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# Community Health Benefits Report



**Mt. Ascutney Hospital and Health Center (MAHHC) is deeply committed to improving the health of the communities we serve. This report is a summary of the work MAHHC and our partners have done to improve the health and wellness in our region. We have used the Community Health Needs Assessment (CHNA) as our guide in this process.**

## 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 Implementation 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 we can develop effective, collective solutions.

In 2019 we have embarked on a new Community Health Implementation Plan based on the 2018 Community Health Needs Assessment. This plan implements a Collective Impact Approach which harnesses the strength of our multiple community partners to exponentially enhance the impact of our work. This report covers the period from 10/1/18 to 9/30/19.

*\*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 Implementation Plan, based on relevant results from the CHNA.*

## ABOUT OUR PROCESS

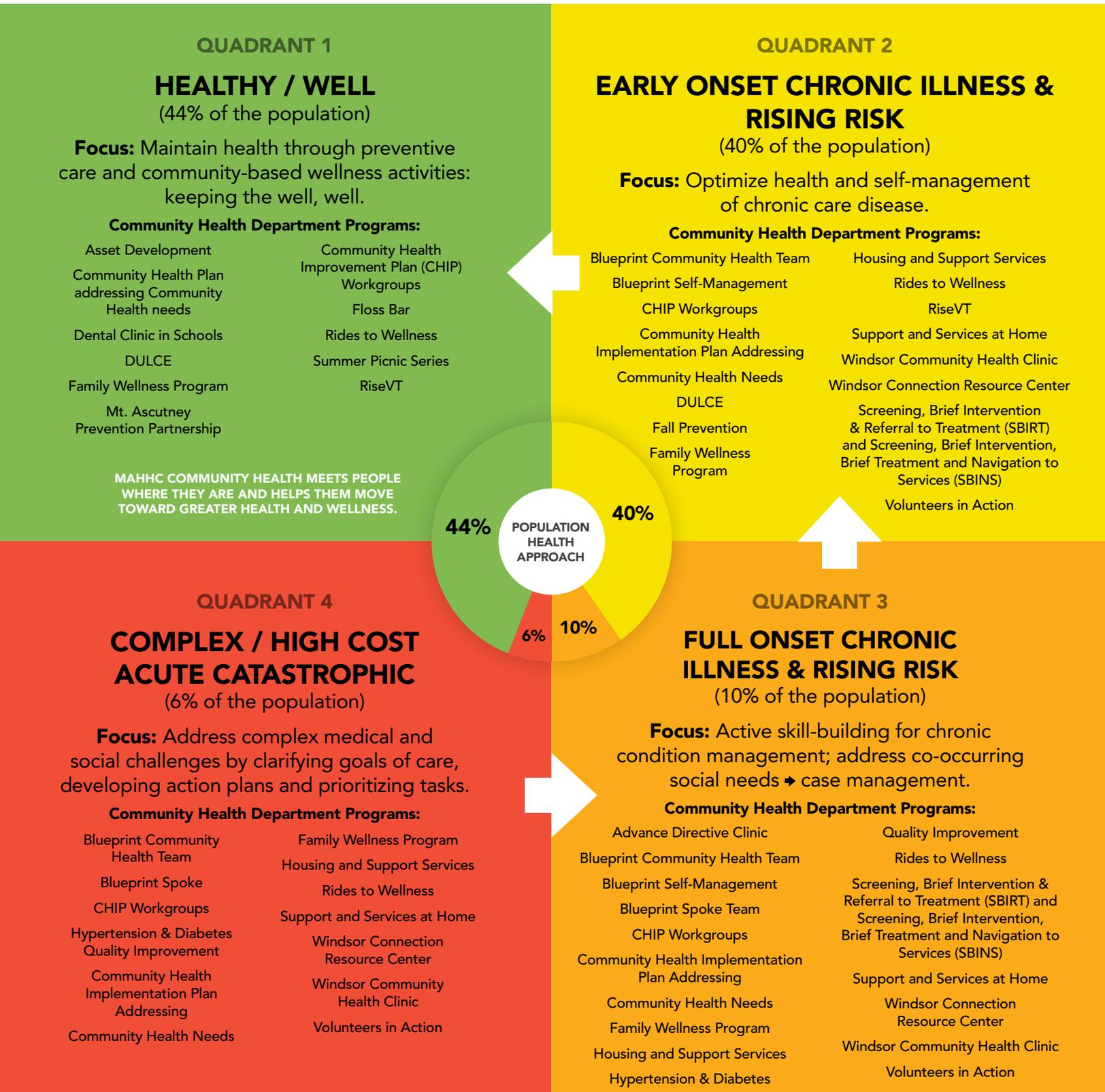
- This year starts a new 3-year cycle of Community Health Implementation Plan activity based on our 2018 CHNA
- After convening a multisector planning team, we organized and hosted two Community Health Summits in Windsor and Woodstock. The summits were designed to educate community partners and citizens about the Community Health Needs Assessment findings and involve them on an Accountable Community for Health which in a collaborative implementation plan designed to improve the health status of our communities.
- The Community Health Implementation Plan was approved by the MAHHC Board of Trustees in December 2018.
- There are 8 primary community health improvement targets identified through the Community Health Needs Assessment. Activities are organized and implemented in each of these areas. You will find the results on our new Community Health Implementation Plan delineated throughout this report.
- Of note, 4 of the community health needs priorities were selected at the two Community Health Needs Assessment summits to become the focus of multi-sector work groups convened in a best-practice learning collaborative format designed to maximize collective impact of our work. These four work groups include **Strengthening Families, Alcohol and Substance Misuse, Housing and Senior Health**. Each of these work groups were structured to identify 5 Core Elements including: A Problem Statement, Root Cause Analysis, Aim- statement, selection of a Best Practice Strategy, and pre-established Results-Based Accountability Evaluation metrics. We also required that each work group incorporate community members with first-hand experience who have been impacted by the issue throughout the work and life cycle of the group.

Mt. Ascutney Hospital and Health Center is the lead organization for our 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 (ACH) we would not accomplish our work without community partners. MAHHC Community Health meets people where they are and helps them move toward greater health and wellness. As the backbone of our ACH, we serve as leaders and integrators of groups working to improve the health and wellbeing of our communities. We form a network that can exponentially improve health by leading the Windsor Health Services Area Community Collaborative, Windsor Area Community Partnership, Planned Approach to Community Health (PATCH), Windsor Area Drug Task Force, Community Health Teams, and Mt. Ascutney Prevention Partnership. As partners, we participate in the Green Peak Alliance (a network of substance misuse prevention coalitions) and in the Hartford and Springfield Integrative Services and OneCare Vermont leadership teams.



## QUADRANT 1

### HEALTHY / WELL

(44% of the population)

**Focus:** Maintain health through preventive care and community-based wellness activities: keeping the well, well.

#### Community Health Department Programs:

- Asset Development
- Community Health Plan addressing Community Health needs
- Dental Clinic in Schools
- DULCE
- Family Wellness Program
- Mt. Ascutney Prevention Partnership
- Community Health Improvement Plan (CHIP) Workgroups
- Floss Bar
- Rides to Wellness
- Summer Picnic Series
- RiseVT

## QUADRANT 2

### EARLY ONSET CHRONIC ILLNESS & RISING RISK

(40% of the population)

**Focus:** Optimize health and self-management of chronic care disease.

#### Community Health Department Programs:

- Blueprint Community Health Team
- Blueprint Self-Management
- CHIP Workgroups
- Community Health Implementation Plan Addressing Community Health Needs
- DULCE
- Fall Prevention
- Family Wellness Program
- Housing and Support Services
- Rides to Wellness
- RiseVT
- Support and Services at Home
- Windsor Community Health Clinic
- Windsor Connection Resource Center
- Screening, Brief Intervention & Referral to Treatment (SBIRT) and Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS)
- Volunteers in Action

## QUADRANT 4

### COMPLEX / HIGH COST ACUTE CATASTROPHIC

(6% of the population)

**Focus:** Address complex medical and social challenges by clarifying goals of care, developing action plans and prioritizing tasks.

