clinic gave out 20 dental vouchers ($6,720) and worked with dentists to connect patients to dental homes* with discounted care.
- Built new partnerships with Dr. Kramer and Dr. Abbott in Claremont.
- Negotiated an agreement with Hanover Oral Surgery to provide discounted care and accept Vermont General Assistance Care and WCHC Dental Vouchers.

***A Dental home is a relationship with a provider/agency where a person gets routine an emergent dental care.**

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Partners and Resources:

- Windsor Community Health Clinic
- Mt. Ascutney Pediatrics, Windsor
- Northeast Delta Dental
- School Dental Hygienist
- Area Dentists and other free clinics
- Windsor Southeast Supervisory Union, School and School Nurse
- Ottauquechee Health Foundation Smiles Program

Mental & Dental Health Funding Supports: MAHHC, Northeast Delta Dental grant & the Byrne Foundation, ($11K), Windsor Community Health Clinic dental voucher funds ($6.7K), VT Association of Mental Health and Addiction Recovery ($1K), Rural Health Sustainability funds ($600 to support food for Wellness Recovery Action Plan groups)

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Objective #4 ~ Access to Affordable Health Insurance & Cost of Prescription Drugs

- Windsor Community Health Clinic (WCHC) assists community members with Vermont Health Connect, and Medicare and Medicaid applications
- Medicare Boot Camp – held March 31, 2017 and July 24, 2017
- **46** Medication Vouchers offered through the Windsor Community Health Clinic in 2017, valued at $2,572

Activities: Windsor Community Health Clinic, general

- Active member of the Vermont Coalition of Clinics for the Uninsured
- Grant supported Case Manager
- Provides a 5-day-a-week program to improve access to care
- Established a new Transportation Voucher Program for rides to medical appointments working with GMAC Taxi, rides provided valued at $645, ($545 taxi vouchers, $100 gas cards)
- Added a VHC navigator to do outreach at OHC,
- 15 MDs, 6 NPs, 17 nurses, 1 Mental Health Provider, 1 Admin, 4 PTs, 8 Radiology and Lab Techs, and 8 Business Office staff participated in the program

Windsor Community Health Clinic:
A member of Vermont Clinics for the Uninsured

# s of Patients Served	2017
BCBS/MVP Enrollment	42
BCBS/MVP Follow-up	123
VT Health Connect Consult	515
VT Health Connect (Status Calls)	515
Medicaid Application	83
Medicare Assistance	73
New Medication Assistance PAP	92
Pharmacy Vouchers	46

#s of Patients Served	2017
Total Interactions	1828
Total Patients Seen	523
New Patients	255
Distinct Patients	586
Case Management	1358
Consults	1149
Dental Referral	54
Financial Applications	507
Social Security Disability	12
Transportation	23

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Objective #5~ Nutrition and Access to Affordable, Healthy Foods

- Worked with partners to provide Summer Food Program, **1070 meals served** and supported Food Drive for Food Shelf
- Implemented *VeggieVanGo* working with the Vermont Food Bank as a monthly community resource. Served **90 -215 families each month**.
- Physicians are writing prescriptions for vegetables to families in need.
- Membership in the Upper Valley Hunger Council
- Implementation of 3–4–50 reaching over 1,000 people through outreach to towns, schools, businesses, day cares and Health and Human Services agencies
- MAH Recognized at the Gold Level for 3-4-50 Worksite Wellness
- Working with Vermont Housing Association, MAHHC and SASH to organize a *Learning Kitchen* class for residents at Union Square Apartments
- Nurse in pediatric clinic created a farmers market flyer to distribute to families
- Participation in community dinners program each Wednesday evening, Sept. – June.

