FY 2020 Community Health Implementation Plan
Adopted November 7, 2019

Executive Summary

From January through August 2018, Alice Peck Day Memorial Hospital created a Community Health Needs Assessment with Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for VT and NH and in partnership with Mt. Ascutney Hospital and Health Center, Valley Regional Healthcare, New London Hospital, and the New Hampshire Community Health Institute.

The purpose of the assessment was to identify community health concerns, priorities, and opportunities for community health and health care delivery systems improvement. For the purpose of the assessment, the geographic area of interest was 19 municipalities in Vermont and New Hampshire comprising the Dartmouth-Hitchcock and Alice Peck Day primary hospital service areas with a total resident population of 69,467 people.

Eleven high priority community health needs were identified through primary and secondary data analysis, as well as qualitative research that was inclusive of a wide spectrum of health and human services professionals and community residents. The prioritized list includes:

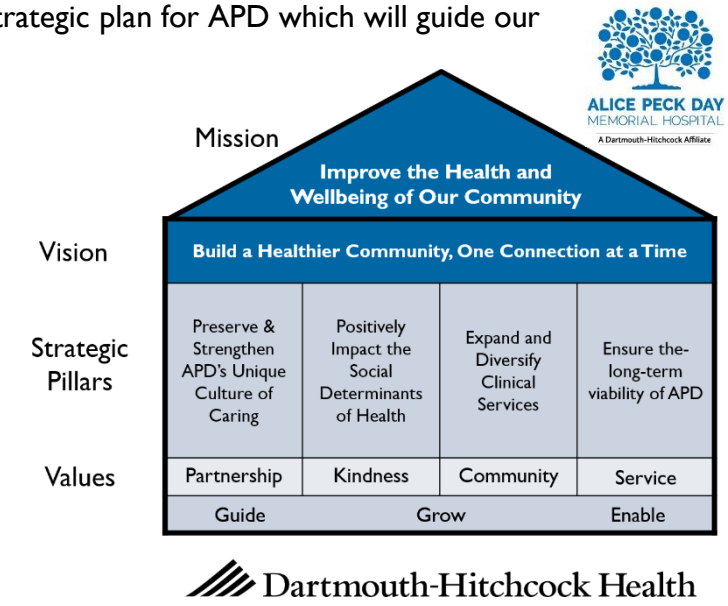
1. Affordable health insurance
2. Access to mental health care services
3. Prevention of substance misuse and addiction
4. Access to substance misuse treatment and recovery services
5. Child abuse or neglect
6. Cost of prescription drugs
7. Availability of primary care services
8. Domestic violence
9. Health care for seniors
10. Affordable housing
11. Access to healthy foods, good nutrition

APD's Community Health Implementation Plan (or CHIP, and contained below in Attachment I) outlines APD's current strategies, impact, and evaluation plan for each of the needs identified above. We also expect the CHIP to undergo revisions in the coming months.

APD's Board of Trustees recently endorsed a revised mission, vision, values, and strategic plan for APD which will guide our organization for the next 3-5 years and which is summarized at right. Among other goals, the plan calls for APD to partner to "positively impact the social determinants of health." These factors are critical to understand and address in APD's CHIP.

At the same, it is important to recognize that this is new territory for APD (the 2017 CHIP, for instance, specifically noted that social determinants were beyond APD's ability to address). Thus, while specific operational tactics are clear for many of the pillars in APD's strategic plan, the work plan for addressing the social determinants in partnership with other organizations is currently in development.

As that work comes together, we will update and modify the APD CHIP.



Attachment I
Alice Peck Day Memorial Hospital Community Health Implementation Plan, FY20

Population Health Concern 1: Access to Affordable Health Insurance

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Provide Marketplace health insurance counseling during Open Enrollment (and for individuals eligible for SEP). *Impact*: Patients with health insurance more likely to seek "the right care at the right time in the right place."	**R**: Conifer Patient Advocates, Manager and Director of Eligibility and Enrollment	Number of counseling sessions held; number of individuals enrolled into new or different health insurance plan during Open Enrollment and/or Special Enrollment Periods
Strategy: Provide hands-on Medicaid enrollment assistance through Primary Care Social Worker to uninsured community members. *Impact*: Low-income patients enrolled in Medicaid are more likely to seek "the right care at the right time in the right place."	**R:** Primary Care Social Worker **C**:Local schools, social service agencies, community organizations as referral sources	Number of applications submitted as "complete" and subsequently opened (approved)
Strategy: Screen uninsured and underinsured patients for APD and NH Health Access Network financial assistance (help with insurance deductibles and co-insurance). *Impact*: Approximately 300 patients assisted.	**R**: Conifer Patient Advocates, Manager and Director of Eligibility and Enrollment	Number of applications processed; value of "write-offs" on annual basis

