Alice Peck Day Memorial Hospital
Community Health Improvement Plan (CHIP)
Fiscal Year 2025

Executive Summary

Alice Peck Day Memorial Hospital (APD), a tax-exempt, charitable hospital organization, is required by federal law to conduct a Community Health Needs Assessment (CHNA) every three years. The purpose of the assessment is to better understand the health-related issues and concerns impacting the well-being of area residents and to inform community health improvement plans, partnerships and initiatives. APD is also required to prepare a Community Health Improvement Plan (CHIP) that describes how the facility plans to address the significant health needs identified through the CHNA.

The 2025 CHNA identified seven priority Community Health Needs and Issues.

1. Availability of primary care and medical subspecialty services
2. Availability and affordability of dental care services for adults
3. Availability of mental health services
4. Services for older adults including opportunities for social interaction and supports for aging in place
5. Cost of health care services including medications, affordability of health insurance
6. Health and human service workforce shortages and challenges navigating the health care system
7. Social drivers of health and well-being such as affordable access to transportation, housing, healthy foods and affordable child care

As a small Critical Access Hospital (CAH), APD must identify the ways in which to use its resources for the most impact. The highest impact will come from capitalizing on the organization's strengths and unique skills to provide services that measurably improve the health of the communities that it serves. The impact of the hospital's programs can be expanded through collaboration and coordination with community partners, where appropriate.

The 2025 CHIP is intended to be a broad roadmap for the community health efforts APD will undertake in the next three years. The community health needs identified are varied and challenging to influence and many have been identified in previous CHNA's. Improvement requires focused effort over many years; therefore, sustaining existing, successful programs is just as important as identifying new approaches.

In addition to sustaining existing, successful programs, APD will provide new or expanded services related to three high impact community health needs:

- Access to medical services thru innovation, health screening events, and education;
- Dental health by expanding and enhancing Upper Valley Smiles programming; and,
- Mental health by exploring a Caring for the Caregiver model for healthcare professionals.

Of note, APD has historically championed community health programs for older adults and seniors (age >65). The hospital remains strongly committed to ensuring that those members of this population receive the highest quality healthcare. The hospital's 2025 Strategic Plan expressly indicates that the organization will continue to overlay geriatric expertise across all services and departments. However, the hospital also intends to shift its community-based eldercare efforts to its subsidiary corporation, APD Lifecare. APD Lifecare has unique expertise in the care of elders living in community and, because of this, the organization is uniquely positioned to partner with other community resources to provide opportunities for social engagement and aging in place. The transition of community health programs from APD to APD Lifecare will occur gradually over the life of this plan.

Introduction

In addition to the general requirements for tax exemption under Internal Revenue Services (IRS) Section 501(c)(3) and Revenue Ruling 69-545, hospital organizations must meet the requirements imposed by Section 501(r). Section 501(r)(3)(A) requires a hospital organization to conduct a Community Health Needs Assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA (IRS CHNA for Charitable Hospital Organizations).

Section 501(r)(3)(B) provides that the CHNA must:

- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- Be made widely available to the public.

APD has elected to conduct its CHNAs in partnership with Dartmouth-Hitchcock Medical Center (DHMC) because the two organizations share a hospital service area DHAPD 2025 CHNA 3.06.2025.pdf. Together DHMC and APD have partnered to conduct a total of four CHNAs to date -2015, 2018, 2021 and now 2025.

The purpose of the assessment is to:

1) better understand the health-related issues and concerns impacting the well-being of area residents; and to,
2) inform community health improvement plans, partnerships and initiatives.

The 2025 Community Health Improvement Plan (CHIP), which aligns with the APD 2025 Strategic Plan, is intended to be a broad roadmap for the Community Health efforts APD will undertake in the next three years. As a broad roadmap, it will leave flexibility to respond to the changing needs of the community and the patients within its service area due to changes in the external environment. These efforts will be made more successful through close collaboration with community organizations and Dartmouth Health (DH) member sites Our Members | Dartmouth Health. To create the highest impact on identified community needs APD will focus new CHIP strategies on specific areas where the organization has unique assets, specific skills and knowledge while maintaining support for existing, successful initiatives

that have been implemented over the past ten years. APD does not intend to create new programming in a subset of specific areas of need identified in the CHNA, based on resource constraints (e.g. childcare), the lack of expertise to effectively address needs (e.g. housing, transportation), and where other facilities in the community are better equipped to address need (e.g. workforce shortages/training/development programs).

APD's 2025 CHIP was created using the principles of co-production (other terms: co-design and co-creation) Glossary | Coproduction Collaboratory The Dartmouth Institute Co-production in research – UKRI with an emphasis on internal (APD employees and leadership) and external (community) engagement.