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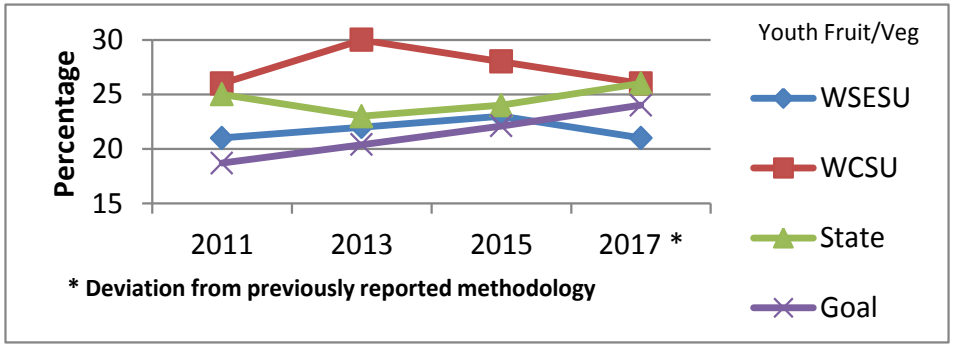
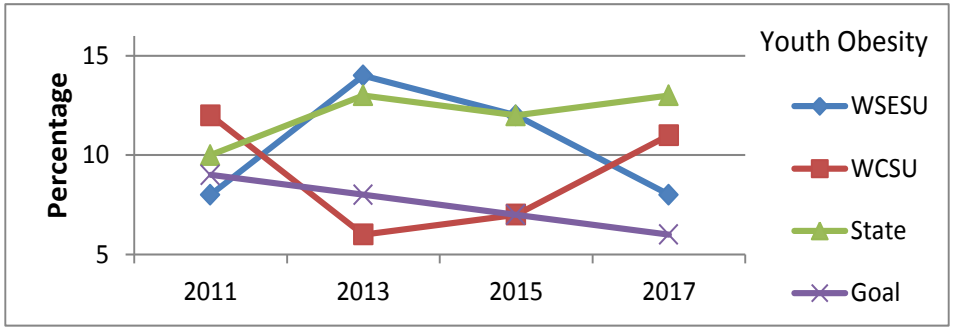
Objective #5~ Nutrition and Access to Affordable, Healthy Foods





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Partners and Resources:

- Windsor Southeast Supervisory Union
- St. Francis Church, Old South Church,
- Trinity Evangelical Free Church
- Windsor Recreation Department
- Windsor Connection Resource Center
- Windsor Food Shelf
- Windsor Affordable Housing agencies
- Hunger Free Vermont
- Town of Windsor
- Southern Vermont Area Health Education Center
- (AHEC)
- Vermont Housing Association
- Support and Services at Home (SASH)
- Vermont Food Bank,
- https://www.vtfoodbank.org/share-food/veggievango

90 – 215 Families each month!

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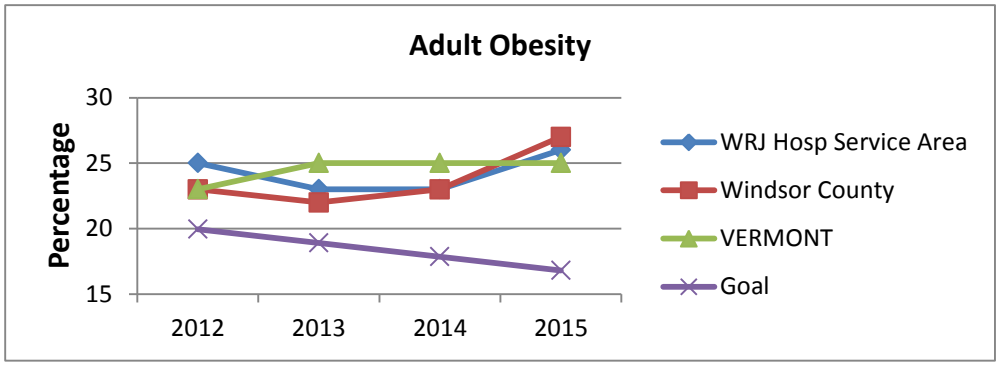
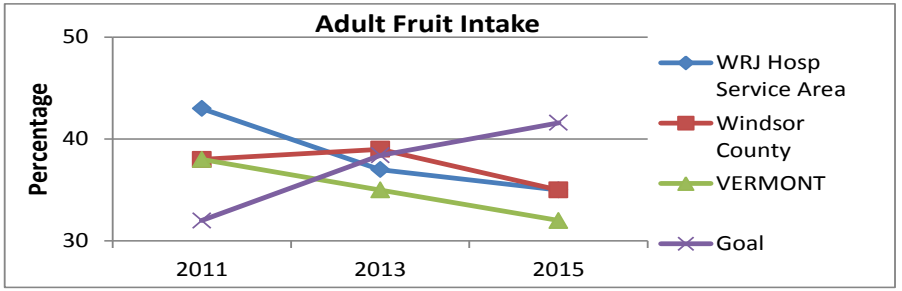
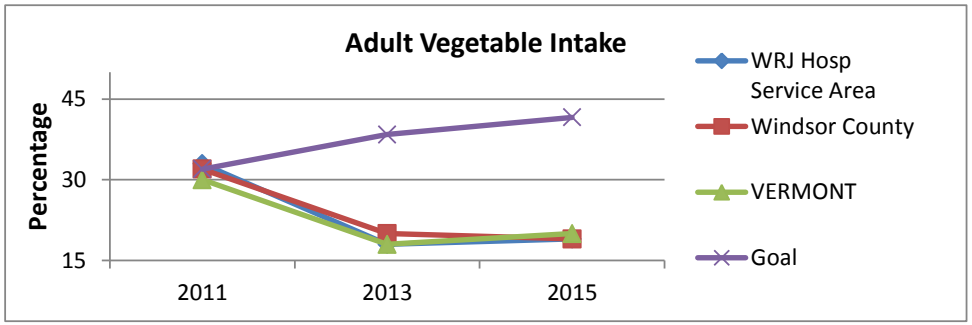
Outcomes: Nutrition







