Appendix B: Summary of State Health Improvement Plan Interventions

State Health Improvement Plan 2013-2017

State Health Improvement Plan Goals

GOAL 1: **Reduce the prevalence of chronic disease**

Indicators:
- % of adults who eat the daily recommended servings of fruit/vegetables
- % of youth who eat the daily recommended servings of fruit/vegetables
- % of adults who meet physical activity guidelines
- % of youth who meet physical activity guidelines
- % of adults who smoke cigarettes
- % of youth who smoke cigarettes

GOAL 2: **Reduce the prevalence of individuals with or at risk of substance abuse or mental illness**

Indicators:
- % of people age 12+ who need and do not receive treatment for alcohol use
- % of youth who binge drink
- # of suicide deaths per 100,000 people
- % of suicide attempts among youth in grades 9-12 that require medical attention

GOAL 3: **Improve childhood immunization rates**

Indicators:
- % of children (19-35 months) who receive recommended vaccines
- % of Kindergarteners with 2+ doses of mumps, measles, rubella (MMR) vaccine
- % of youth age 13-15 who are vaccinated with one dose of Tdap vaccine

Comprehensive Strategies

Strategies impacting multiple SHIP priorities

All SHIP indicators

Appendix B: Summary of State Health Improvement Plan Interventions

State Health Improvement Plan 2013-2017

GOAL 1: **Reduce the prevalence of chronic disease**

INDICATORS:
% of adults who eat the daily recommended servings of fruit/vegetables
% of youth who eat the daily recommended servings of fruit/vegetables
% of adults who meet physical activity guidelines
% of youth who meet physical activity guidelines
% of adults who smoke cigarettes
% of youth who smoke cigarettes

Strategies	Level of Prevention Model	Target Audience	Performance Measures	Lead Organization/Partners
Schools will participate in the Agency of Transportation Safe Routes to School program	Organizations/Community	Schools in communities with highest risk populations	# of schools participating in the School Wellness Awards	Lead: VDH (HPDP) Partners: AOT/DOE
Develop policies to address poor nutrition and physical inactivity in childcare facilities	Organizations	Childcare facilities in communities with highest risk populations	# of childcare centers engaged in developing policy and environmental change strategies to address poor nutrition and physical inactivity	Lead: VDH (HPDP) Partners: DCF, childcare facilities
Establish community based sites for the delivery of evidence based prevention programs	Organizations/Community	Highest risk communities	# of community coalitions in rural areas of the state implementing local policy/environmental change strategies to address poor nutrition and physical inactivity	Lead: DAIL Partners: AAA, Adult Day, SASH, VDH

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Create and promote Healthy Food in Older Americans Act Nutrition Program pledge for meal providers	Organizations	Meal Providers for older Vermonters	# of pledge agreements signed by meal providers	Lead: DAIL Partners: AAA, Meal Site Providers
Develop social marketing strategies to raise public awareness about Aging and Disabilities Resource Connection (ADRC) among older adults, people with disabilities, caregivers and providers	Individual/Relationships/Organizations	Consumers and providers in communities with highest risk populations	# of ADRC public activities and media events	Lead: DAIL Partners: AAA, Vermont Family Network, Vermont Center for Independent Living, Brain Injury Association of Vermont, Vermont 211
Implement health/physical wellness programs in Community and Rehabilitation Treatment (CRT) programs	Organizations	CRT programs	# of CRT programs with health/physical wellness programs	Lead: DMH
Encourage use of Vermont Quit Network	Community	Smokers and any referral source	# of registrants to the Vermont Quit Network	Lead: VDH (HPDP)
			% of the smoking population with a HS education or less using any arm of the Vermont Quit Network	
Provide community coalitions with tobacco cessation technical assistance	Organizations	Community Coalitions	% of Community Coalitions participating in one technical assistance call per quarter that offers policy guidance and success/barrier sharing	Lead: VDH (HPDP)

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GOAL 2: **Reduce the prevalence of individuals with or at risk of substance abuse or mental illness**

INDICATORS:
% of people 12+ who need and do not receive treatment for alcohol use
% of youth who binge drink
# of suicide attempts per 100,000 people
% of suicide attempts among youth in grades 9-12 that require medical attention

Strategies	Level of Prevention Model	Target Audience	Performance Measures	Lead Organization/Partners
Increase Out Patient/Intensive Out Patient engagement among Preferred Providers Implement a new level of care for opioid addictions (via the Hub and Spoke model)	Individual	Individuals and families with 12+ and at risk of substance abuse issues	% of people giving reason as treatment completion or transfer for ending treatment.	Lead: VDH (ADAP) and Preferred Provider System
Increase use of Addictions Severity Index and the Comprehensive Health Assessment for Teens (ASI/CHAT) tool among clinicians providing addiction services	Individual	Individuals and families with 12+ and at risk of substance abuse issues	# of people treated through the ASAM Guided, ADAP provider system.	Lead: VDH (ADAP) and Preferred Provider System