The intended audience for APD's 2025 CHIP includes APD employees and Board of Trustees (BoT), community organizations and community residents in APD's hospital service area.

2025 APD/DHMC Community Health Needs Assessment (CHNA)

Seven priority community health needs were identified through primary and secondary data analysis, as well as qualitative research that included a wide spectrum of health and human services professionals and community residents. DHAPD 2025 CHNA 3.06.2025.pdf

The 2025 Priority Community Health Needs and Issues that were identified by this year's CHNA are shown on **Figure 1**:

Figure 1

APD

Since 1932, APD has been a community-based healthcare organization with a mission to improve the health and well-being of our community. APD's areas of clinical excellence include surgical services, primary care, geriatric care, sleep health, orthopedics, and emergency services. As a Center for Medicare and Medicaid (CMS) designated Critical Access Hospital (CAH)with twenty-three beds, a 10 bed short stay unit and a staff size of roughly five hundred, APD ensures that essential services remain available in our rural community where health disparities are prevalent.

APD's service area includes 19-municipalities with a total resident population of 72,736 people (March 2025). DHAPD 2025 CHNA. These municipalities include: Canaan, Dorchester, Enfield, Fairlee, Grafton, Grantham, Hanover, Hartford, Hartland, Lebanon, Lyme, Norwich, Orange, Orford, Piermont, Plainfield, Sharon, Thetford and Woodstock. Currently, approximately 54% of all APD patients are from New Hampshire (NH), with another 39% from Vermont (VT). This duality across state lines is reflected again when noting that the highest percentage of APD patients come from Lebanon NH (13%) but the next highest percentage comes from White River Junction, VT (8^{+}%). Approximately 40% of APD's patient population is between the age of 50 to 80-year-old and 46% of the patient population is on Medicare or Medicare Managed plans. Furthermore, an additional 9% of the patients are on Medicaid. Each year,

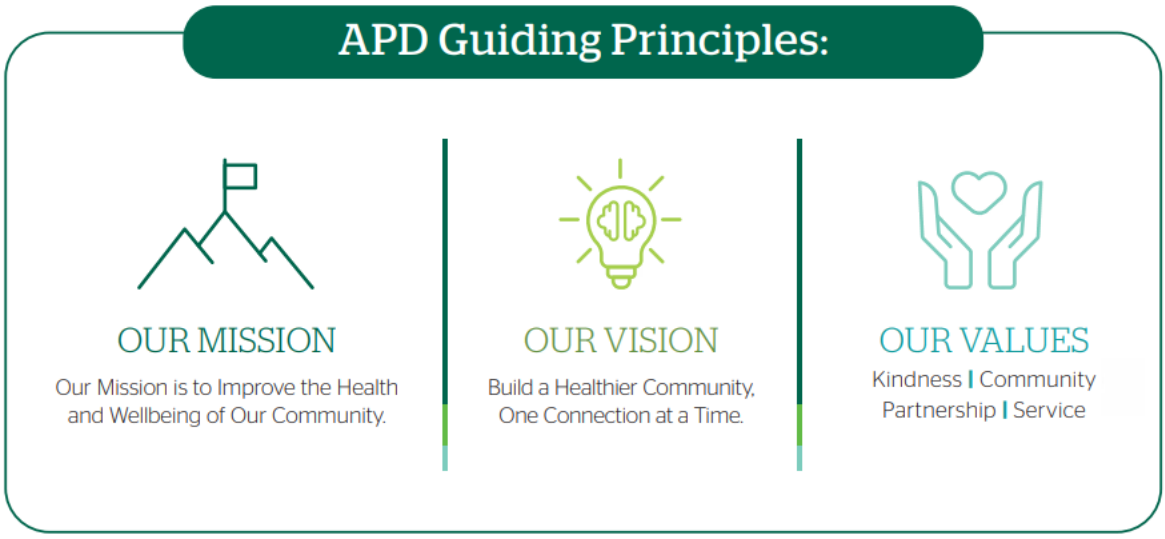
the APD Primary Care team sees nearly 36,000 patient visits, the Emergency Department (ED) treats over 13,000 patients, and the inpatient unit cares for more than 2,300 patients. Another nearly 28,000 patients are seen in the other ambulatory clinics such as orthopedics, podiatry, physical therapy, and occupational therapy with over 2,300 outpatient surgeries performed per year.

Because of its close proximity to DHMC, APD is unique within the DH system and its ability to partner with its much larger member provides critical context for this CHIP. As indicated in the tables below, APD often partners with DHMC's Community Health Department to align and amplify our efforts.