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Expenditures- Nutrition

- MAHHC $ 22,500
- Grants $1,500

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Objective #6 ~ Lack of Physical Activity, need for recreational opportunities and active living

- Readiness Assessment for Town Health and Wellness Committees in Windsor, Weathersfield and Woodstock
- Implementation of 3-4-50 reaching over 1,000 people through outreach to towns, schools, businesses, day cares and Health and Human Services agencies
- MAH registered for and was recognized at the Gold Level for 3-4-50 Worksite Wellness activities
- Conducted Health Readiness Assessment interviews in 3 towns to serve as catalyst to concept of town health and wellness committees
- Disseminated *Supporting Healthy Communities Policy Guide* (includes plans for active living design) to towns across Windsor County with invitation letter to contact MAPP for prevention policy support (guide was created with TRORC last year)

Partners and Resources:

- Two Rivers Ottauquechee Regional Commission
- Towns of Weathersfield, Woodstock, Windsor
- VT Department of Health, 3-4-50 statewide campaign
- Windsor HSA Community Collaborative, 3-4-50 Subcommittee
- Governor's Council on Worksite Wellness
- RiseVT

RISE VT

VERMONT DEPARTMENT OF HEALTH

3 › 4 › 50 VERMONT

TRORC Two Rivers-Ottauquechee REGIONAL COMMISSION

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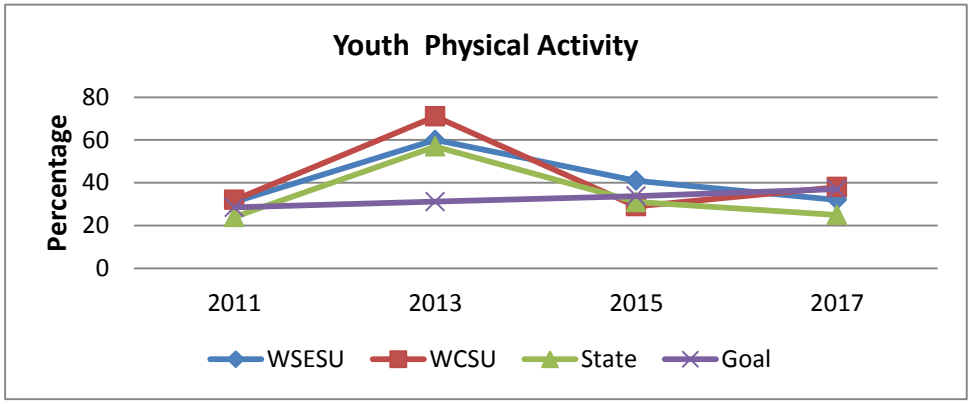
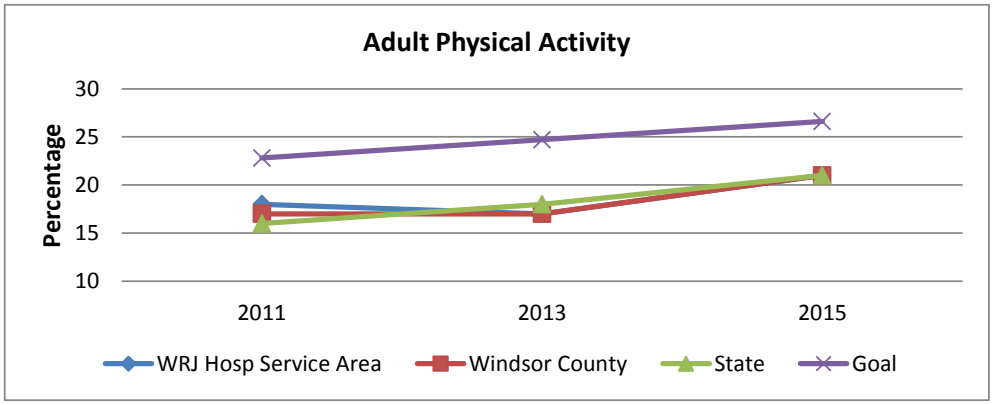
Outcomes: Physical Activity





