Dartmouth Health

Alice Peck Day Memorial Hospital

FY 2023-2025 Community Health Improvement Plan
Adopted October 20, 2022

Executive Summary

In 2021, Alice Peck Day Memorial Hospital created a Community Health Needs Assessment with Dartmouth-Hitchcock and Visiting Nurse and Hospice for VT and NH in partnership with Mt. Ascutney Hospital and Health Center, New London Hospital, Valley Regional Healthcare, Lake Sunapee Region VNA & Hospice, and the New Hampshire Community Health Institute.

The purpose of the assessment was to:

- Better understand the health-related issues and concerns impacting the well-being of area residents;
- Inform community health improvement plans, partnerships and initiatives; and
- Satisfy state and federal Community Health Needs Assessment requirements for Community Benefit reporting.

For the purpose of the assessment, the geographic area of interest was 19 municipalities comprising the primary service area of Mary Hitchcock Memorial Hospital and Alice Peck Day Memorial Hospital with a total resident population of 69,612 people. These municipalities include: Canaan, Dorchester, Enfield, Grafton, Hanover, Lebanon, Lyme, Orange, Orford, Piermont, Grantham, and Plainfield in NH and Fairlee, Thetford, Hartford, Hartland, Norwich, Sharon, and Woodstock in VT.

Five 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. Two additional community health needs were added to the list to reflect APD's on-going efforts in those areas. The prioritized list includes:

1. Availability of mental health services
2. Cost of health care services, affordability of health insurance
3. Improved resources and environment for healthy eating, nutrition, and food affordability
4. Alcohol and drug use prevention, treatment, and recovery
5. Affordability and availability of dental care services
6. Health Care for Seniors/Aging
7. Physical Activity/Active Living

APD's Community Health Improvement Plan outlines APD's current strategies, impact, and evaluation plan for each of the needs identified above. The hospital will collaborate with community partners to leverage available resources and increase capacity to collectively address the health priorities identified.

Impact of COVID-19

COVID-19 impacted our ability to collect data for the 2022 Community Health Needs Assessment and impacted the content of community input. More than half of respondents to the community survey indicated that they were currently experiencing increased stress or anxiety because of the COVID-19 pandemic. The needs of the community may continue to evolve as cases of COVID-19 decrease and our strategies to address those needs will continue to evolve as well.

Population Health Concern 1: Availability of mental health services

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Continue 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
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, Resource Specialist **C:** Community mental health providers	Number of patients who receive care
Strategy: Offer streamlined access to behavioral health care for patients in the Emergency Department through Emergency Department Rapid Referral Program *Impact:* Improves mental health in ED patients.	**R:** Emergency Department Staff **C:** West Central Behavioral Health	Number of patients referred

Population Health Concern 2: Cost of health care services, affordability of 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 individuals enrolled into health insurance plans 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
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; Primary Care Social Worker	Number of applications processed; value of "write-offs" on annual basis
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 determining patient eligibility for this as well as other public insurance options and prescription assistance programs. *Impact*: Patients receive needed medication within 24 hours.	**R:** Community Health Department annual budget allocation and Primary Care Social Worker	Number of vouchers awarded

Population Health Concern 3: Improved resources and environment for healthy eating, nutrition, and food affordability

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Continue free summer lunch program for children who live in low-income housing sites. *Impact*: Reduces food insecurity experienced by low-income school age children during the summer.	**R**: Community Health & Relations Officer; cash donation; volunteers **C**: Hartford Community Coalition, Twin Pines, Lebanon Housing Authority	Number of meals served
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
Strategy: Offer Emergency Food Bags of non-perishable food and Meal Cards for a free, hot meal at the APD café to patients who express need for food supports *Impact:* Reduces food insecurity in APD patient population	**R:** Primary Care Social Worker; Care Management Team **C:** Upper Valley Haven	Number of bags of food distributed

Strategy: Donation of prepared foods from APD Kitchen to LISTEN Community Services *Impact:* Reduces food insecurity experienced by community	**R:** APD Kitchen Staff **C:** LISTEN Community Services	Value of food donated

Population Health Concern 4: Alcohol and drug use prevention, treatment, and recovery

