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Community Health Improvement Report

Mt. Ascutney Hospital and Health Center (MAHHC) is deeply committed to improving the health of the people and communities we serve. This report is a summary of the work MAHHC and its partners have done to enhance health and wellness in our region, based on the Community Health Needs Assessment (CHNA).

INTRODUCTION

The mission of Mt. Ascutney Hospital and Health Center (MAHHC) is to improve the lives of those we serve. To accomplish this, we and our community partners regularly reach out to engage in dialogue with people across our area about pressing health needs. The result of this work is a comprehensive local **community health needs assessment** (CHNA).*

This assessment is designed to identify community health concerns, priorities and opportunities to improve community health and health care delivery systems. The geographic area covered by the assessment is 13 municipalities in Vermont and New Hampshire that comprise the Mt. Ascutney Hospital and Health Center service area.

The CHNA leads to a local Community Health Improvement Plan (CHIP) with strategies and metrics to improve health and reduce risks leading to chronic disease—not only for individuals, but for the entire community.

This CHNA-CHIP process, which incorporates input from people who represent the community's broad interests, is an essential part of creating an accountable community for health. It's the law for tax-exempt hospitals, as part of the Patient Protection and Affordable Care Act. But it's also sound medicine. The assessment process fosters engagement, and the results help us understand the specific issues facing our communities so that we can develop effective, collective solutions.

This 2018 Community Health Department Improvement Report details activities implemented to support the final year of our 2015 CHIP. It covers the period from 10/1/2017 to 9/30/2018.

**Mt. Ascutney Hospital's local CHNA is conducted in conjunction with Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, New London Hospital, and Valley Regional Healthcare, who share local information and analysis to form a comprehensive picture of population health for the Upper Valley region. Each participating hospital develops its own Community Health Improvement Plan, based on relevant results from the CHNA.*

ABOUT OUR PROCESS

- This past year completes a 3-year cycle of CHIP activity based on our 2015 CHNA.
- Early last year, we began preparing for the 2018 CHNA, with a focus on increasing input from underrepresented populations. Our efforts resulted in a 126% increase in the number of survey participants over the 2015 CHNA.
- CHNA results were released in September 2018. We promptly convened a multi-sector planning team that organized and hosted 2 community health improvement summits – in Windsor and Woodstock. The summits were designed to:
 - » educate community partners and citizens about the CHNA findings, and;
 - » involve them, as an accountable community for health, in generating a collaborative implementation plan designed to improve the health status of our communities.
- This Community Health Implementation Plan will be submitted to the MAHHC Board of Trustees for approval, then implemented across the next 3-year period.
- The 3-year cycle will begin again with the 2021 Community Health Needs Assessment.

Mt. Ascutney Hospital is the lead organization for the regional Accountable Community for Health. Our approach integrates a network of community partners, stakeholders, and citizens for collective impact.

Oversight is administered through the Community Health Committee of the MAHHC Board of Trustees.

MAHHC IMPLEMENTS ONECARE VT'S POPULATION HEALTH MODEL

As an Accountable Community for Health we could not accomplish our work without community partners. MAHHC Community Health meets people where they are and helps them move toward greater health and wellness.



COMMUNITY HEALTH ORGANIZATIONAL CHART

Board of Trustees, Mt. Ascutney Hospital and Health Center and Community Health Subcommittee

Chief Executive Officer (CEO/CMO)

Joseph L. Perras, MD

Director of Community Health

Jill Lord, RN, MS

MAHHC Community Health Department

PROGRAM	STAFF – FTE			Q1	Q2	Q3	Q4
Windsor Connection Resource Center	Steve Henry, Service Coordinator – 0.5	Susan Whittemore, Service Coordinator – 0.5	Meg Sterns, Service Coordinator – Per Diem				
Family Wellness Program	Courtney McKaig, Wellness Coach – 0.75	Katrin Tchana, MSW, Family Wellness Therapist – 0.5	Alice Stewart, Evaluation – 0.1				
RiseVT	Alice Stewart, RiseVT Program Manager – 0.45	Courtney Hillhouse, Prevention Coordinator – 0.05					
Mt. Ascutney Prevention Partnership	Melanie Sheehan, Reg. Prevention Program Mgr – 0.90	Courtney Hillhouse, Prevention Coordinator – 0.95	Alice Stewart, Grant Implementation Team Leader – 0.45				
Blueprint Self-Management	Tracey Hayes, Community Health Program Manager – 0.22	Sarah Doyle, Coordinator – 0.5					
Windsor Community Health Clinic (self-management programs)	Samantha Ball, Coordinator – 1.0	Kristi Clark, Assistant Coordinator – 0.3					
Housing and Support Services	Bess Klassen-Landis – 0.22						
Support and Services at Home	Rita Bennett, RN – 0.17						
Volunteers in Action	Martha Zoerheide – 0.6	Scottie Shattuck – 0.72	Peggy Kehew – Per Diem				
Blueprint Community Health Team	Carla Kamel – 1.0 Liz Sheehan, RN – 1.0	Amy Swarr, RN – 1.0	Vacant, MSW – 1.0				
Blueprint Spoke Team	Suzette Barbour, RN – 1.0 Katie Whyman, CMHC, LADC – 1.0	Owen Murray, LMFT – 1.0	Ashley Hutton, RN – 1.0				

Alignment to OneCare's Population Health Approach

QUADRANT 1 = Healthy/Well, 44% of the population

QUADRANT 2 = Early Onset Chronic Illness & Rising Risk, 40% of the population

QUADRANT 3 = Full Onset Chronic Illness & Rising Risk, 10% of the population

QUADRANT 4 = Complex/High Cost Acute Catastrophic, 6% of the population

Note: This chart reflects the Community Health Organizational Chart as of publication date.