- ***Funding Supports, Nutrition & Physical Activity:*** MAHHC ($15,000) and 3 – 4 - 50 supports, VDH / Tobacco Prevention ($1K) covers 3 – 4 – 50 costs.

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Objective # 7 ~ Income, Poverty, Family Stress

- A Family Wellness Program in Windsor and Woodstock Pediatric Clinics continues.
- Serving on both WSESU and WCSU health and care teams
- Promise Community
- Collaborative Problem Solving and Attentive Parenting
- The Windsor Connection Resource Center (WCRC) worked throughout 2017 to achieve its mission of furnishing its PATCH Team members with collocation to bring vital services, education, and enrichment opportunities to the community, offering information, referral, advocacy, and case management services while building a positive sense of community.
- Provided interagency care planning, coordination and management to high risk pediatric and complex chronic care patients using tools and a best practice model
- Promote 4 best practice approaches to address poverty:
    1. Care coordination (working with One Care)
    2. Volunteerism (VIA, RSVP, Thompson Sr. Center)
    3. Peer Support (Turning Point)
    4. Financial Literacy (Working Bridges, Ready to Work, Faith and Finance)

Windsor Connection Resource Center

WCRC Service Provision	2017
Alcohol & Drug	224
Child Care	8
Housing	62
Community Health Outreach	470
Computer/Email	254
Crisis/Fuel/Elec./Shelter, Etc.	50
Dept. of Corrections	-
Economic Services	188
Education	
Adult	332
Early	7
Ages 5-18	160
Employment (VABIR)	-
Giving Room	654
Disability	17
Mental Health	336
PATCH	123
Phone/Fax/Copier	547
Taxes	83
Tobacco cessation	-
Other	292

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Partners and Resources:

- UVM's Vermont Center on Children Youth & Families
- Albert Bridge School's Principal, Jennifer Aldrich
- Building Bright Futures & Promise Community Steering Committee members
- Ottauquechee Community Partnership & WCSU
- Mt. Ascutney Hospital Pediatrics, Family Wellness Coach
- Windsor Connection Resource Center, PATCH Network
- Agency of Human Services, Springfield District

Building Bright FUTURES

Albert Bridge School
CURIOUS. CREATIVE. CARING.

Vermont Center for Children Youth & Families
Vermont Family Based Approach

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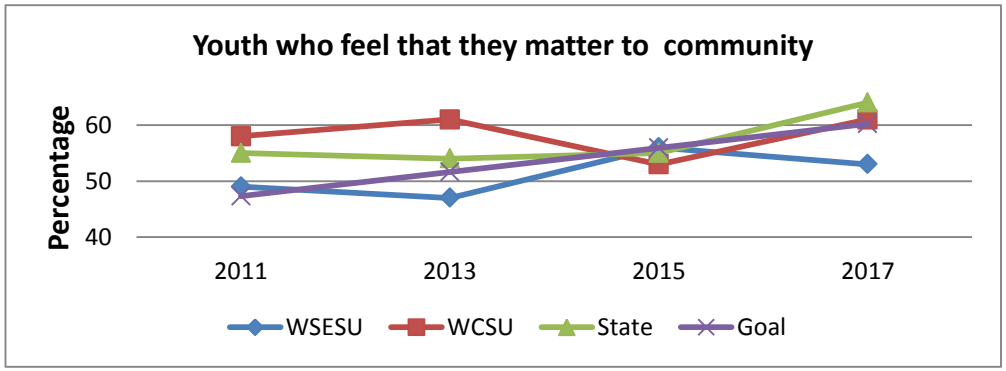
Outcomes: Income, Poverty, Family Stress