#### Community Health Department Programs:

- Blueprint Community Health Team
- Blueprint Spoke
- CHIP Workgroups
- Hypertension & Diabetes Quality Improvement
- Community Health Implementation Plan Addressing
- Community Health Needs
- Family Wellness Program
- Housing and Support Services
- Rides to Wellness
- Support and Services at Home
- Windsor Connection Resource Center
- Windsor Community Health Clinic
- Volunteers in Action

## QUADRANT 3

### FULL ONSET CHRONIC ILLNESS & RISING RISK

(10% of the population)

**Focus:** Active skill-building for chronic condition management; address co-occurring social needs → case management.

#### Community Health Department Programs:

- Advance Directive Clinic
- Blueprint Community Health Team
- Blueprint Self-Management
- Blueprint Spoke Team
- CHIP Workgroups
- Community Health Implementation Plan Addressing
- Community Health Needs
- Family Wellness Program
- Housing and Support Services
- Hypertension & Diabetes
- Quality Improvement
- Rides to Wellness
- Screening, Brief Intervention & Referral to Treatment (SBIRT) and Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS)
- Support and Services at Home
- Windsor Connection Resource Center
- Windsor Community Health Clinic
- Volunteers in Action

# COMMUNITY HEALTH ORGANIZATIONAL CHART

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

**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
<b>Windsor Connection Resource Center</b>	Steve Henry, Service Coordinator – <b>0.5</b>	Susan Whittemore, Service Coordinator – <b>0.5</b>	Carol Rice, Shannon Lagrow, Louise LaCroix – <b>Per Diem</b>				
<b>Family Wellness Program</b>	Courtney McKaig, Wellness Coach – <b>0.75</b>	Katrin Tchana, MSW, Family Wellness Therapist – <b>0.5</b>	Alice Stewart, Evaluation – <b>0.01</b>				
<b>RiseVT</b>	Alice Stewart, RiseVT Program Manager – <b>0.37</b>	Elizabeth Kelsey, Communications Specialist – <b>0.05</b>					
<b>Mt. Ascutney Prevention Partnership</b>	Melanie Sheehan, Reg. Prevention Program Mgr – <b>0.90</b>	Courtney Hillhouse, Community Outreach – <b>1.0</b> Elizabeth Kelsey, Communications Specialist – <b>0.7</b>	Alice Stewart, Grant Implementation Team Leader – <b>0.62</b>				
<b>Blueprint Self-Management</b>	Sarah Doyle, Coordinator – <b>0.5</b>						
<b>Windsor Community Health Clinic (self-management programs)</b>	Samantha Ball, Coordinator – <b>1.0</b>	Kristi Clark, Assistant Coordinator – <b>0.3</b>					
<b>Housing and Support Services</b>	Bess Klassen-Landis – <b>0.22</b>						
<b>Support and Services at Home</b>	Rita Rice, RN – <b>0.17</b>						
<b>Volunteers in Action</b>	Lori Rogers – <b>0.9</b>	Scottie Shattuck – <b>0.725</b>	Martha Zoerheide – <b>Per Diem</b>				
<b>Blueprint Community Health Team</b>	Carla Kamel – <b>1.0</b> Liz Sheehan, RN – <b>1.0</b>	Amy Swarr, RN – <b>1.0</b>	Jenna Austin – <b>1.0</b>				
<b>Blueprint Spoke Team</b>	Suzette Barbour, RN – <b>1.0</b> Gail Mears – <b>0.5</b>	Ashley Hutton, RN – <b>1.0</b>					

**Alignment to OneCare Vermont’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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**Improving the mental health status of our community is a critical component of our plan. The following delineates the effort we have invested in this goal:**

- **A full-time psychiatrist** is embedded in the Patient-Centered Medical Home.
- We have a contractual agreement for **monthly pediatric psychiatry consultation**.
- We have an **embedded HCRS clinician available** in our PCMH 3-4 days a week.
- We have provided **2 Wellness Recovery Action Plan (WRAP) self-management courses**.
- We have provided **5 Mental Health First Aid courses** (adult) - mental health and suicide prevention.
- We have provided **2 Mental Health First Aid courses** (children) - mental health and suicide prevention.
- We have provided **419 mental health counseling sessions** at the Windsor Connection Resource Center.
- We have distributed **7 cases of gun locks** as part of our suicide prevention initiative.
- We have **increased staff support** through Chaplaincy services.
- We have **updated our community-based Mental Health Resource Guide**.



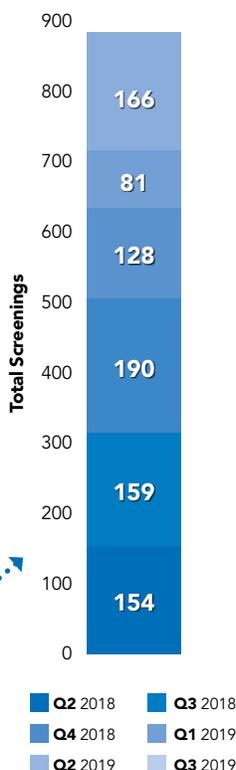
## Alcohol and Substance Misuse

**Alcohol and substance misuse is a pervasive condition which leads to chronic disease and death. The following is the effort we have invested to improve this problem:**

### MEDICAL-BASED PREVENTION, TREATMENT AND RECOVERY

- We track and disseminate the outcomes of the quarterly Vermont Prescription Monitoring System.
- Windsor County has achieved the lowest rate of opioid analgesic prescriptions in the state for 3 years.
- Windsor County has a second lowest rate of prescriptions of benzodiazepines and stimulus medications for 3 years.
- We have implemented Screening Brief Intervention and Referral to Treatment (SBIRT) in the clinic. **In 2019, 384+ individuals were screened and referred to treatment as indicated.**

**SBIRT Screenings Completed**



MAHHC hires staff in conjunction with the Blueprint for Health within the Hub and Spoke Program. We provide nurses and counselors in specialty addiction practices of Connecticut Valley Recovery Services and Bradford Psychiatric Associates. We also provide Spoke staff support at OHC and for pediatric patients receiving Medication Assisted Therapy. Two of our Spoke nurses have become certified in acupuncture for recovery. This certification is called Acudetox.

In September 2018, a second Opiate Death Summit was held and 4 goals were identified to reduce deaths in Windsor County. One goal was to create an effective recovery network for our region. To this end, MAHHC took action. With the leadership of Dr. Perras, intensive work has been done by Dr. Marasa, Seamus Geoghegan RN and their team in the Emergency Department to open up Rapid Access to Medication Assisted Therapy. Best practice protocols were implemented. This program links patients struggling with addiction directly to therapy at Connecticut Valley Recovery Services for ongoing care. Our Emergency Department has also become a Naloxone distribution site for the community placing lifesaving medication in the hands of friends and relatives whose loved ones otherwise may have died from an overdose.

A multidisciplinary team consisting of a primary care provider, an addiction specialist provider, a pain specialist provider, a psychiatrist, a physical therapist, a recreational therapist, hospital administrator, self-management

## COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP

Alcohol and substance misuse was identified as one of the top community health needs. Through a series of community health summits, this issue was identified as a priority and a multisector work group was formed.

*“The thoughtfulness and passion in the CHIP workgroup has been remarkable. I am thrilled to be a part of this critical effort.”*

– Kate Lamphere, HCRS

## SUBSTANCE MISUSE PARTNERS

- MAHHC
- Turning Point Recovery Center- Springfield
- Artistree
- Southern Vermont Area Health Education Center
- Statistical and Evaluation Research
- Vermont Department of Health
- Valley Court Diversion Program
- Health Care and Rehabilitation Services
- The Family Place
- Two Rivers Ottauquechee Regional Planning Commission
- Trinity Evangelical Church
- Qualidigm
- Vermont State Senate
- TLC Nursing
- United Ways VT & VT-211
- HIV/HCV Resource Center
- Second Wind Foundation

coordinator, massage therapist, and acupuncturist continue to meet on a monthly basis to provide consult and support to providers managing the care of chronic pain patients.

The Community Health Implementation Plan has incorporated an Alcohol and Substance Misuse, Treatment and Recovery Work Group whose aim is to decrease barriers to treatment.

We have provided two Blueprint Self-Management Workshops for chronic pain management.

MAHHC worked with Springfield Turning Point Recovery Center to prepare for and implement a program that links Recovery Coaches to patients in the Emergency Department for support in the recovery process for Substance Use Disorder. This service is available 7 days a week 24 hours a day. Once the patient consents, the Recovery Coaches will meet with the patient in the Emergency Department. They will also follow the patient to provide support in the first 10 days after their Emergency Department visit.