Population Health Concern 2: Access to Mental Health Services

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Provide site and in-kind technical assistance to the "Rx for School Success" program. https://www.alicepeckday.org/services/primary_care/rx_for_school_success/ *Impact:* Addresses a generally unrecognized and thus under-served population through improved anticipatory guidance regarding the inter-related factors that impact a child's physical and mental health, learning, and overall well-being.	**R**: Primary care clinic space, Pediatricians, Informatics, community-based funding sources (e.g., private donors, United Way, etc.) **C**: Center for School Success; community mental health providers and learning specialists	*Quantitative*: number of children screened (where they score regarding risk level); number of children in the program; total number of annual program visits *Qualitative*: Feedback from primary care providers, primary care patients, and their family members. Feedback from school teachers regarding their experience with a child who has been in the program.
Strategy: Expand screening for depression to include all primary care patients ages 12 through adult during annual wellness visit. *Impact:* Early identification and intervention.	**R**: Primary Care Clinical Staff	Number of patients screened and referred
Strategy: Offer mental health services through Behavioral Health Specialist for patients who screen positively for depression or anxiety, including appropriate follow-up treatment or a referral for ongoing counseling support. *Impact:* Improves mental health in patients.	**R:** Behavioral Health Specialist **C:** Community mental health providers	Number of patients who receive care, number of patients referred
Strategy: Participate in Region 1 Integrated Delivery Health Network (IDN). http://region1idn.org/	**R:** Primary Care Clinical Staff **C:** Headrest, West Central Behavioral Health, and other behavioral health care services	Number of patients referred to community behavioral health care services

Impact: Increases integration of primary care with community behavioral health care for Medicaid patients and reduces gaps in care during transitions across care settings.		

Population Health Concern 3: Prevention of Substance Misuse and Addiction

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Pursue Tobacco 21 ordinance for City of Lebanon. *Impact:* Reduces youth access to tobacco products and e-cigarettes.	**R**: Community Relations and Volunteer Specialist **C**: Lebanon Partners United for Safety and Health (PUSH), Lebanon Police Department, Dartmouth-Hitchcock Medical Center	Adoption of ordinance
Strategy: Implement Advanced Transit marketing campaign regarding tobacco use. *Impact:* Increases rates of tobacco cessation.	**R:** Marketing and Communications Manager **C:** Advanced Transit	Visits to URL in ad (www.alicepeckday.org/quit) and new patients requesting support for tobacco cessation.
Strategy: Screen young adults or teenagers or at-risk adults using Dartmouth-Hitchcock pediatric screener for substance use, social determinants of health, depression, and anxiety. *Impact*: Early identification and intervention.	**R:** Providers who evaluate screener **C:** Community resources	Number of patients who screen positive and are referred

Population Health Concern 4: Access to Substance Misuse Treatment and Recovery Services

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Continue to offer free meeting space for local AA and Al-Anon groups. *Impact*: Over 300 hours of weekend meeting time offered each year, with 20-25 participants attending one or more support group meetings per week.	**R**: Hospital conference room space	Unable to evaluate due to confidentiality restrictions
Strategy: Screen NH Medicaid patients for substance abuse using Comprehensive core Assessment tool (CCSA) and refer patients to local resources. *Impact*: Early identification and intervention.	**R:** Primary Care Social Worker and Behavioral Health Specialist **C:** Referrals to appropriate community resources as needed	Number of patients who screen positive and are referred
Strategy: Screen young adults or teenagers or at-risk adults using Dartmouth-Hitchcock pediatric screener for substance use, social determinants of health, depression and anxiety. *Impact*: Early identification and intervention.	**R:** Providers who evaluate screener **C:** Community resources as needed	Number of patients who screen positive and are referred
Strategy: Host collaborative care team weekly meetings with Headrest for primary care patients in MAT. *Impact:* Improves patient care plans and increases ease of appointment coordination for patients.	**R:** Primary Care Clinical Staff, Social Worker, and Behavioral Health Specialist **C:** Headrest and other relevant community organizations	Number of patients who, upon rescreening, screen positive or see decline in scores
Strategy: Provide Suboxone treatment for all substance use disorder patients in primary care clinic (Medication Assistance Treatment). *Impact:* Reduces rates of opioid addiction.	**R:** Primary Care Clinical Staff, Social Worker, and Behavioral Health Specialist **C:** Headrest and other relevant community organizations	Number of current and new patient appointments

Population Health Concern 5: Child Abuse or Neglect

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Evaluate patients in Primary Care and ER for child abuse and neglect and utilize Trauma Informed Care in Pediatrics and ER. *Impact*: Early identification and intervention.	**R:** Providers and Clinical Staff **C:** Child Protective Services in VT and NH	Number of patients who, upon rescreening, screen positive or see decline in scores
Strategy: Participate in regional "Strong Families Strong Starts" initiative including evidence informed staff education and Reach Out and Read enrollment. *Impact:* Improves social supports for young children and families.	**R:** Pediatric staff **C:** Dartmouth-Hitchcock Community Health Improvement staff	Number of books distributed, number of staff trained, number of referrals to community-based services