- ***Funding Supports, Income/Poverty/Family Stress:*** MAHHC ($17,900) and 3 – 4 – 50 supports, VDH / Tobacco Prevention ($1K) covers 3 – 4 – 50 costs, Family Wellness ($250K – Canaday Fund and private donations), DHMC Prevention Grant ($15K), ADAP Prevention Infrastructure Grant (20K), Windsor Connection Resource Center ($46.5K), Promise Communities ($150K)



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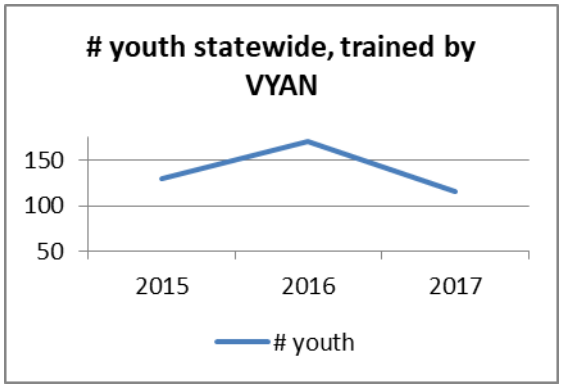
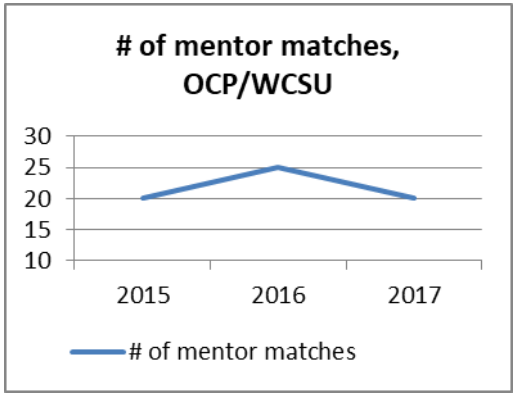
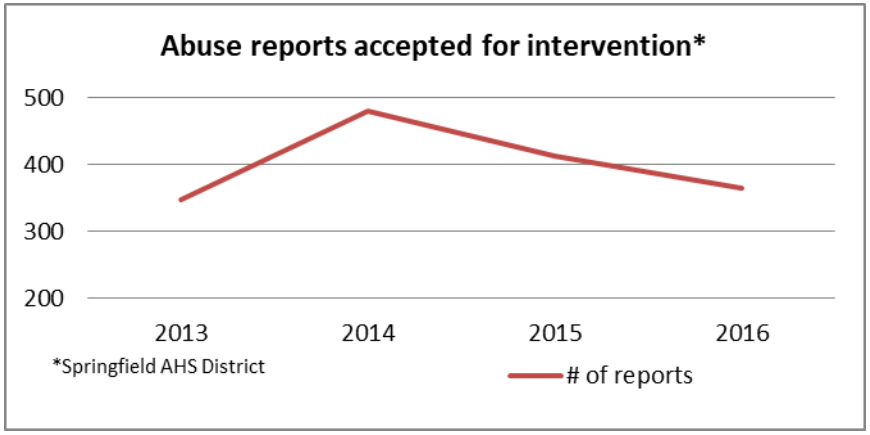
Outcomes: Income, Poverty, Family Stress







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Objective #8 ~ Access to Transportation

- Participating in Regional Transportation Coalition
- Volunteers in Action provision of rides
- Use of transportation vouchers
- Work with VTrans, The Current and local community partners on *Rides to Wellness* grant initiative
- Developed and distributed 2 transportation algorithms to maximize use of existing resources

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Partners and Resources:

- Volunteers in Action
- CT River Transit
- Southern Windsor County Regional Planning Commission

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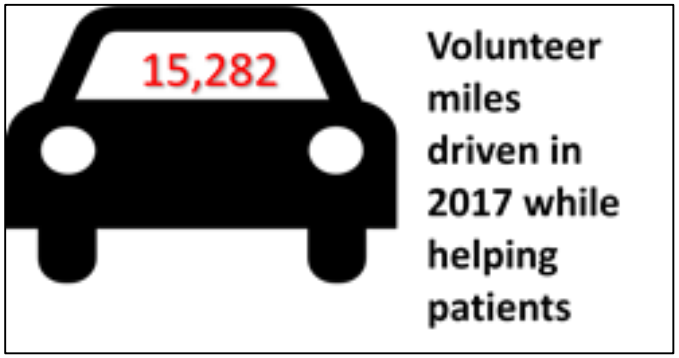