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MEDICAL-BASED PREVENTION

Our medical staff has worked diligently to implement best practice protocols and change prescribing practices. We have been tracking the outcomes in the quarterly Vermont Prescription Monitoring Program and can proudly say that we have had the lowest rate of opioid analgesic prescriptions in the State and the second lowest rate in the prescription of benzodiazepines and stimulants for 2 years.

YOUTH PREVENTION SUMMIT

- MAHHC and the Windsor Area Drug Task Force convened a summit to review data, share concerns, and create solutions for Youth substance misuse in October 2017.
- Workgroup convened to create two resource guides: Prevention Activities & Youth substance misuse treatment programs.
- MAHHC is working to host a searchable online platform where community members can search for activities that youth can participate in. Youth treatment options will also be listed.

TREATMENT

- The Interdisciplinary Chronic Pain Consult Team met on a monthly basis to provide support for managing challenging chronic pain patients.
- The Blueprint Self Management program also convened two Chronic Pain Self Management classes this reporting period.

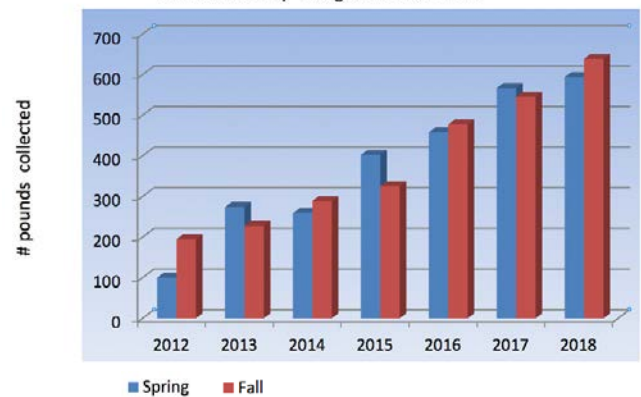
COMMUNITY-BASED PREVENTION

- MAPP staff was invited to draft prevention recommendations related to a tax and regulate system for recreational marijuana for Governor Scott.
- Designed and implemented Marijuana Law community survey to gauge understanding and identify marijuana education needs. 602 responses collected across Windsor County.
- Distributed 10+ prescription medication mail-back envelope display units to various locations.
- Expanded regional approach by contracting with Gifford Health Care and Little Rivers Healthcare to participate in prevention efforts.
- Continued to disseminate statewide media campaigns, specifically parentupvt.org – website for parent coaching on how to talk to teens about substance misuse.
- Purchased Michigan Model (substance misuse prevention curricula) for Windsor, Hartland, and Weathersfield schools for 2018/2019 school year implementation.
- Co-created the “Green Peak Alliance”- a member organization of multiple prevention coalitions and community stakeholders across Windsor County, partnering to build healthier communities.



Mt. Ascutney
PREVENTION PARTNERSHIP

Windsor County - Drug Take Back Totals



- Promoted Spring and Fall 2018 DEA Drug Take Back Days for record collection amounts

PREVENTING OPIATE DEATHS SUMMITS

- MAHHC and the Windsor Area Drug Task Force convened “Beyond Naloxone: Prevention of Opiate Deaths Summit”. The first was held in June and the second in September 2018.
- 30+ participants attended each summit, 4 workgroups were formed and are actively working to implement solutions.
- Participants included Law Enforcement, Fire/EMS, Probation & Parole, Treatment Programs, Mental Health Agencies, Needle Exchange Programs, Recovery Centers (including recovering addicts) and MAHHC Leadership and Providers.



See Page 10
for data trends

PREVENTING OPIOID DEATHS

Across Vermont, the 2017 opioid-related fatality data shows that fatalities are leveling off. This is seen by a 25 percent drop in deaths from 2015-2017.

According to the VT Prescription Monitoring System, Windsor County has the lowest rate of opioid prescriptions in the State and the second lowest rate for benzodiazepines and stimulant prescriptions.

However, Windsor County has the second highest death rate in the State for opioid-related deaths.

2017 data shows that fentanyl is present in two-thirds of the fatalities, and prescription opioids, heroin, and cocaine (new in 2017) are present in one-third each of all fatalities.