Recovery Coaches have been a true strength to the work of the Community Health Implementation Plan work group

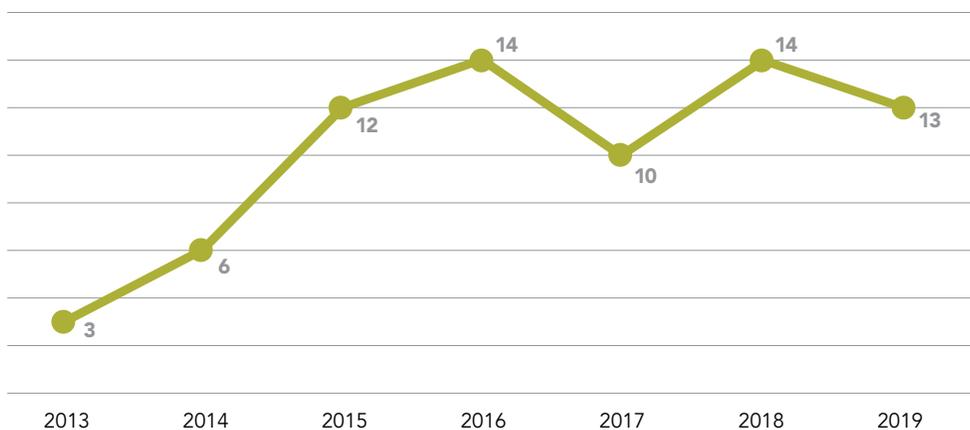
for Alcohol and Substance Misuse.

Individuals receiving Medication Assisted Therapy have previously been isolated from the recovery networks. We have intentionally linked patients in our Spoke practices to the Turning Point Recovery Centers of Springfield and Wilder.

MAHHC has hosted AA and Al-Anon meetings for more than 25 years.



Number of opioid-related fatalities recorded in Windsor County



### PROBLEM STATEMENT

Substance misuse (all substances) treatment options are underutilized by the adult population.

### ROOT CAUSES

The components contributing to the adult population under-utilizing treatment include System, Resources, Environment, and People. The root causes are complex and do not indicate that there is a lack of availability of treatment options, but a lack of personal engagement, for various reasons.

### AIM STATEMENT

Decreasing the following barriers to substance misuse treatment for adults in the Windsor Health Services Area within 3 years: availability of services, stigma (guilt and shame), life circumstances & competing priorities/chaos, and ambivalence with regard to recovering.

## COMMUNITY-BASED PREVENTION

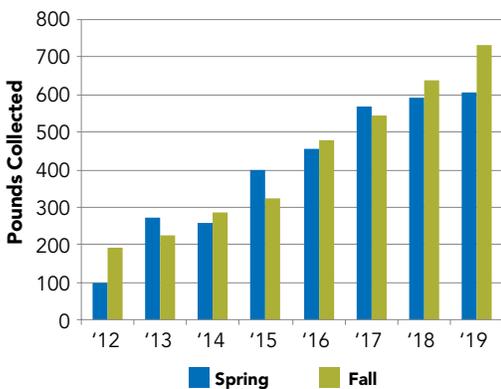
Mt. Ascutney Hospital was the sole recipient of a VT Department of Health Prevention Network Grant (PNG) issued in July of 2019. The PNG is a capacity and infrastructure building grant that will allow MAHHC to subaward prevention funds to the Windsor and Orange County Communities in 2020. The Mt. Ascutney Prevention Partnership (MAPP) is a division of the Community Health Department that implements prevention initiatives at the local level.



MAPP works with multiple partners to successfully decrease access to dangerous medications or “adult only” substances, increase policies that work to prevent substance misuse, and finds ways to increase factors that protect youth and communities from risky choices. This past year, we have worked to launch a new website: visit [www.mappvt.org](http://www.mappvt.org). Other activities included:

- Disseminated 30 prescription medicine mail-back envelope kiosks across Windsor and Orange Counties through multiple partnerships. Created “home visitors” prescription medicine mail-back envelope packets for distribution through Visiting Nurse, Senior Solutions, Meals on Wheels, SASH, and others.
- Continued to support biannual Drug Take Back Days.
- Purchased Michigan Model Prevention Curricula for 100% of Windsor Southeast Supervisory Union (WSESU) schools.
- Created school policy checklist for schools working to assess strengths and opportunities for improving existing policies aimed at preventing youth substance misuse.
- Co-created Town Plan Health Chapter Template with Two Rivers Ottauquechee Regional Commission. Chapter was adopted by towns of Bridgewater, Plymouth, and is being considered by others.
- Created and presented to two municipalities on the impacts of Marijuana Commercialization in an effort to engage in a town visioning process.
- Conducted a new marijuana law survey across Windsor and Orange Counties, generating 685 total responses. Engaged data analyst to draft report and then used results to design marijuana education campaign.
- Created CBD informational flyer, CBD press release, and shared across communities and with Pediatric Clinics.
- Attended National Public Health Marijuana Summit.
- Provided facilitation of community dialogue around community action and prevention in town of Hartland and in Windsor Central Supervisory Union (WCSU). Supported WCSU in addressing substance misuse in new District Strategic Plan and provided ongoing support for Student Assistance Professional (SAP) and Empower Up! mentoring program.
- Contract and support for Gifford Health Center and Little Rivers Healthcare to address gaps in Prevention efforts across Orange County.

**Windsor County**  
Drug Take Back Totals



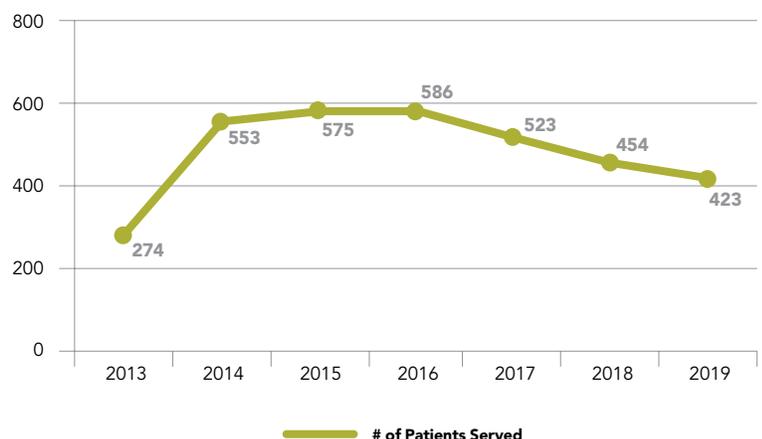
See Page 15 for data trends

## Access to Affordable Health Insurance and Prescription Medication

**The Windsor Community Health Clinic is an embedded service of our Patient-Centered Medical Home. We have been members of the Vermont Coalition of Clinics for the Uninsured (VCCU) for over 20 years. We have:**

- Increased voucher limits for dental and medications from \$500 and \$150 to \$1,000 and \$400.
- Partnered with Best Taxi to provide rides for NH residents.
- Made strides in community outreach and provided open enrollment discussions to increase awareness of Medicare and Vermont Health Connect. Norwich Library and Thompson Senior Center hosted these events.
- A dental grant application was created to streamline the voucher request process and ensure the best use of grant funds to serve as many people as possible.

**WCHC # of Patients Served**



## Windsor Community Health Clinic

### Connecting a Young, Working Vermonter with Medications and Health Insurance

John\*, a 22-year-old man with a full-time job, presented to the Mt. Ascutney Hospital and Health Center Emergency Department seeking immediate medical assistance. His employer did not provide health insurance as a benefit and, as a consequence, John was uninsured. Nonetheless, he needed medical attention – and, more immediately and importantly, medications he could not afford. Without being able to purchase those medications, John would have to be admitted to the hospital as an inpatient in order to receive the necessary care.

To assist with the situation, the Windsor Community Health Clinic (WCHC) was called to see what could be done.

Staff went to the ED and met with the patient to screen him. They determined he was outside of the financial limit for Medicaid. Since it was April, he was also outside the open

enrollment period for obtaining insurance through the Health exchange. This is a common predicament that is encountered regularly as free clinic leaders seek to provide timely referral and counseling services to patients in need.

WCHC was able to purchase the medications John needed through a grant, and he was also set up with free medications through a pharmaceutical company. In addition, he was scheduled for an appointment during the open enrollment period in November so insurance options could be reviewed with him.

Back on the road to wellness, John made it to that November appointment with WCHC. He enrolled in an MVP health care plan for 2020 and can now afford the medications he needs to continue his care.

\*The patient's name has been changed to respect privacy, protect identity, and assure confidentiality.

## Strengthening Families: (Including Poverty and Childhood Trauma)

### Comments from families describing how the Family Wellness Program benefited them:

- “ Courtney gave us visuals to help with our child. Ideas of schedules for routines, dinner discussions and bedtime discussions to unwind for our children's day and we continue to use all of these.”
- “ Talking in a calm manner about anxiety and how things and people are mostly good. Doing peach/pit at dinner.”
- “ I think we are learning to consider our son's perspective much more than we did prior to working with Courtney. We are also learning how to be calmer during really tricky moments.”
- “ Courtney was a huge help in working with us to problem solve some trouble we were having with our 4-year-old. She gave us great insight and ideas which have made a positive impact on his behavior and our family well-being.”
- “ Helped our daughter find ways to overcome her anxiety.”