- ✓ Transportation demonstration grant activities are pending
- ✓ **$450** given in vouchers of elderly transportation
- ✓ **43** volunteers offered rides

- ***Funding Supports:*** MAHHC ($13,500), Volunteers in Action (ViA), Windsor Community Health Clinic (WCHC), Grants ($79,500)

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Objective #9 ~ Access to Primary Health Care

- Achievement of NCQA re-designation as a Level III Patient Centered Medical Home
- Implementation of Annual Wellness
- Recruitment of primary care providers
- Successful recruitment of staff psychiatrist to serve Windsor and Woodstock primary care practices
- SASH and MAT staff

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Reducing Chronic Disease through best practice: SELF-MANAGEMENT, 2017 stats:

- 12 Self-Management programs in 2017
- 92 participants registered
- 49% completion rate (attending 80% or more sessions)

Trends:

	2014	2015	2016	2017
# Groups	17	11	13	12
# Registered	189	119	89	92
% Complete	35%	51%	39%	49%

- ***Funding Supports:*** MAHHC ($30,000), VT Blueprint for Health grant ($129K), Blueprint Community Health Team ($198K); Blueprint Spoke Team ($451K); DHMC Prevention Grant ($15K), School Nurse ($15K, Reading)

Objective #10 ~ Health Care for Seniors

- Interagency care management in partnership with Senior Solutions
- Participated in the creation of a new Woodstock Area Adult Day Services – "Scotland House"
- Aging in Place Initiatives by ViA—new group formed in Weathersfield, Brownsville, and Reading
- SASH Wellness Nurse
- HASS at Olde Windsor Village

Partners and Resources:

- Aging in Hartland
- Senior Solutions
- Volunteers in Action
- Support and Services at Home (SASH)
- Housing and Support Service (HASS)
- Stewart Property Management
- Thompson Senior Center
- Woodstock Area Adult Day Services

Senior SOLUTIONS
Council on Aging for Southeastern Vermont

SASH a caring partnership
SUPPORT AND SERVICES AT HOME

- ***Funding Supports:*** MAHHC ($56,300), Aging in Hartland ($2.5K), HASS ($9K), SASH ($18.5K)

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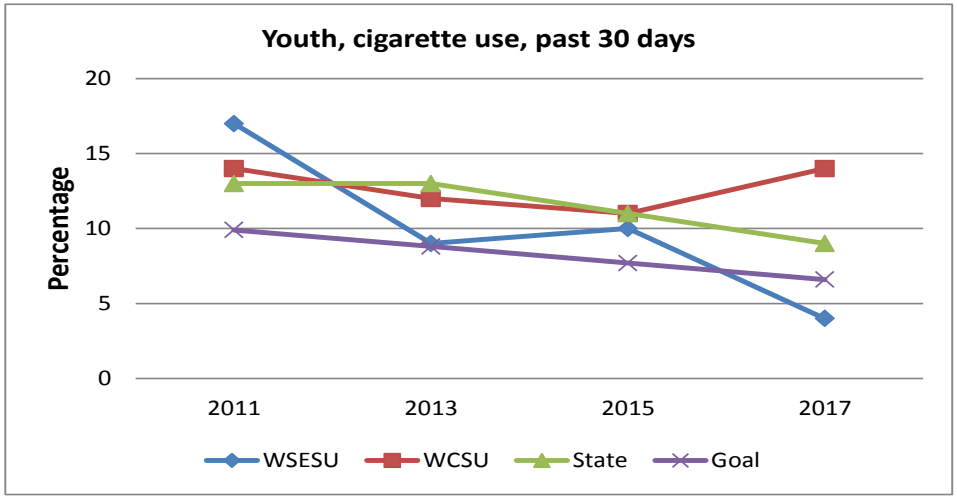
Objective #11 ~ Tobacco Use/Smoking

- Regular cessation groups and 1:1 counseling has been provided
- Prevention activities to decrease tobacco advertising and use
- Implementation of 3-4-50 and non-smoking pledge cards
- Community education about the impact of vaping and flavored tobacco provided
- Recognized at the Gold Level for 3-4-50 Worksite Wellness
- "Counter Balance"
- VKAT
- OVX
- Conducted store surveys with **20** retailers