DRUG-RELATED FATALITIES IN WINDSOR COUNTY

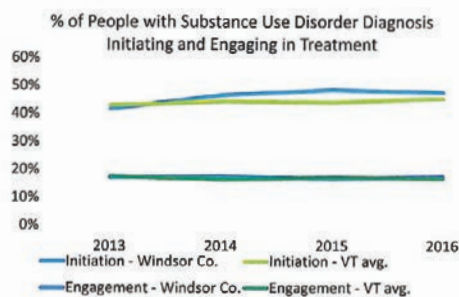
	2012	2013	2014	2015	2016	2017	2018
Opioid-related fatalities	5	3	6	12	18	12	18
Prescription-related fatalities	3	3	2	8	8	1	4
Heroin-related fatalities	1	0	5	4	7	5	9
Fentanyl-related fatalities	1	0	1	4	5	7	12

*DNA - data not available

MEDICAL BASED INTERVENTION & TREATMENT:

The Windsor Health Services Area Community Collaborative is a multi-sector team looking at both clinical and community level interventions that measure population health improvement over time. This group worked in the last year to develop “quality dashboards” for each measure. This one is related to Substance Use Disorder Treatment.

Substance Use Disorder Treatment



Measure Definition The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: initiation of AOD treatment through an admission, encounter, or visit within 14 days; engagement of AOD treatment including 2 or more add'l services within 30 days of the initiation visit. Measure is NQF #0004 defined [here](#). Rates have been adjusted for Medication Assisted Treatment and Behavioral Health Residential Treatment.

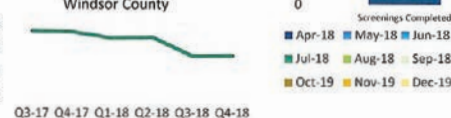
Source Vermont Department of Health data

Notes Project underway building SBIRT into Emergency Department workflow through CHT staff, making referrals to treatment as needed.

New HCRS Substance Use Disorder Treatment Clients in Windsor County



Active HCRS Substance Use Disorder Treatment Clients in Windsor County



Spoke Medication Assisted Treatment Resources, November 2018

MDs prescribing	16
MDs prescribing to ≥ 10 patients	6
Staff FTE Hired	4.5
Medicaid Beneficiaries	329

Access to Mental Health Services

- Wellness Recovery Action Plan (WRAP) workshops delivered for skill building and self-management support for anxiety, depression and general mental health
- Expansion of an HCRS embedded LADC to 4 days a week in Patient-Centered Medical Home (PCMH), supported by Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant
- Psychiatrist embedded in Patient Centered Medical Home
- Mental health counseling sessions at Windsor Connection Resource Center increased from 336 in 2017 to 776 in 2018
- Embedded HCRS clinician available in PCMH 4 days a week



Access to Dental Care



In 2018, the Windsor Community Health Clinic supplied 12 dental vouchers which totaled **\$6,701.25 worth of services.**

Working with Northeast Delta Dental and Alice Peck Day Community Health, MAHHC organized a dental clinic in the Windsor Elementary School called Windsor Smiles Program.

Windsor Smiles Program Services	2016	2017	2018
Number of students available for screening	▲ 244	▲ 252	▼ 231
Number of students return consent	▲ 244	▼ 172	▼ 131
Number of students screened	▲ 82	▼ 60	▼ 41
Number of students screened w/ untreated decay	▲ 22	▼ 13	▼ 9
Number of students screened w/ treated decay	▲ 19	▼ 15	▼ 10
Number of students w/ hx of decay	▼ 33	▼ 20	▼ 15
Number of students screened w/ ex sealant on perm molar	▼ 35	35	35
Number of students receiving DSF (decay stopping fluoride)			▲ 8
Number of students screened w/sealant applied in school year	▼ 62	▼ 60	▼ 35
Number of preventative sealants placed	▲ 585	▼ 483	▼ 224
Number of students receiving urgent treatment	▼ 6	▼ 5	▼ 2
Number of students receiving non-urgent care	▼ 16	▼ 8	▼ 7

Access to Affordable Health Insurance and Prescription Medication

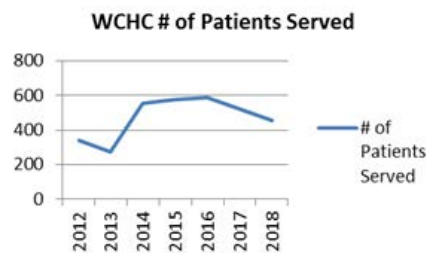


The Windsor Community Health Clinic assists clients with VT Health Connect, Medicare, and Medicaid applications.

Also helps patients complete applications for reduced price medications from pharmaceutical companies.

- In 2018, 5 medical doctors, 5 registered nurses, 2 mental health professionals, 8 mid-level nursing providers, and 1 licensed clinical social worker donated their time to support the Clinic.
- A total of \$852,318 of in-kind support was offered, with paid program expenses being \$78,464.
- A total of \$8,396 was spent on medication vouchers in 2018.

