

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:

- I. 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.

Alice Peck Day Memorial Hospital Community Health Improvement Plan, FY 2023-2025

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

Resources/Collaborators	Evaluation Plan
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
R: Primary Care Social Worker C:Local schools, social service agencies,	Number of applications submitted
community organizations as referral sources	
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
R: Primary Care Social Worker	Number of PAP applications submitted, number of patients
C: Grafton County ServiceLink as referral source	approved for assistance
	R: Conifer Patient Advocates, Manager and Director of Eligibility and Enrollment R: Primary Care Social Worker C:Local schools, social service agencies, community organizations as referral sources R: Conifer Patient Advocates, Manager and Director of Eligibility and Enrollment; Primary Care Social Worker R: Primary Care Social Worker C: Grafton County ServiceLink as

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.	R: Community Health Department annual budget allocation and Primary Care Social Worker	Number of vouchers awarded
Impact: Patients receive needed medication within 24 hours.		

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.	R: Community Health & Relations Officer; cash donation; volunteers	Number of meals served
Impact: Reduces food insecurity experienced by low-income school age children during the summer.	C: Hartford Community Coalition, Twin Pines, Lebanon Housing Authority	
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	R: APD Kitchen Staff	Value of food donated
Kitchen to LISTEN Community Services		
	C: LISTEN Community Services	
Impact: Reduces food insecurity experienced by		
community		

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	R: Hospital conference room space	Unable to evaluate due to confidentiality restrictions
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.		
Strategy: Screen adult patients for substance abuse using Adult Screener and refer patients to local resources.	R: Primary Care Social Worker and Behavioral Health Specialist C: Referrals to appropriate community	Number of patients who screen positive and are referred
Impact: Early identification and intervention.	resources as needed	
Strategy: Screen young adults or teenagers or atrisk adults using Dartmouth-Hitchcock pediatric	R: Providers who evaluate screener	Number of patients who screen positive and are referred
screener for substance use, social determinants of health, depression and anxiety.	C: Community resources as needed	
Impact: Early identification and intervention.		

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	R: VP of External Affairs C: Families Flourish Northeast (FFNE)	Meet conditions of the Letter of Interest and enter into lease agreement
Impact: Increases recovery services for women and their children		

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

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

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	R: Primary Care Social Worker	Number of patients screened
applications for local resources and make referrals.	C: SASH coordinators (STATE of VT), The Upper Valley Haven, Listen	
Impact: Reduces housing as a barrier to clinical care.	Community Services	

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

Additional Population Health Concern: Health Care for Seniors

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

Strategy: Continue the Elder Friend program (matching frail elders referred by Senior Care team staff to volunteers who make home visits).	R: Community Health & Relations Officer, Senior Care Team, volunteers	Length of time (number of weeks/months) matched pairs participate; feedback from Senior Care Team
Impact: Vulnerable elders' lives are enriched by		
interaction with a volunteer, and vice versa.		
	- ADD 146	
Strategy: Increase collaboration with APD Lifecare.	R: Appropriate APD and APD Lifecare	Progress on Lifecare integration plan
	clinical leaders	related to clinical areas
Impact: Improved clinical services and supports for		
Lifecare residents.	C: Relevant community organizations	
	and businesses focused on seniors, as	
	needed	

Additional Population Health Concern: Physical Activity/Active Living

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

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