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School-based substance abuse prevention and early intervention services	Organizations/Community	ADAP funded schools	Of those students at funded schools who screen positive for substance abuse and/or mental disorders, the percent who are referred to substance abuse treatment and/or mental health services	Lead: VDH (ADAP) and Schools
Encourage community coalitions to employ evidence based practices to reduce the proportion of individuals engaging in binge drinking	Organizations/Community	Community Coalitions in highest risk communities	Of those funded community coalitions that are working to reduce binge drinking, the percent that are employing evidence-based practices	Lead: VDH (ADAP) and Community Coalitions
Enhance consumer and provider understanding and utilization of the ADRC (Aging and Disabilities Resource Connection)	Individual/Relationships	All Vermonters	# of DAIL clients funded through the Elder Care Clinician program	Lead: DAIL Partners: AAA, Vermont Family Network, Vermont Center for Independent Living, Brain Injury Association of Vermont, Vermont 211, Howard Center

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Create a public education campaign about suicide awareness and prevention for Vermonters aged 30 to 60	Individual/Relationships/ Community	Vermonters aged 30 to 60	# of Vermonters assessed by mental health Designated Agency emergency services Amount of wait time from receipt of emergency services to receipt of further non-emergency designated agency services	Lead: DMH
Through the Vermont Youth Suicide Prevention Coalition, utilize the *UMatter* public awareness campaign materials and strategies; continue training education staff in the *LifeLines* curriculum; continue promoting community *Gatekeeper* approach	Individual/Relationships/ Organizations/Community/Policies	Those affected by the loss of someone to suicide or have attempted suicide	# of *LifeLines* curriculum trainings provided to education staff	Lead: DMH and Center for Health and Learning Partners: School communities, professionals (e.g., mental health, physical health, social workers, clergy, and law enforcement)

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GOAL 3: **Improve childhood immunization rates**

INDICATORS:
% of children (19-35 months) who receive recommended vaccines
% of Kindergarteners with 2+ doses of mumps, measles, rubella (MMR) vaccine
% of youth age 13-15 who are vaccinated with one dose of Tdap vaccine

Strategies	Level of Prevention Model	Target Audience	Performance Measures	Lead Organization/Partners
Conduct VFC and /or AFIX site routine periodic reviews to provide feedback on practice level Immunization Registry (IMR) completeness and coverage rates	Relationships	All potential VFC and AFC providers	% of public and private providers enrolled in VFC who have received a VFC and/or AFIX visit that includes feedback on practice level IMR completeness and coverage rates	Lead: VDH (HS)
Send reminder-recall letters to parents of children 8-20 months of age who are in the IMR	Individual/Relationships/Organizations	All children in IMR	% of children 8-20 months of age in the Immunization Registry whose parents are sent a reminder/recall letter	Lead: VDH (HS)
Provide IMR training to provider offices	Individual Relationships	VFC and AFC providers	# of provider offices that receive IMR training	Lead: VDH (HS)
Establish a statewide Immunization Coalition	Individual/Relationships/Organizations / Community/Policies and Systems	Vaccine hesitant parents	% of Kindergarteners provisionally admitted to school	Lead: Vermont Public Health Association Partners: VDH, Bi-State Primary Care, VCHIP, DCF, DAIL, Hospital Association, United Way

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Implement electronic transmission of immunization data from provider electronic health records into the Immunization Registry using HL7 messaging	Organizations/Community/Policies and Systems	20 healthcare provider practices	# of providers enrolled in the Vaccines for Adults program	Lead: VDH (HS) Partners: Bi-State, VITL, DVHA (Blueprint)

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Strategies impacting multiple SHIP priorities

All SHIP indicators

Strategies	Level of Prevention Model	Target Audience	Performance Measures	Lead Organization/Partners
Develop and promote strategies for integrating health improvement policies and physical environment changes in town plans	Policy	Towns with highest risk populations	# of new policies adopted in a community that increase access to physical activity # of environmental changes made in a community that increase access to physical activity	Lead: VDH Partners: Towns
Revise *VT Worksite Wellness Resource* to include SHIP priorities	Organizations	Small businesses employing lower wage earners	# of small businesses with written strategies incorporating at least one of the VDH five outcomes	Lead: VDH Partners: DMH/DOL, worksites
			# of employers receiving Breastfeeding Friendly Employer designation from VDH	Lead: VDH
Promote and implement the Coordinated School Health Model recommended by CDC	Organizations	Schools with highest risk populations	% of schools that report no students with provisional admittance	Lead: VDH (MCH) Partners: DOE/DMH

			% of schools that use Youth Risk Behavior Survey data to inform programs and improve child health outcomes % of schools that teach required health education course in middle level grades % of students in public school reported as having asthma who have an Asthma Action Plan	
Build capacity in communities by investing in community-based interventions that reduce multiple risk factors associated with chronic disease	Policy/Community	Towns/districts with highest risk populations	# of community assessments completed for access to healthy foods # of community assessments completed for opportunities for physical activity	Lead: VDH Partners: DAIL
Assure an appropriate range of preventive, primary care and specialty services to meet the health care needs of Vermonters	Policy/Community	Medicaid Beneficiaries	# of Vermonters who currently have access to Patient Centered Medical Homes and Community Health Team Services # of Vermonters who are likely to have access to Patient Centered Medical Homes and Community Health Team	Lead: DVHA

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Provide better coordination of health care services for all populations, particularly for high cost and high utilization populations	Policy/Community	Medicaid Beneficiaries	Services	