	2016	2017	2018	
VT Health Connect consult	488	515	320	
VT Health Connect (status calls)	488	515	227	
Medicaid application	115	83	95	
Medicare assistance	149	73	131	
New medication assistance PAP	24	92	117	
Pharmacy vouchers	62	46	47	



# of Patients Served	2016	2017	2018	
Total interactions	1385	1828	1044	
Total Patients seen	586	523	454	
New Patients	349	255	216	
Case Management	1682	1358	994	
Consults	586	1149	247	
Dental Referral	45	54	22	
Financial Applications	298	507	454	
Social Security Disability	2	12	247	

Health Care for Seniors



- Established a regional, community-based Falls Prevention best practice program involving EMS in Woodstock and Windsor, Historic Homes of Runnemede, Old Windsor Village, Retired Seniors Volunteer Program (RSVP), Patient-Centered Medical Home, MAHHC physical therapy; adoption of Falls Free statewide program (Stedi System); developed EMS protocol; provided training; promoted referrals to PT and community-based skills training; and provided balance and strength training for seniors.
- Interagency care management and care coordination through the Community Health Team for high-risk chronic care elders.
- Leadership and board participation for the creation of Scotland House adult day health and wellness program.
- Support and Services at Home (SASH) wellness nurse served over 100 patients with assessments, education, monitoring and care coordination. Involved in 2 quality initiatives with MAHHC Patient-Centered Medical Home including hypertension and diabetes quality initiatives.
- Housing and Supportive Services (HASS) coordinator worked to decrease social isolation by providing one-on-one visiting for 31 residents, with classes and events including gardening, book clubs, crafts, art and music.

Nutrition / Access to Affordable, Healthy Food

PARTNERS

- Schools
- Churches
- Recreation Department



- VT Housing Association
- VT Food Bank
- Union Square and Old Windsor Village
- Windsor Connection Resource Center
- Regional food shelves

VT Department of Health **3-4-50** campaign outreach to over 300 children in five schools.

3 > 4 > 50
VERMONT

Community-wide "**favorite vegetable**" contest ~ carrots are the winners!
(Students participated in getting votes of their peers)

Sponsored distribution of free cookbooks, "**Eat Well on Four Dollars a Day**" by Leanne Brown, to families at risk for food insufficiency



Hosted VT Food Bank's "**VeggieVanGo**" every month (delivery of free vegetables to the community). Serves 90 to 215 families each month. MAHHC Medical Providers give "prescriptions" for vegetables and "VeggieVanGo."

Organized a **learning kitchen class** for residents living in local subsidized housing units.

MAHHC Registered Dietician and Certified Diabetes Educator provided **nutritional counseling** on an ongoing basis.



Prevent Type 2 Diabetes Support Group workshops were held on a monthly basis from January through September. New topics were reviewed under the guidance of experts in diabetes and related fields.

Supported the "restart" of **Rachel's kitchen** – serving free community breakfast Monday through Friday year round. Served between 70 and 100 people each week.



Organized Summer Picnic series. Served daily, free lunch to children across the school district. Three locations served over an 8-week period to about 70 children per day, for a total of about **2,800** lunches served.



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for data trends

Physical Activity and Obesity

- In July 2018, MAHHC joined the first cohort of 6 hospitals expanding the RiseVT program statewide. The program increases our capacity for more opportunities related to physical activity and addresses food insecurity/nutrition in WSESU towns. Organized a 20-member, cross-sector Steering Committee to help shape plan for 2019.
- Mt. Ascutney Prevention Partnership (MAPP) conducted readiness assessments for Town Health & Wellness committees in Windsor, Woodstock, and Weathersfield.
- Community outreach related to increasing physical activity through the Vermont 3-4-50 campaign resulted in over 2,000 contacts.
- MAHHC is at the 3-4-50 Worksite Wellness "Gold" level for hosting a myriad of wellness incentives and exercise offerings.
- Disseminated "healthy policy" guides to local municipalities containing policy solutions for promoting and increasing opportunities for physical activity.



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for data trends



PROGRAM DATA

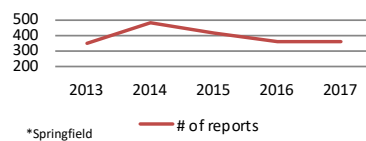
- **266** Family Wellness Coaching sessions scheduled (87% increase over previous year)
- **237** FWC sessions attended (106% increase over previous year)
- **89%** participation rate (9% increase over previous year)
- **154** families served (86% increase over previous year)
- **87** parents, care givers, educators, and providers given CPS training (180% increase over previous year)

- Family Wellness Program is embedded in the pediatric clinic and employs the Vermont Family-Based Approach methodology.
- Parent training in Collaborative Problem-Solving® (CPS).
- Windsor became a Promise Community to promote kindergarten readiness and emotional-social competence of children and families. MAHHC provided backbone support to a cross-sector steering committee. Project activities included training for early childhood educators, establishing free take-a-book boxes in 4 towns, and creating a family-friendly activity space at the Windsor Connection Resource Center.
- PATCH services at the Windsor Connection Resource Center include economic services, mental health counseling and visits for employment counseling.
- The Resource Center's economic services served 202 people, an increase from 188 in 2017; mental health counseling increased from 336 to 776; employment counseling increased from zero to 6.
- MAHHC and the PATCH team intentionally promote the four best practice approaches to address poverty:
 1. Care coordination (with OneCareVT)
 2. Volunteerism (Volunteers in Action, RSVP, Thompson Senior Center)
 3. Peer support (Turning Point Recovery Center)
 4. Financial literacy (Working United, Ready to Work, Faith and Finance)

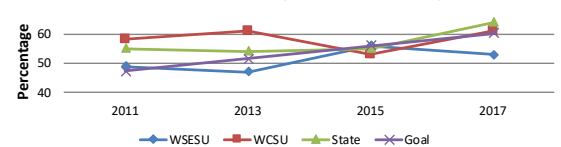
Below are some indicators we have tracked over time related to Income, Poverty and Family Stress.