### FAMILY WELLNESS

The Family Wellness Program is embedded in the Pediatric Clinic and follows the Vermont Family Based Approach. The Family Wellness Program at Mt. Ascutney Hospital and Health Center embeds a Family Wellness Coach and Family Therapist in the Pediatric Clinics of MAHHC and OHC.

The program was developed in collaboration with the Vermont Family Based Approach, which was created by Dr. James Hudziak at the Vermont Center for Children, Youth and Families at the University of Vermont Larner College of Medicine. The Family Wellness Program adheres to 3 wellness principles: emotional behavioral health is the foundation of all health; health runs in families; we can change our brains through certain practices. The program's Wellness Coach works to keep the well, well, and to protect families who are at risk, while the Family Therapist treats families whose emotional behavioral health has been traumatized. The program's wellness domains include parenting, mindfulness, nutrition, exercise, reading, sleep/relaxation, music, and community involvement. Participating families receive individual education, counseling, and support, as well as group parenting workshops.

In 2019, there were 230 referrals to the program. Our data shows:

- **127** individual patients were seen by the Wellness Coach in 233 sessions.
- **86** individuals were seen by the Family Therapist in 336 sessions.
- **A total of 213** individuals were served in 569 sessions.
- **28** parents, caregivers, educators and providers given CPS training.
- **6** parents, caregivers, educators and providers given circle of security training (100% increase over previous year).
- **92%** of families reported that their experience with the Family Wellness Program was valuable.
- **92%** of families reported that they learned positive ways to interact and guide behavior of their child/children.
- **96%** of families reported they were able to get an appointment in the time frame that worked for them.
- **92%** of family stated they would recommend the Family Wellness Program to other families.

## DULCE PROGRAM

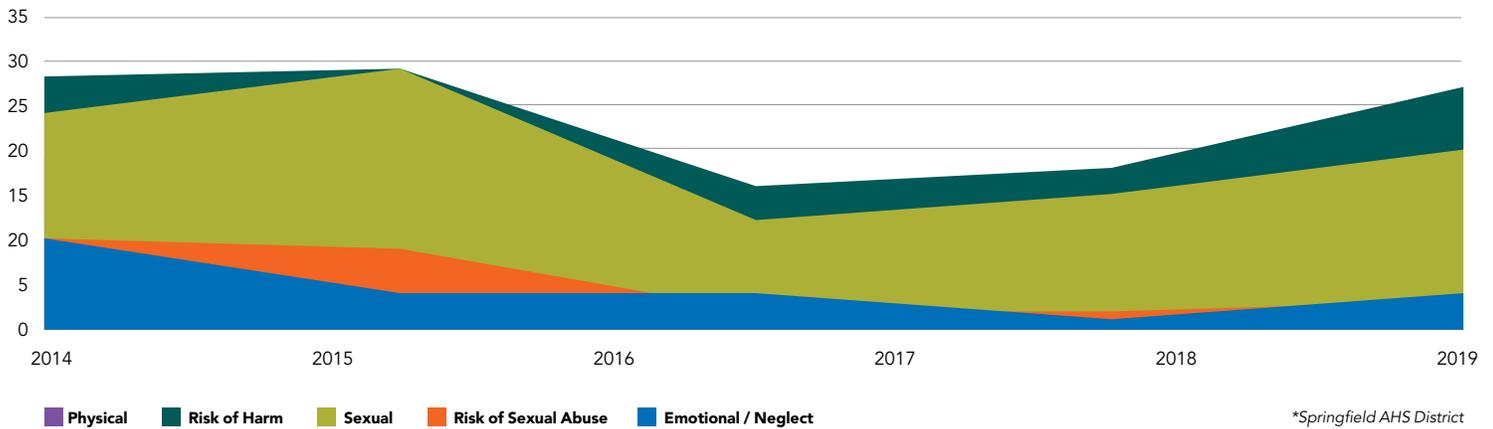
MAHHC and OHC Pediatric Programs were selected to become a DULCE site. (Developmental Understanding and Legal Collaboration for Everyone)

Funding from Vermont Department of Health Title 5 funding and OneCare Vermont funding has been given to the Springfield Parent-Child Center and Family Place Parent-Child Center to embed two family specialists. These family specialists serve infants 0-6 months in the DULCE Program and care coordination for children and families 0-6 years of age. This year intense planning was done for an implementation date in November 2019.

**DULCE is unique** in its approach by:

- Sharing well child visits with the pediatrician and a family specialist together.
- Employing a medical-legal partnership for patient reviews.
- Delivering a high level of integration between the medical practice, The Parent-Child Center, and community resources.
- Delivering a safety net for families by addressing the social determinants of health that impact their lives.

**Child Abuse & Neglect: Substantiated Reports, by Type\***



## DEVELOPING ASSETS

*Sled Dog Disco* is the name chosen for a group of MAHHC staff and others from the community who have worked together to create asset development activities in our community in an effort to build a flourishing community. Some of the activities coordinated by Sled Dog Disco in 2019 are:

**In December 2018, the group identified two themes for the focus of our work:**

1. Families → connected
2. Teenagers → valued

**For supporting families feeling connected, Sled Dog Disco:**

- Supported the Ascutney Mountain Promise Community 1<sup>st</sup> Annual New Year's Eve Noon Countdown.
- Hosted a Celebrate Summer event to kick off the Summer Picnic Series at WCRC.
- Recruited providers for activities during the Summer Picnic Series at WCRC.
- Sponsored a school supplies drive for all children in WSESU participating in the Summer Picnic Series – partnered with MAHHC, Mascoma Bank, and Peoples Bank to gather supplies using a Giving Tree model.

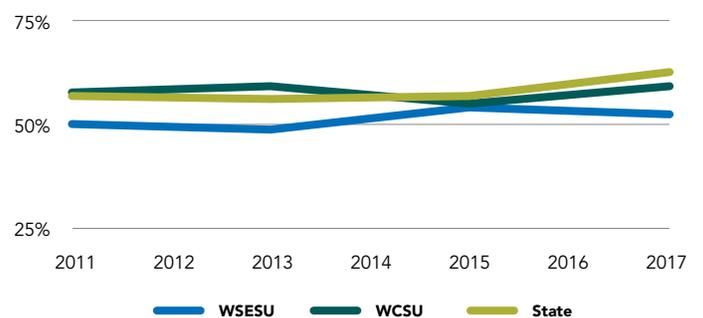
**For working to help teenagers feel valued:**

- Recruited teens to help out on Fridays during the Summer Picnic Series to provide asset development opportunities for both the teens and children participating in the program.
- Worked with the Girls Learn International Club at Windsor High School on a variety of initiatives, including coaching on quality improvement, pointers on how to work with legislators, and gathering input to improve summer meals.
- Provided support to group of students exploring the feasibility of establishing a teen center in Windsor.

**Other activities included:**

- Maintained fully-stocked Promise Community book boxes.
- Partnering to launch Little Free Libraries in Windsor and Hartland – maintained stocking of Windsor book box.

**Youth Who Feel They Matter to the Community**



## STRENGTHENING FAMILIES COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP

Strengthening Families, Including Poverty and Childhood Trauma was identified as one of the top community health needs. Through a series of community health summits, this issue was identified as a priority and a multisector work group was formed.

*“We are an inclusive, diverse, open group of passionate, committed community members in the Upper Valley and surrounding regions of Vermont. We share a vision that families will have the resources and skills to have joy and support for each member to nurture growth and resilience. To accomplish this, we will work to help communities (however they are defined) recognize their role, responsibility and opportunities in strengthening families. We believe every person has a stake in strong families.”*

– Sara Kobylenski, Courtney McKaig, & Geraldine Fowler- Couch Family Foundation, Mt. Ascutney Hospital and Health Center, & Unitarian Universalist Church Woodstock.