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Re-open meeting rooms to offer free meeting space for local AA and Al-Anon groups once COVID-19 precautions have been removed from APD campus *Impact*: Over 300 hours of weekend meeting time offered each year, with 20-25 participants attending one or more support group meetings per week. Paused during the pandemic.	**R**: Hospital conference room space	Unable to evaluate due to confidentiality restrictions
Strategy: Screen adult patients for substance abuse using Adult Screener 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 and prioritize establishing care with residential patients at Headrest without Primary Care. *Impact:* Improves patient care plans and increases ease of appointment coordination for patients.	**R:** Primary Care Social Worker **C:** Headrest of the Upper Valley	Number of patients who receive collaborative care
Strategy: Provide Suboxone and Sublocade treatments 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 of the Upper Valley	Number of current and new patient appointments
Strategy: Continue 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: Continue to support efforts to establish a residential treatment center for women in recovery from substance use disorder and their children *Impact:* Increases recovery services for women and their children	**R:** VP of External Affairs **C:** Families Flourish Northeast (FFNE)	Meet conditions of the Letter of Interest and enter into lease agreement

Population Health Concern 5: Affordability and availability of dental care services

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Continue to provide Upper Valley Smiles, a school based oral health program, to children at Upper Valley elementary schools *Impact:* Improves oral health in Upper Valley children	**R:** Upper Valley Smiles staff **C:** Upper Valley Elementary Schools	Number of children who participate in the program
Strategy: Incorporate fluoride varnish application into well child visits *Impact:* Prevents dental caries in young children	**R:** Pediatricians, flow staff	Number of children with fluoride varnish application
Strategy: Financially support and refer patients in MAT for dental care at local dental office *Impact:* Increases recovery efforts of patients with substance use disorders	**R:** Primary Care Social Worker, Community Health & Relations Officer, Community Health funding **C:** Local dental offices	Number of patients referred for dental care

Population Health Concern 6: Socio-economic conditions affecting health and well-being such as housing affordability, livable wages, and affordable, dependable child care

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategy: Screen adult patients for housing needs using Adult Screener 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), The Upper Valley Haven, Listen Community Services	Number of patients screened

Strategy: Increased the minimum wage to $17/hour for APD employees and continue to adjust the pay of employees affected by this compression of wages *Impact:* Increases financial stability of employees	**R:** APD annual budget	Adjust employee wages affected by the compression of wages created by raising the minimum wage
Strategy: Continue to fund APD's Employee Navigator position who assists employees with non-work related stressors including housing, transportation, childcare, legal issues, or mental health concerns. *Impact:* Improve employee stability and retention	**R:** Employee Navigator, employee benefits **C:** Community resources	Number of employees who visit with APD's Employee Navigator

Additional Population Health Concern: 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 Health & Relations Officer, 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 Lifecare integration plan related to clinical areas

Additional Population Health Concern: Physical Activity/Active Living

Strategy/Impact	**Resources/Collaborators**	**Evaluation Plan**
Strategy: Continue to offer FitScripts, a program for adult primary care patients who can receive a "prescription" from their primary care provider for monthly memberships at local fitness centers *Impact:* Increases levels of physical activity in patients for whom cost is a barrier to a gym member	**R:** Primary Care Clinical Staff, Development, Community Health & Engagement Officer **C:** Upper Valley Aquatic Center (UVAC) and Carter Community Building Association (CCBA)	Number of active participants in the program
Strategy: Support and invest in the Mascoma River Greenway (MRG), APD Nature Trails, and organizations that maintain and develop trails (UV Trails Alliance) *Impact:* Increases opportunities for physical activity and outdoor activity	**R:** External Affairs, Community Health funding **C:** Mascoma River Greenway Coalition and Project Partners, City of Lebanon, Upper Valley Trails Alliance	Number of trails in the Upper Valley

Strategy: Continue to offer bike helmets to children, patients, and staff and to support additional efforts to increase biking in the community including Cowbell Mobile Bike Shop bikes services and bike racks located outside clinical locations *Impact:* Increases biking in the community and the number of patients and employees who bike to APD	**R:** External Affairs staff, Community Health annual budget **C:** Cowbell Mobile Bike Shop, Dartmouth Health Injury Prevention Center	Number of bike helmets distributed; Number of employees who use bike services
Strategy: Support and advocate for community infrastructure that increases community health including sidewalks and bus routes. *Impact:* Builds community, increases safety, and reduces use of cars	**R:** External Affairs staff **C:** City of Lebanon, Vital Communities, and other organizations	Number of Letters of Support written by APD