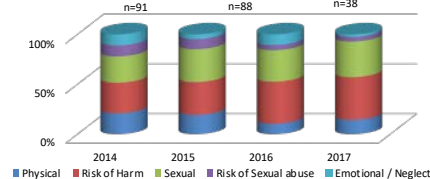
Abuse reports accepted for intervention*



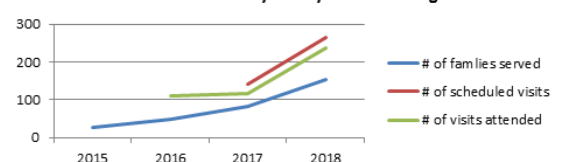
Youth who feel that they matter to community



Substantiated reports, by abuse type*



of families served by Family Wellness Program



*Springfield AHS District

Ascutey Mountain Promise Community **2018**

of family events to date **8**

of books distributed **620**



Since April, the Rides to Wellness program has assisted **30** patients and has given a total of **78** rides through Volunteers in Action, prepaid gas cards and taxi vouchers.

VOLUNTEERS IN ACTION:

49 drivers gave **826** trips for **50** people for a total of **11,314** miles.

ACCESS TO TRANSPORTATION

- Implemented Rides to Wellness pilot program with Vermont Public Transportation Association. Volunteers provided medical transportation when needed. Vouchers and gas cards were provided through our free clinic.
- Published an article with national exposure through the American Hospital Association, entitled, "Huddle for Care" about reducing barriers to transportation in a rural environment.
- April 2018, which highlighted our transportation algorithms and efforts presented a national WebEx through the federal Office of Rural Health entitled "Transportation - A Social Determinant of Health Promoting Solutions."

Access to Primary Health Care



ACCESS TO PRIMARY HEALTH CARE

- Achievement of NCQA redesignation as Level III Patient-Centered Medical Home.
- Recruitment of primary care providers.
- Community Health Team working with community partners to decrease costs and increase quality for high risk and very high risk, complex, chronic care patients.
- Care coordination outreach with SASH, Senior Solutions, VNH, BAYADA, and HCRS.
- Provided leadership for regional implementation of OneCare Vermont and Blueprint for Health programs and initiatives.



The Mt. Ascutney Prevention Partnership (MAPP) organized and implemented the following action to address tobacco product use in local communities:



- As part of the statewide “Counter Tools” campaign, worked with area convenience stores to assess youth access to and advertising for tobacco products. Retailers in 4 surrounding towns received Gold/Silver/Bronze level “Healthy Retailer” designations. 5 local stores received Silver status, and 2 achieved Gold status. Retailers were presented with a copy of the assessment and a window sticker reading, “Community Partner.” The Junction Youth Center employed 5 youth on various days to complete assessments in Hartford.
- Town presentations to selectboards on policies/ordinances related to “adult-only” products including tobacco, flavored tobacco products, cannabis products, and alcohol.
- Met with area town select board members to discuss “adult only” retail establishment and how retail outlet density, location, and product advertising can impact town culture.
- Hosted “World No Tobacco Day” at Mt. Ascutney Hospital – disseminated information on flavored tobacco products, cessation opportunities, and secondhand smoke.

- Sponsored a PSA contest for area school youth to create prevention messaging around tobacco, vaping, and alcohol use.
- Continued work with Windsor’s Autumn Moon Festival planning committee on making the Festival a smoke-free event. Worked to create Festival marketing materials advertising this status.
- Worked with Wild Women of Windsor and Windsor Rotary to sponsor tobacco sidewalk buttlers to combat tobacco litter and secondhand smoke exposure. Community partner sponsors held fundraisers to support the purchase of 12 “buttlers”
- Multiple presentations to Regional School Nurses group on vaping education to increase adult knowledge of youth vaping trends in schools and to engage them in finding solutions.
- Presented to the Upper Valley Public Health Council on regional prevention strategies for tobacco and MAPP work with towns and regional planning commissions.



 **See Page 10**
for data trends



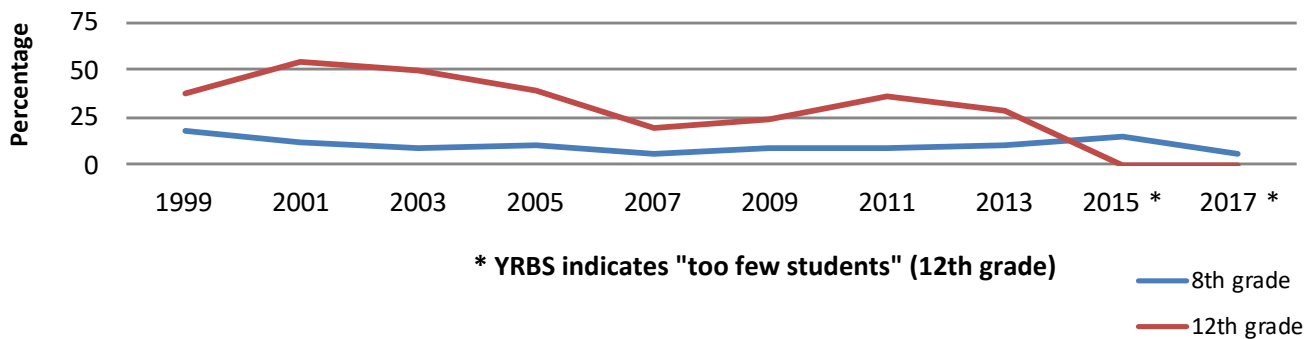
Retail stores are the primary place where tobacco companies recruit new users.