Population Health Concern 6: Cost of Prescription Drugs

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Continue offering Prescription Assistance Program to uninsured and/or underinsured patients needing help paying for medications. *Impact:* Low-income patients with chronic conditions who are approved for free or low-cost medications are more compliant with treatment plans.	**R**: Primary Care Social Worker **C**: Grafton County ServiceLink as referral source	Number of PAP applications submitted, number of patients approved for assistance
Strategy: Continue providing pharmacy voucher program for low-income uninsured patients with acute medication needs and assistance in	**R:** Community Health Department annual budget allocation and Primary Care Social Worker	Number of requests for assistance; number of vouchers awarded; number of patients enrolled in

determining patient eligibility for this as well as other public insurance options and prescription assistance programs. *Impact*: Patients receive needed medication within 24 hours.		Medicaid, Medicare Part D, other insurance programs

Population Health Concern 7: Availability of Primary Care Services

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Continue providing space for Good Neighbor Health Clinic's Lebanon free health clinics, from one per month to two-three per month depending on volunteer capacity. *Impact*: Greater numbers of uninsured patients gain access to free primary and specialty care provided by GNHC volunteer providers.	**R**: In-kind donation of clinic space **C**: Good Neighbor Health Clinic and Geisel School of Medicine	Monthly reports summarizing patient appointment totals by clinician, and no-show rates
Strategy: Recruit Primary Care Physician. *Impact:* Increased access to primary care.	**R:** Multi-Specialty Clinic Executive Director, Medical Director and Practice Director of Primary Care, and other staff and providers as needed. **C:** Relevant local organizations and businesses as needed to assist with partner recruitment, real estate, schooling, and other issues of importance to candidates	Number of candidates interviewed and brought to campus for interview; offer made and accepted by a candidate
Strategy: Provide funding for APD Providers to launch pilot projects aimed at addressing Social Determinants of Health in the community.	**R:** Providers who will serve on evaluation committee for project proposals; clinical staff	Number of projects proposed and launched every six months.

Impact: Promotes health equity and reduces barriers to clinical care.	**C:** Organizations and individuals with whom projects will be co-created in the community	

Population Health Concern 8: Domestic Violence

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Screen NH Medicaid patients in ER and Multi-Specialty Clinic for domestic violence using CCSA and refer patients to local resources. *Impact*: Early identification and intervention.	**R:** Primary Care Clinical Staff **C:** WISE	Number of patients who, upon rescreening, screen positive or see decline in scores

Population Health Concern 9: Health Care for Seniors

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Continue Senior Care Team's home-based primary care program for frail elderly in the local community. *Impact*: Approximately 250 home-bound frail elderly patients are served annually, the majority of whom have current advance directives in place to assure their wishes for end of life care are met.	**R**: 2 geriatricians, 1 nurse practitioner, 1 social worker, 1 nurse care coordinator and 2 flow staff members **C:** All senior-focused community organization and businesses	Review of number of patients with advanced directives; number of readmissions of patients; number of patients who die in a setting of their choice
Strategy: Host "Elder Forum," a networking/educational forum for health and human services organizations focused on the elderly, is hosted monthly at APD. *Impact:* 25-30 professionals meet 10 times/year.	**R**: Administrative support **C**: Upper Valley Community Nursing Project, Alice Peck Day Lifecare	Number of meetings held per year; number of participants per meeting; annual member feedback survey

Strategy: Continue the Elder Friend program (matching frail elders referred by Senior Care team staff to volunteers who make home visits). *Impact:* Vulnerable elders' lives are enriched by interaction with a volunteer, and vice versa.	**R:** Community Relations and Volunteer Specialist, Senior Care Team, volunteers	Length of time (number of weeks/months) matched pairs participate; feedback from Senior Care Team
Strategy: Increase collaboration with APD Lifecare. *Impact*: Improved clinical services and supports for Lifecare residents.	**R:** Appropriate APD and APD Lifecare clinical leaders **C:** Relevant community organizations and businesses focused on seniors, as needed	Progress on FY20 Lifecare integration plan related to clinical areas

Population Health Concern 10: Affordable Housing

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Screen NH Medicaid patients for housing needs using CCSA and assist patients with applications for local resources and make referrals. *Impact:* Reduces housing as a barrier to clinical care.	**R:** Primary Care Social Worker **C:** SASH coordinators (STATE of VT), WISE, The Haven, Listen	Number of patients screened, number of patients referred to housing assistance programs

Population Health Concern 11: Access to Health Foods, Good Nutrition

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Continue free summer lunch program (APD Lunch Friends) for the Lebanon School District.	**R**: Community Relations and Volunteer Specialist; cash donation for initial start-up costs; volunteers	Number of meals served

Impact: Reduces food insecurity experienced by low-income school age children during the summer.	**C**: Lebanon School District, Hartford Community Coalition, Twin Pines	
Strategy: Improve in-patient and coffee shop menu with healthier food choices. *Impact:* Reduces number of unhealthy food options on menu.	**R:** Manager of Nutrition Services **C:** Local producers and distributors of healthy food	Number of menu items that are healthy