## PATCH

MAHHC provides the leadership for PATCH, a collaboration of health and human service providers who offer services at the Windsor Connection Resource Center (WCRC). PATCH services at the Windsor Connection Resource Center provided 295 visits for Economic Services. This is an increase of 93 people when compared to 2018. Care was provided for community members experiencing domestic violence/assault from WISE. There were 113 visits in 2019. The Windsor Connection Resource Center also provided support for 101 requests related to childcare. Major issues addressed by the team this year include:

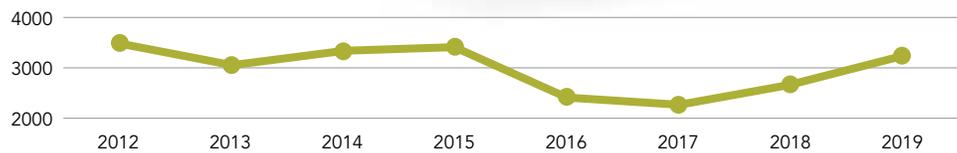
- Creation of a WISE satellite at WCRC for outreach services for domestic violence, abuse, stalking and human trafficking.
- Creation of a community team of drivers for the Warming Shelter.
- Installation of a washer, dryer and shower for use by the homeless and families in need.
- Partnership in the Community Health Implementation Plan.
- Increase in support for community in the areas of: crisis fuel, electric, shelter, economic services, housing/homelessness and child care.

## Success through guidance...

*In June of 2019 I began working with a 35 year old single mother of a 7 year old daughter. This young mom was struggling with addiction and numerous medical issues that prevented her from working and maintaining a stable household. She had previously held three jobs- two part time and one full time to provide a good life for her and her daughter. Well bad times hit and this young mom suffered severe hip/back injuries and was prescribed opiates for pain. It took no time and she was hooked. After admitting herself to the Brattleboro Retreat she began working with a licensed therapist in Springfield and asking me if she had a chance to become eligible for Social Security Disability. She was referred to work with SS Specialist Marie Zukowski of VABIR. Marie provides supports through the first two of three stages of applying for disability. After many trying events in her life and working extremely hard to better herself, this young woman was ultimately approved for SSDI. Not only will she make almost as much as she did when she worked, but she was able to parlay this success into a new, safer, bigger apartment closer to her daughter's school. Not only is it now sustainable but they are all safer and happier in a new location. This is a fine example of guiding a person thru the system to obtain the positive outcome necessary to grow and thrive in a community setting.*

– Bob Brickey, Reach Up Case Manager, Springfield, VT

# of People Served by WCRC



## STRENGTHENING FAMILIES PARTNERS

- MAHHC
- WISE
- Windsor Southeast Supervisory Union
- Windsor Rotary
- MoonRise Therapeutics
- Town of Hartland
- HCRS
- Building Bright Futures
- Vermont Community Foundation
- Windsor Central Supervisory Union
- UU Church-Woodstock
- Windsor Southeast Supervisory Union
- DHMC
- VISTA
- Southern Windsor County Regional Planning Commission
- Gifford Medical Center
- Springfield Area Parent Child Center
- Upper Valley Haven
- The Family Place
- Two Rivers Ottauquechee Regional Planning Commission
- Vermont Department of Health
- Vermont Agency of Human Services
- Couch Family Foundation
- United Ways VT & VT-211
- Ottauquechee Health Foundation
- Windsor County Head Start

### PROBLEM STATEMENT

Why are not more children socially and emotionally ready for kindergarten?

### ROOT CAUSES

Social isolation is the root cause that we identified as most actionable and most impactful.

### AIM STATEMENT

To increase social connections of caregivers in the Mt. Ascutney Hospital service area within the next 5 years.

**Mt. Ascutney Hospital and Health Center is a NCOA recognized Patient-Centered Medical Home. Being a Patient-Centered Medical Home means that we meet or exceed all of the required standards of best practices for primary care.**

Access to primary care was identified as one of the top community health needs. Much work has been done to increase access to primary care. In 2019, 3 new primary care providers were hired.

Much work was done in 2019 by a primary care team led by Dr. Leesa Taft, DNP, ARNPC, Director of Clinical Operations in Primary Care, to prepare for the new NCOA recognition process. This process has now become an annual process.

Our Community Health Team working with community partners to provide care coordination and interventions that will improve the quality of care for high risk and very high risk complex chronic care patients and decrease the cost of care. MAHHC has provided leadership for regional implementation of a care coordination process with our community partners of SASH, Senior Solutions, VNH, Bayada and HCRS. We have begun to use the Care Navigator system from OneCare Vermont which is an electronic platform that allows unified care plans, interventions and team members to be identified. The following graphs identify the

extent of our care coordination activities along with those of our community partners.

MAHHC has provided leadership for regional implementation of OneCare Vermont and Blueprint for Health Programs and initiatives.

We have created a Dashboard of metrics regarding diabetes and hypertension to reflect the quality improvement work accomplished by the clinic providers to improve outcomes in a Population Health Approach. This Dashboard is presented to the Windsor HSA Community Collaborative on a quarterly basis. The 10/16/2019 Quarterly Dashboard as presented, is below.

Self-Management Workshops have been provided through the support of the Blueprint for Health in an effort to prevent disease, reduce complications and improve the quality of life of those with chronic conditions. These workshops include pre-diabetes, diabetes, chronic pain, mental health, and chronic disease.

## QUALITY IMPROVEMENT INITIATIVES



### Skill building workshops trends

	# groups	# registered	% complete
2014	17	189	35%
2015	11	119	51%
2016	13	89	39%
2017	12	92	49%
2018	8	54	83%
2019	12	72	80%

### Hypertension

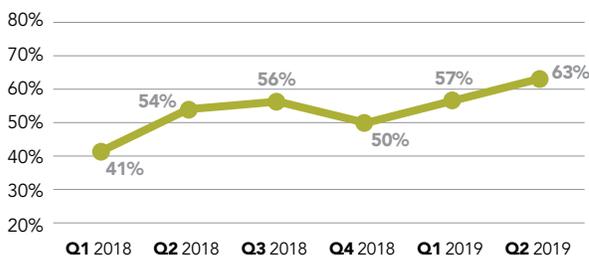
- Providers are following best practice guidelines in caring for patients.
- CCNs have developed disease management protocols and patient education, providers refer to CCNs for follow up.
- Chronic disease self-management classes are offered.
- Kathleen Meyers, RN is leading a Green Belt Quality Improvement project, the goal of actively capturing 2nd BP measurement when the first is out of range.

### Diabetes Care

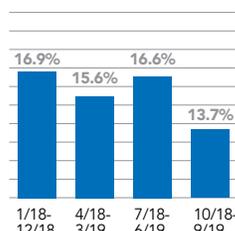
- 72% improvement in diabetic patients with an A1C test in the last 12 months.
- Dr. Levin is leading a quality improvement process, has developed a best practice algorithm and protocol and has worked with providers to implement it.
- CCNs have best practice order sets for lab work, patient education and follow up.
- Nancy McCullough, RN, CDE managed a best practice ADE recognized diabetes clinic.
- Nancy McCullough, RN, CDE and Linda Wilson, APRN, DNP taught diabetes and pre-diabetes self-management classes.

### Blood pressure in control:

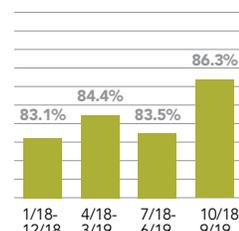
% of Mt. Ascutney Hospital patients with hypertension whose last blood pressure measurement was in control



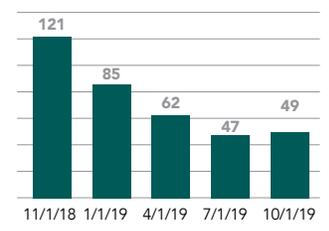
A. % of patients with diabetes whose most recent A1c was >9



B. % of patients with diabetes whose most recent A1c was in control (6.5 - 9)



C. Number of patients with diabetes with no A1c test in the past 21 months



## COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP

Care for our rural seniors was identified as one of the top community health needs. Through a series of community health summits, this issue was identified as a priority and a multisector work group was formed.

*“ This group is passionate about and committed to connecting the older Vermonters in their communities with services. It’s inspiring to be in the role of co-facilitator with them.”*

— Mark Boutwell, Senior Solutions

## SENIORS PARTNERS

- MAHHC/OHC
- Thompson Senior Center
- Ottauquechee Health Foundation
- Aging in Hartland
- Green Mountain RSVP
- Support and Services at Home (SASH)
- Health Care & Rehabilitation Services (HCRS)
- UU Church Woodstock
- VISTA
- Senior Solutions
- Vermont Department of Health
- Granite United Way
- Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)
- Scotland House
- Volunteers in Action
- OneCare VT
- Seniors Together
- Qualidigm
- Scotland House
- Vermont-211



**Vermont has the highest percentage of rural elders in the nation. MAHHC has worked to improve health care for elders in the following ways:**

- We have convened a group initiated by Hartland Aging in Place called Seniors Together. This group explored the opportunity of creating a senior center without walls.
- Volunteers in Action has actively worked with local communities to strengthen Aging in Place groups.
- We have engaged seniors in our intergenerational programs such as becoming pen pals with high school students and writing notes to our youth that were distributed with school supplies.
- We have established a regional, community-based Falls Prevention Best Practice Program. This program led by MAHHC partners with EMS in Woodstock and Windsor, Historic Homes of Runnemedede, Olde Windsor Village, Retired Senior Volunteer Program (RSVP), the Collaborative Care Nurses of our Patient-Centered Medical Home, MAHHC Physical Therapy, long-term care facilities from our region, and visiting nurse agencies from our region in the adoption of a the CDC’s recommended STEADI system.
- We have provided interagency care coordination and care management through the Community Health Team and our community partners for high risk chronic care elders.
- We have provided leadership and Board participation in the creation and first year of operations for 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. This involved several quality initiatives with MAHHC’s Patient-Centered Medical Home including hypertension and diabetes.
- The Housing and Supportive Services (HASS) coordinator is a MAHHC employee who has worked to decreased social isolation by providing one-on-one visiting as well as classes and events which include book clubs, gardening, crafts, art and music.