Nearly 90% of new users are underage youth. In fact, according to their own internal documents, tobacco companies try to attract new, young smokers by targeting stores near schools and playgrounds.

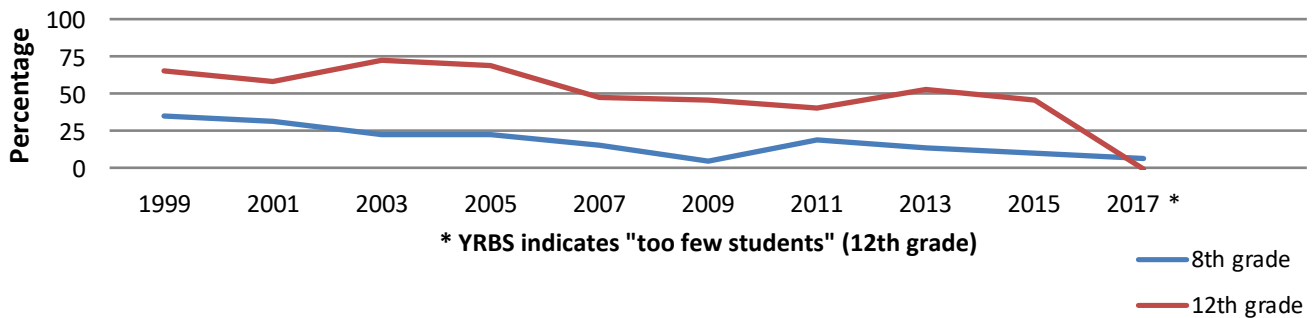
Prevention Works - Trends we are Tracking Over Time

Our work in substance misuse dates back to the late 1990s. The graphs on this page show the trends related to marijuana, alcohol, and tobacco use by 8th and 12th graders in the Windsor Southeast Supervisory Union over time. Prevention efforts at the community level are effective at lowering rates of substance use among youth.

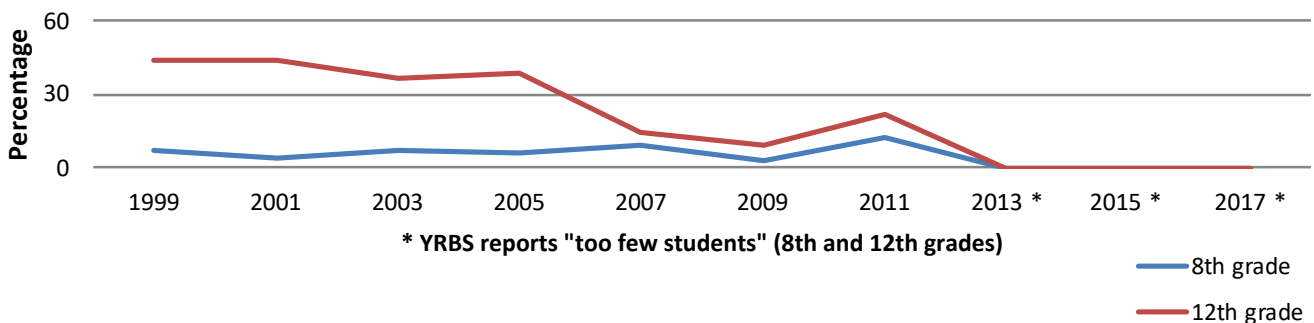
WSESU Youth, Marijuana past 30 day use trend