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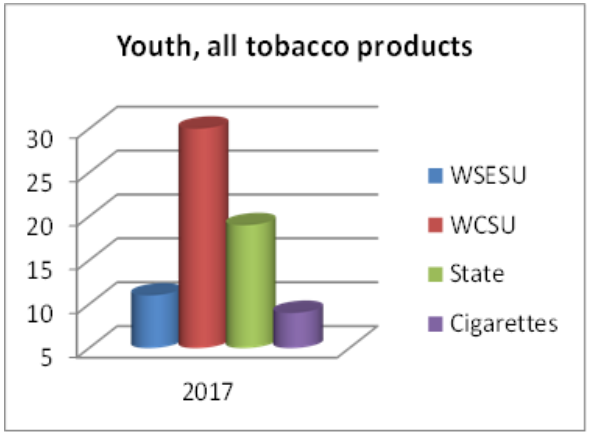
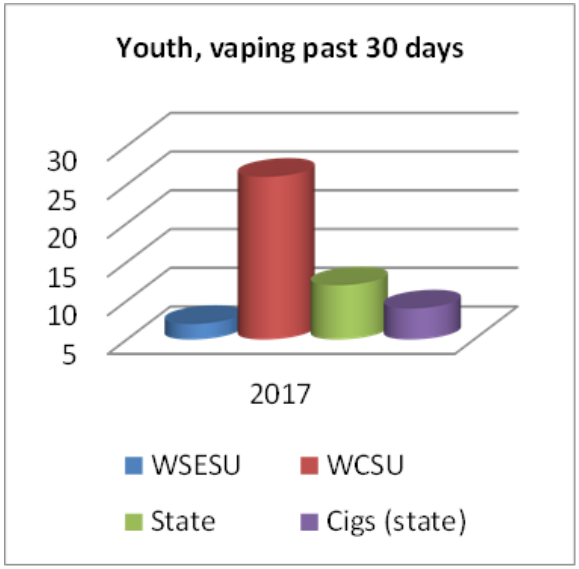
Outcomes: Tobacco Use





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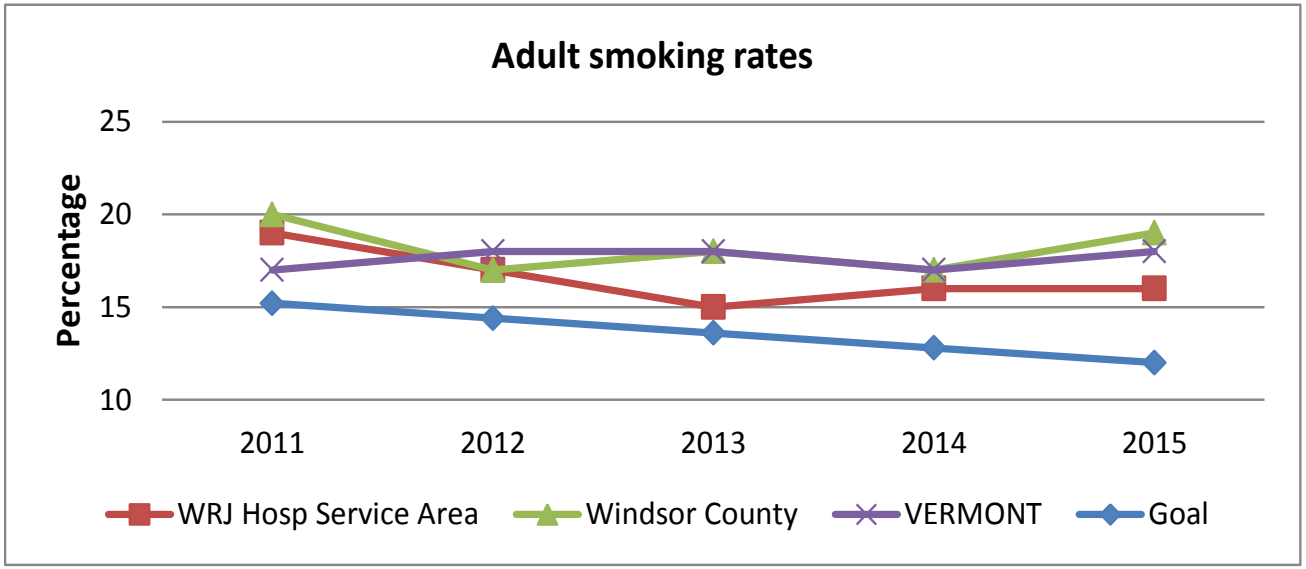
Outcomes: Tobacco Use



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