### PROBLEM STATEMENT

Seniors are not accessing services that are available to them.

### ROOT CAUSES

There is a lack of knowledge around resources amongst seniors.

### AIM STATEMENT

To increase the connection of seniors to needed resources in the Mt. Ascutney Hospital service area within the next 3 years.

## COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP

Concern about access to affordable housing was identified as one of the top community health needs. Through a series of community health summits, this issue was identified as a priority and a multisector work group was formed.

### HOUSING PARTNERS

- MAHHC
- Vital Communities
- Twin Pines Housing Trust
- Aging in Hartland
- Springfield Supportive Housing
- Southeastern Vermont Community Action
- Southern Windsor County Regional Planning Commission
- Granite United Way
- Southern Vermont Area Health Education Center
- Woodstock Economic Development Commission, Woodstock Planning Commission
- Upper Valley Haven
- Alice Peck Day Hospital
- Public Health Council of the Upper Valley
- Vermont Agency of Human Services
- Health Care & Rehabilitation Services (HCRS)
- Two Rivers Ottauquechee Regional Commission
- Norwich Planning Commission, Federal Home Loan Bank of New York
- St. Paul's Episcopal Church
- Chair of Windsor Improvement Corp. Housing Committee
- Housing Project Manager
- River Valley Property Management
- WISE
- Statistical and Evaluation Research



*“What would compel more than two dozen people, including representatives of multiple non-profits, four planning commissions, property management and development, and the health care field to meet regularly? What would keep them coming back, month after month, analyzing complex issues, sharing expertise and looking for solutions? An affordable housing crisis, and the recognition that the health benefits of safe, high quality homes—for individuals and communities—are life long and profound. Finding the paths to create more affordable places to live is the challenge that we’ve accepted!”*

– Mike Kiess & Faye Grearson, Vital Communities & Twin Pines Housing Trust

**The 2018 Community Health Needs Assessment identified housing as one of the top priority needs. MAHHC has contributed to improving this issue in 2019 in the following ways:**

- Community Health Team utilized as an assessment tool to identify housing vulnerability as one of the Social Determinants of Health. We have actively assisted vulnerable patients to find or stabilize their housing.
- MAHHC obtained funding to install shower and laundry facilities at the Windsor Connection Resource Center for the homeless and vulnerable.
- MAHHC signed an agreement to participate in the Hartford District Coordinated Entry Partnership.
- We worked with Housing Matters from Windham Windsor Housing Trust to provide home buyer workshops at MAHHC for the community.
- We spearheaded a community team to address the issue of homelessness and evaluate the need to establish a Warming Shelter in the Windsor area. The outcome was to partner with the Springfield Warming Shelter. We have organized a team of community driver's that will take guests to the Springfield Warming Shelter for the 2019/2020 winter season.
- There were 152 visits for fuel, electric, shelter with the support of Southeastern Vermont Community Action at the Windsor Connection Resource Center.
- Springfield Supported Housing helped local citizens find permanent housing. There were 76 visits in 2019 compared to 14 in 2018. MAHHC staff participated in a drive to donate laundry baskets filled with home supplies, laundry items, and more. for those who have been homeless as they enter transitional housing.
- Through a series of community health summits, this issue was identified as a priority and a multisector work group was formed.

### PROBLEM STATEMENT

There is a mismatch between the amount of housing that is available and affordable, and the number of people seeing a place to live.

### ROOT CAUSES

Potential landlords need support and education to reduce risk and increase willingness to choose among different rental models. Communities—individually and collectively—have not clearly defined housing goals.

### AIM STATEMENT

Promote and create conditions for a broad cross-sector regional effort to increase housing availability.

1. Increase use of existing housing stock through landlord and tenant awareness and proficiency in creating good rental situations.
2. Develop a broad base of public support for creating new housing that meets community needs and desires



#### In 2019 Floss Bar provided:

- 4 Cleanings
- 2 Cleanings with Limited Exam
- 1 Cleaning and Full Mouth X-ray
- 2 Cleaning, Bitewing X-ray and Whitening
- 16 Cleanings and Bitewing X-rays

### DENTAL CARE IS IMPORTANT TO YOUR HEALTH!

In fact it is the gateway to your body for eating and nutrition, how you look and how you are perceived and can impact confidence in yourself. Many people are not regularly seen by a dentist. We want to help increase access, and we also want to avoid dental pain. Floss Bar is going to help overcome the gap of dental services in the Windsor area. We offered two Clinics partnering with Floss Bar. We are now offering this service to the community on a quarterly basis.

25 patients total were treated from two events in 2019.

We provided access to dental vouchers in our Windsor Community Health Clinic through a generous donation from Dorothy Byrne. In 2019, a total amount of **\$20,909** was used to assist eligible patients.

We organized dental clinics for the third year in the Windsor Schools grades K-6 with support from Northeast Delta Dental, Alice Peck Day and Little Rivers Healthcare. Statistics from the dental clinic are shown below.

Windsor Smiles Program Services	2016	2017	2018	2019
Number of students available for screening	▲ 244	▲ 252	▼ 231	▶ 230
Number of students return consent	▲ 244	▼ 172	▼ 131	▲ 204
Number of students screened	▲ 82	▼ 60	▼ 41	▲ 78
Number of students screened with untreated decay	▲ 22	▼ 13	▼ 9	▲ 19
Number of students screened with treated decay	▲ 19	▼ 15	▼ 10	▲ 19
Number of students with history of decay	▼ 33	▼ 20	▼ 15	▲ 19
Number of students screened with ex sealant on perm molar	▼ 35	35	35	▲ 38
Number of students receiving DSF (decay stopping fluoride)			▲ 8	▲ 0
Number of students screened with sealant applied in school year	▼ 62	▼ 60	▼ 35	▲ 37
Number of preventative sealants placed	▲ 585	▼ 483	▼ 224	▲ 325
Number of students receiving urgent treatment	▼ 6	▼ 5	▼ 2	▲ 5
Number of students receiving non-urgent care	▼ 16	▼ 8	▼ 7	▲ 14

**Food insecurity is a major concern of MAHHC. We have implemented the following initiatives to address food insecurity in the communities we serve:**

Screening is done to identify food insecurity in our pediatric clinic and by our Community Health Team. If food insecurity is identified, we help our patients access food programs such as **3 Squares, WIC, and food shelves**. Through a donation, we also purchased copies of **"Eating Well on \$4 a Day."** These cookbooks were distributed through our pediatric clinic.

MAHHC staff lead and participate in the Wednesday Community Dinners at the **American Legion** September through June.



MAHHC is a strong community partner in organizing the **Summer Picnic Series** which served 2,500 children in 2019.



Our providers write "prescriptions" for vegetables. We host the **VT Food Bank VeggieVanGo**. In 2019, we served 215 -250 families a month with fresh vegetables and fruits.



**Volunteers in Action** volunteers served 395 Meals on Wheels and hosted 130 community lunches for members to attend at various locations in the community.

**RiseVT** is stimulating change at the local level through amplify grants. 29 grants were issued with projects covering physical activity, nutrition, and mindfulness.



RiseVT is also stimulating change to increase physical activity in communities. Examples include: organizing **Rise to 5K** in Windsor, providing outdoor program activity equipment through amplify grants by working with libraries, schools, towns, and recreation centers.



MAHHC was the first organization that worked with **RiseVT** to collect and distribute food to the food shelves specifically designed to serve people with chronic disease. MAHHC contributes weekly to the **Windsor Food Shelf at Trinity Evangelical Church**. MAHHC collects food for the Thanksgiving baskets working with the Windsor Food Shelf.