WSESU Youth, Alcohol past 30 day use trend

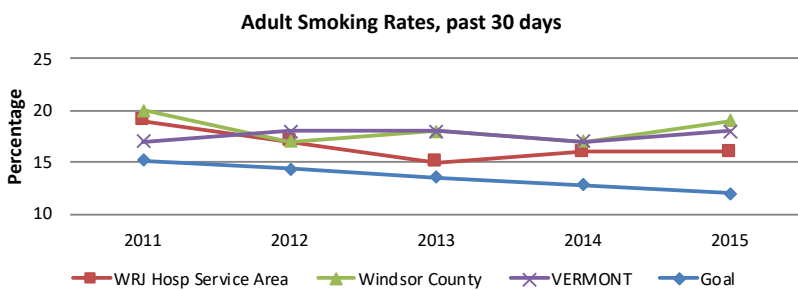
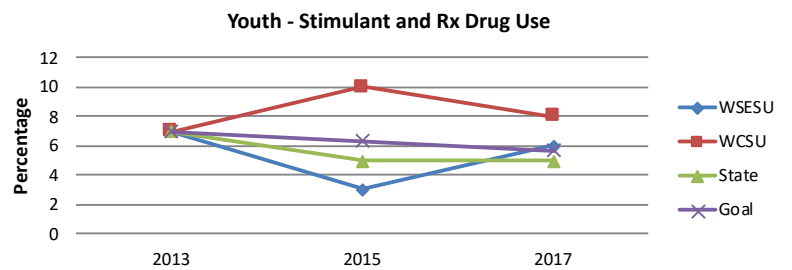
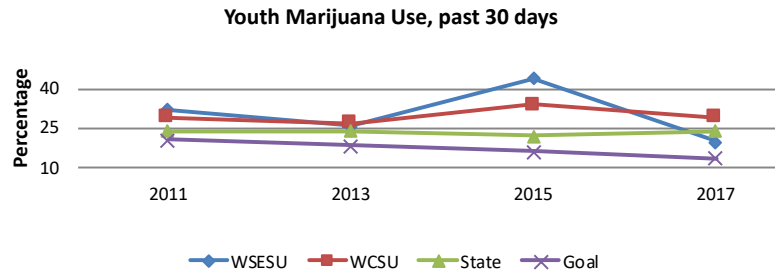
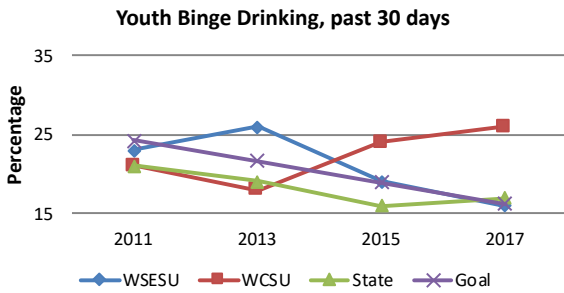
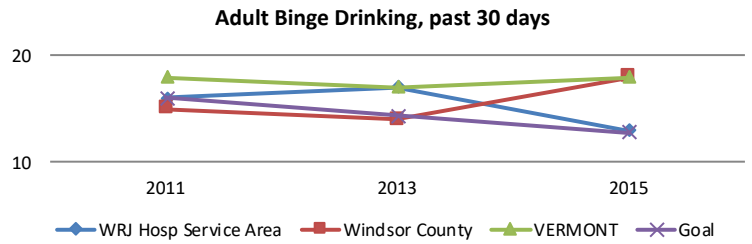
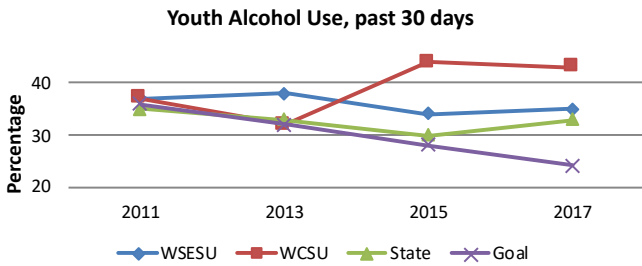


WSESU Youth, Tobacco use past 30 day trend

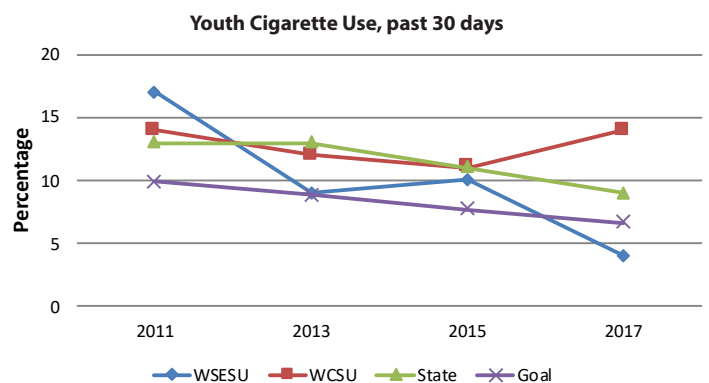
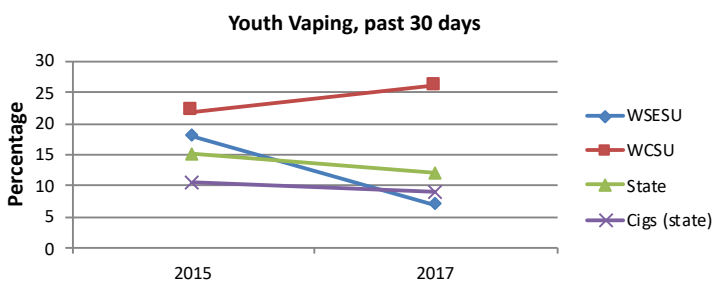