Prevention is the major focus of our care for Quadrant 1 of the Population Health Model—"keeping the well, well." As a result we have created quality dashboards that reflect metrics about physical exercise and the activities of RiseVT. This dashboard is presented to the Windsor HSA Community Collaborative on a quarterly basis.

RiseVT Amplify Grants Awarded	For Physical Activity	For Nutrition	For Mindfulness	Partner Organizations Involved
Oct 2018 –Dec 2018	2	2	0	5
Jan 2019 – March 2019	8	4	1	11
April 2019 – June 2019	6	3	1	3
July 2019 – Sept 2019	2	0	0	1
<b>Total Awards</b>	18	9	2	20



**Tobacco use remains the #1 cause of preventable death and disease in the U.S. While tobacco use trends are declining, vaping has created serious health hazards leading to lung illness and disease similar to cigarettes. The following details describe our efforts to address this issue.**

- Designed and implemented Windsor Election Day Smoke-free & vape-free parks survey; received 106 responses with 93% in support of smoke/vape free areas. Shared results in presentation to Select Board, proposing policy solutions to address vaping concerns.
- Worked with Town of Windsor to get support for 12 "Buttlers" to be installed around town to address concerns of cigarette litter. One was installed at Paradise Park; 50% have already been installed, continued distribution in FY20. *(The Sidewalk Buttler is the world's first "smart receptacle" for tobacco waste. Collected butts are not only 100% recycled, but all units have the ability to track waste disposal totals).*
- Designed signage to promote use of Buttlers.
- Conducted literature review on vaping concentrates to support the development of NRT Protocol for teens who are addicted. Also, worked with Pediatrics to implement a screening tool to gauge levels of nicotine addiction.



- Secured private foundation funding to provide teens access to vaping and tobacco cessation medications through the pediatric clinic. Teens without insurance coverage for these medications can receive them free of charge when enrolling with MAHHC Tobacco Cessation Coach.
- MAHHC, through the Self-Management Program, hosted 3 Tobacco Cessation classes. A total of 13 participants completed the course, representing a 92% completion rate. To contact Blueprint Self-Management Regional Coordinator, Sarah Doyle, call (802) 674-7089, who can provide options for smokers who are interested in quitting tobacco.

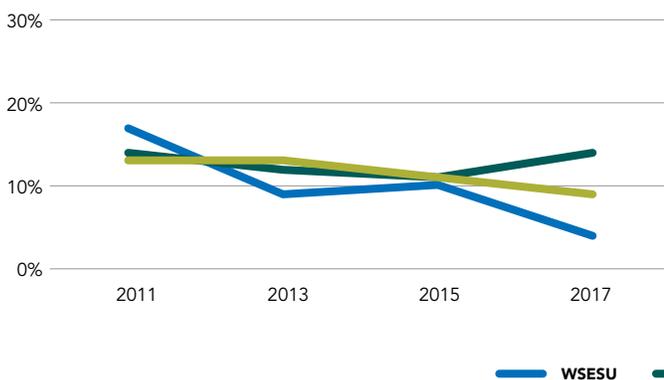


Mt. Ascutney  
**PREVENTION  
PARTNERSHIP**

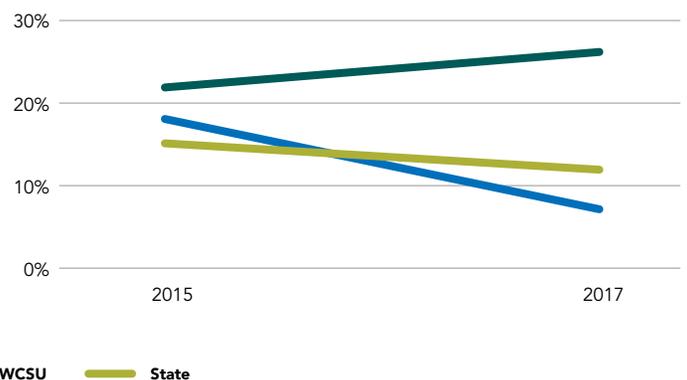


**802  
QUITS**  
YOU CAN QUIT.  
WE CAN HELP.

**Youth cigarette use, past 30 days**



**Youth vaping, past 30 days**





### PROGRAM STATISTICS:

#### Volunteers in Action ~ 2019

# rides given	1423
# miles driven	12669

#### Rides to Wellness ~ 2019

# rides given	209
# miles driven	3658

Our Volunteers in Action, in their 22<sup>nd</sup> year of connecting neighbors with needs to people who care, also provide transportation to those in need. In 2019, ViA helped coordinate a new effort to provide transportation to a local winter shelter for homeless individuals.

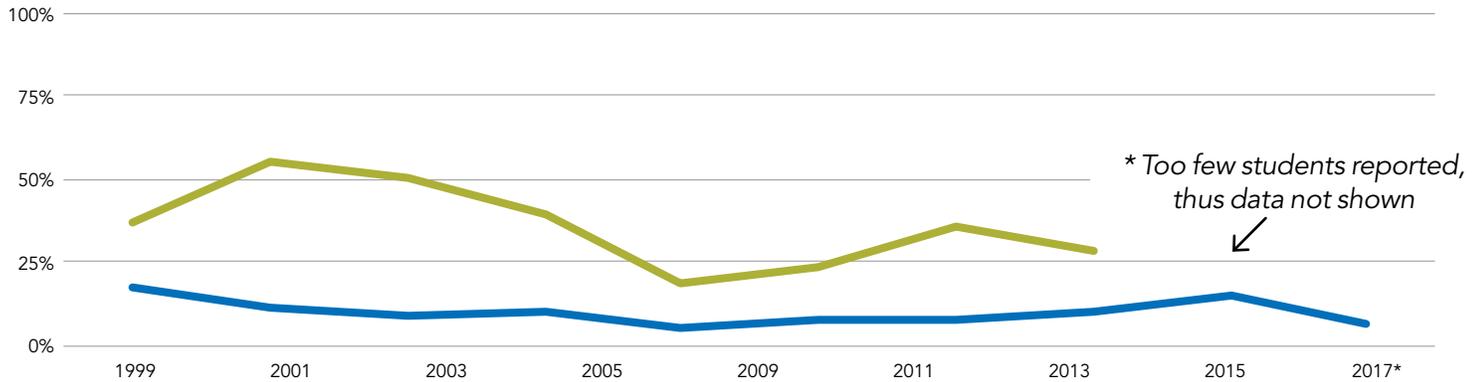
MAHHC has entered into a grant program with the Vermont Agency of Transportation to provide medical rides for local community members. This program is called Rides to Wellness.

Our Windsor Community Health Clinic provides gas cards to those in need through the generosity of a donation from Dorothy Byrne.

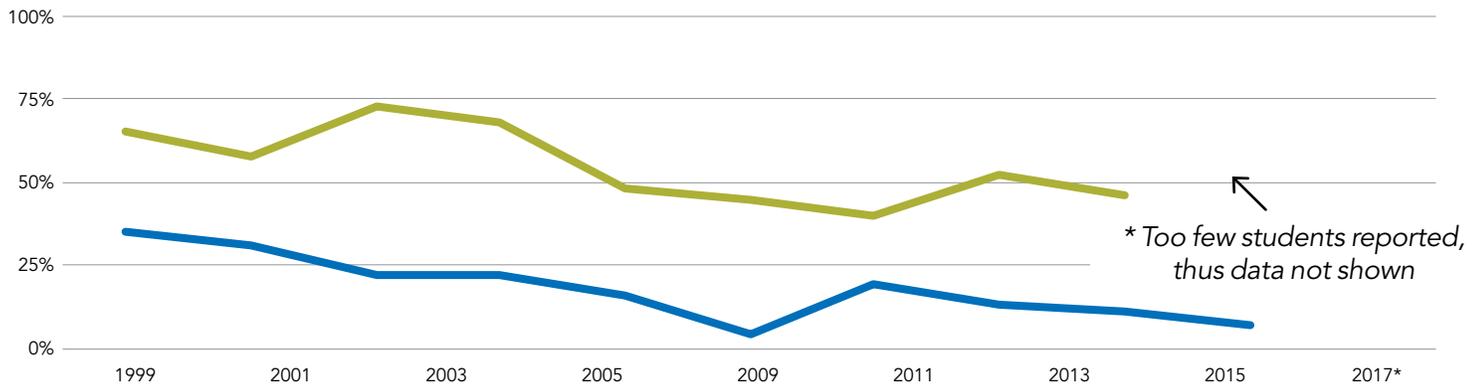
# Prevention Trends Over Time for Alcohol and Substance Misuse

Our work in substance misuse dates back to the late 1990s. The graphs on this page show the trends related to marijuana, alcohol, tobacco, and vaping use by 8<sup>th</sup> and 12<sup>th</sup> 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.