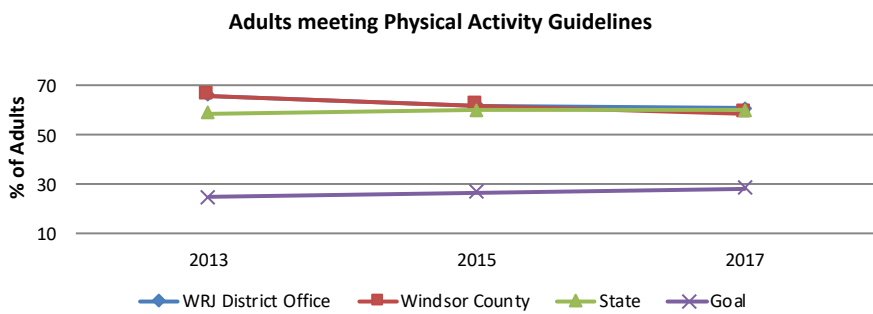
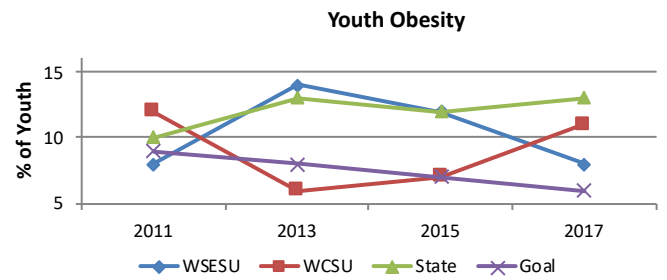
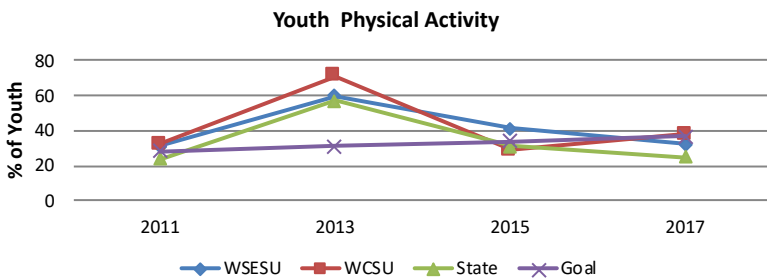
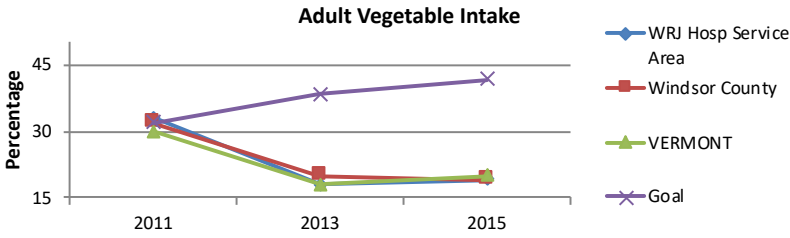
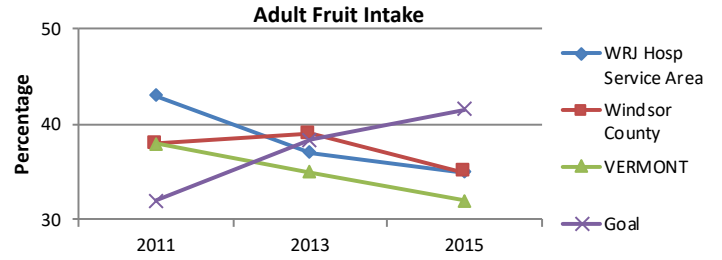
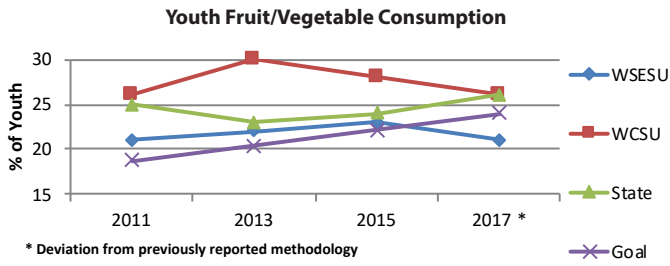
Data Sources: All youth-related graphs in this section are based on the Youth Risk Behavior Survey (YRBS). All adult-related graphs are based on data from the Behavioral Risk Factor Surveillance System (BRFSS). Both of these surveys are overseen by the Centers for Disease Control (CDC) and the Vermont Department of Health every 2 years.

Alcohol and Drug Misuse (Including Heroin & Pain Medications)



Smoking / Tobacco Use / Vaping





MT. ASCUTNEY HOSPITAL AND HEALTH CENTER COMMUNITY HEALTH – RESPONSE TO THE CHNA

Period: October 1, 2017 thru September 30, 2018
(actual cost incurred for 9 months + 3 months projected)

Description	Total Cost	MAHHC Paid	Grants, Foundations, Private Contributions
Population/Community Health at MAHHC	\$109,500	\$107,000	\$2,500
Alcohol and drug misuse (including heroin and use of pain medicines)	\$361,500	\$81,500	\$280,000
Access to mental health	\$295,000	\$290,000	\$5,000
Access to dental health	\$28,000	\$18,000	\$10,000
Access to affordable health insurance, cost of prescription drugs	\$82,500	\$15,000	\$67,500
Nutrition/access to affordable food	\$24,000	\$22,500	\$1,500
Lack of physical activity, need for recreational opportunities and active living	\$16,000	\$15,000	\$1,000
Income, poverty and family stress	\$261,000	\$17,000	\$244,000
Access to Primary Care	\$290,500	\$30,000	\$260,500
Transportation	\$93,000	\$13,500	\$79,500
	\$1,561,000	\$609,500	\$951,500