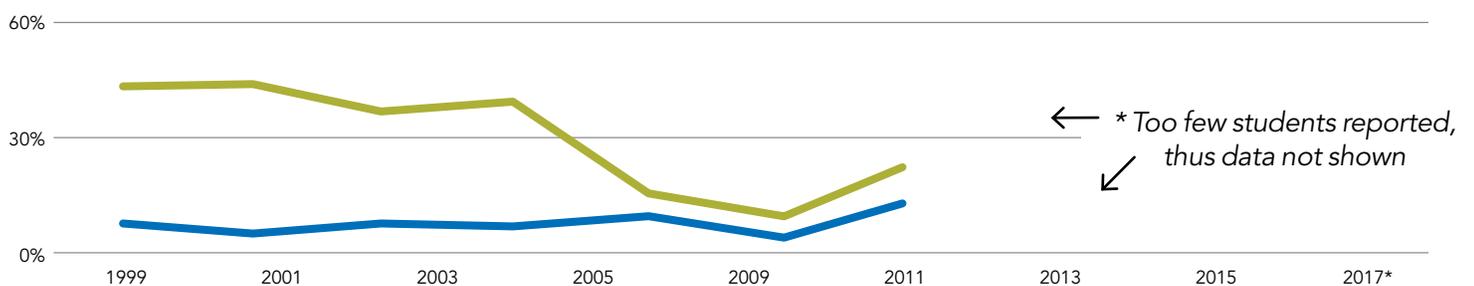
**Windsor Southeast Students, Marijuana use past 30 days**



**Windsor Southeast Students, Alcohol use past 30 days**



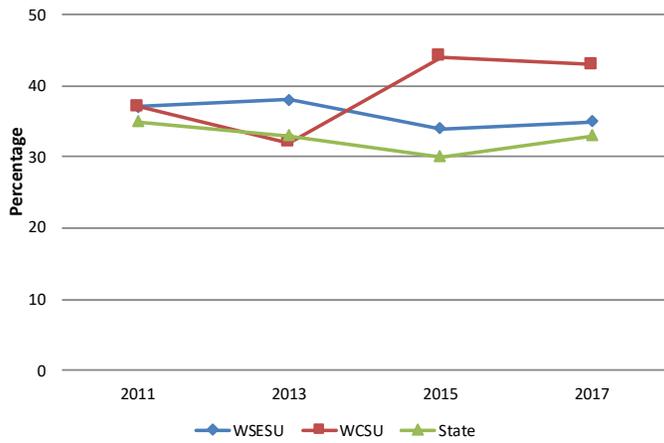
**Windsor Southeast Students, Tobacco use past 30 days**



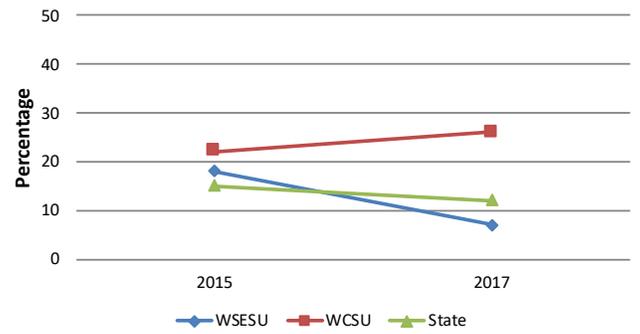
\* YRBS indicated "too few students"



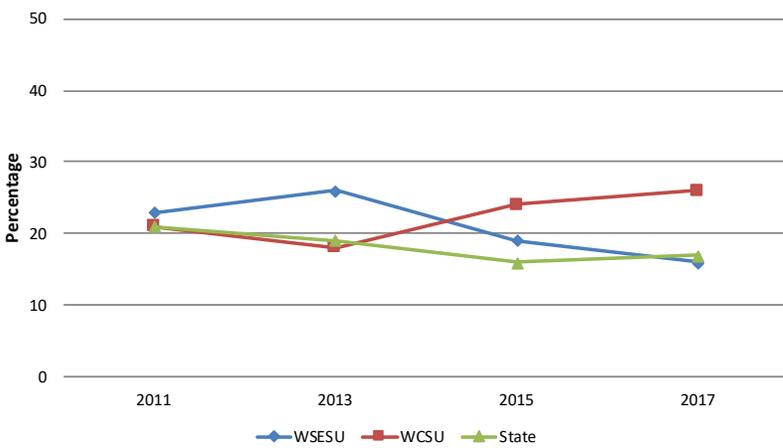
**Youth Alcohol Use, past 30 days**



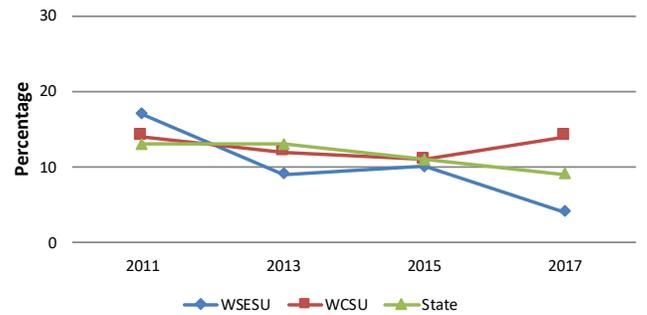
**Youth, Vaping past 30 days**



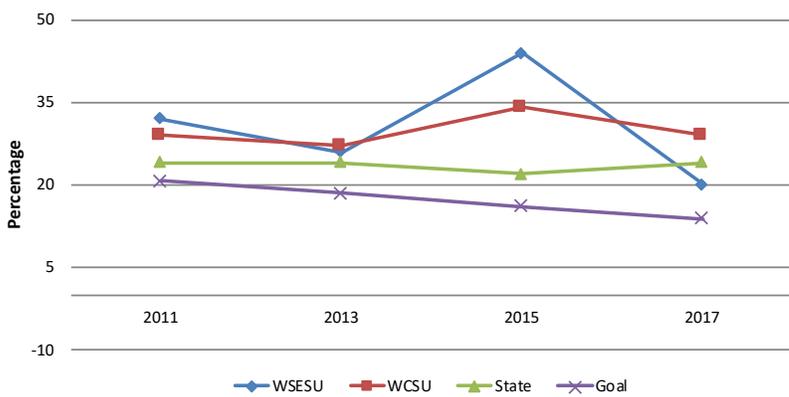
**Youth Binge Drinking, past 30 days**



**Youth, Cigarette Use, past 30 days**



**Youth Marijuana Use, past 30 days**



MT. ASCUTNEY HOSPITAL AND HEALTH CENTER  
**CHNA COMMUNITY HEALTH COSTS AND FUNDING SOURCES**

October 1, 2018 – September 30, 2019

Description	Total Cost	MAHHC Paid	Grants, Foundations, Private Contributions
MAHHC - Community Health Infrastructure	\$84,855	\$84,855	\$0
Access to Mental Health	\$43,336	\$24,108	\$19,228
Alcohol and Substance Misuse	\$811,390	\$87,644	\$723,746
Access to Affordable Health Insurance, Cost of Prescription Drugs	\$89,633	\$5,137	\$84,496
Strengthening Families: (Including Poverty and Childhood Trauma)	\$308,654	\$12,104	\$296,550
Access to Primary Care Services	\$528,032	\$198,649	\$329,383
Senior Health	\$69,500	\$32,545	\$36,955
Affordable Housing	\$7,007	\$6,457	\$550
Access to Dental Care	\$19,258	\$5,568	\$13,690
Transportation	\$76,055	\$42,746	\$33,309
Food Insecurity: Nutrition/Access to Affordable Food	\$55,886	\$19,993	\$35,893
	<b>\$2,093,605</b>	<b>\$519,806</b>	<b>\$1,573,800</b>

BLUEPRINT COMMUNITY  
MT. ASCUTNEY HEALTH TEAM  
PREVENTION PARTNERSHIP  
SUPPORT AND SERVICES AT HOME  
BLUEPRINT SELF-MANAGEMENT  
RISEVT  
VOLUNTEERS  
IN ACTION  
WINDSOR  
CONNECTION  
RESOURCE CENTER  
FAMILY WELLNESS PROGRAM  
HEALTH CLINIC  
COMMUNITY  
WINDSOR  
BLUEPRINT  
SPOKE TEAM  
SERVICES  
SUPPORT  
HOUSING &



Mt. Ascutney Hospital  
and Health Center  
Dartmouth-Hitchcock