As previously noted, the APD BoT updated and revised the hospitals' Strategic Plan in early 2025. The plan lays out four strategic pillars: focus, invest, engage and adapt, all of which are critical to the future of the organization. ***The "Invest" pillar has a stated goal of leveraging community health initiatives to advance the hospital's mission***.

The 2025 Strategic Plan notes that to truly impact community health, "APD must commit to working outside the walls of the hospital and clinics" further noting that "identifying and committing resources to high leverage, key community health projects is critically important." All APD plans and strategies are founded on our hospital's guiding principles, which are illustrated on **Figure 2**. As a community hospital, APD is accessible to the public (free from unfair treatment and discrimination), provides excellent medical care in a cost-effective setting, while helping to prevent illnesses and injury, and investing in community collaboration and partnerships.

Figure 2



APD 2025 Strategy – Leverage Community Health Initiatives to Advance our Mission

With the combined forces of the 2025 BoT Strategic Plan revision and the 2025 CHIP cycle, APD is making a clear commitment to impacting community health in the Upper Valley catchment area.

While APD Community Health is a small department with limited resources responsible for multiple and varied commitments, APD as a whole has a lot of talented, innovative, knowledgeable and dedicated staff and providers. Furthermore, the Upper Valley is rich in social services organizations, many of which are also working to improve the health of the community. Although the APD Community Health department cannot tackle large projects in each of the identified need areas, determining how to make a significant impact by working with community partners remains a key approach to this work. Focusing on a few key, high impact projects while sustaining successful past work and partnerships is central to this plan.

2025 APD Community Health Improvement Plan (CHIP) by Community Health Need

1) Community Health Need: Availability of primary care and medical-subspecialty services

Strategy	Outcomes
Establish an Urgent Care Center at APD in FY26	• Increased access to non-emergency care which is less expensive to patients, health system and community. • Reduced burden on Emergency Department and Primary Care.
Explore opportunities to support and collaborate with Community Nurse Program for out of hospital care	Increased: • communication and collaboration between hospital and community, • geographic coverage of community nurses, • number of patients and families/ care partners served.
Provide community-based health screenings and health fairs in APD's hospital service area	• Enhanced identification of risk factors in patient population. • Improved connection of community members with clinical care.
Support programming to promote prevention, health literacy and self-management in partnership with community organizations and DH system	• Increased patients' health confidence; health literacy; self-management skills and improved access to clinical care.
In collaboration with DH system members and community organizations, implement and pilot innovative and financially viable value-based care models that allow for interprofessional coordinated care	• Increased access to specialty care. • Decreased provider burden. • Increased provider bandwidth (especially primary care).

Strategy	Outcomes
Examples: Collaborative Care Model (CoCM) Collaborative Care Model, Diabetes Clinic, Hypertensive Clinic, Senior Care Program	• Improved outcomes for a population of patients and individuals.
Continue Mobile Integrated Health (MIH) Program in collaboration with DH system and community partners	• Increased access to care in community and improved care coordination. •

2) Community Health Need: Affordability and availability of dental care services

Strategy	Outcomes
Sustain, improve and grow APD's Upper Valley Smiles Program, a free school-based dental/oral health program provided to children at Upper Valley elementary schools	• Improved access to oral health in Upper Valley children, families and guardians. • Be a model for DH system in providing oral health to children. • Increased access to oral health interventions, education and resources.
Partner with regional and local leaders in oral health and DH system partners	• Improved coordination; programming; advocacy efforts; learning and innovation in oral health. Example: Mobile Medicaid Dental Clinic expansion to Upper Valley FY25 Solvere Health Corp.
Incorporate Fluoride Varnish application into well child annual visits and pilot application of Silver Diamine Fluoride (SDF) when indicated.	• Prevents dental caries in children. • Promotes good oral health. • Slows dental decay.
Support patients to access mobile (virtual) Medicaid services for intake (DentiQuest), with a focus on patients enrolled in the Medication Assisted Treatment (MAT) Program.	• Increased access to oral health services. • Reduced stigma with increased patient confidence. • Supports successful recovery process.

3) Community Health Need: Availability of mental health services

Strategy	Outcomes
Continue providing mental health care support to professional- clinical and non-clinical -caregivers within APD. Evaluate disseminating programs to community organizations that are at risk for trauma induced mental health needs (i.e., first responders).	• Addresses mental health needs; burnout and work satisfaction of professional caregivers. • Enhanced sustainability of workforce.
Screen primary care patients for depression and anxiety during annual wellness visit. Offer acute mental health services through APD Behavioral Health Specialist for primary care patients who screen positive for depression and/or anxiety and support referrals for ongoing counseling with community partners. Continue to grow mental health services skillset (i.e., Eye Movement Desensitization and Preprocessing (EMDR)) and evaluate applications of technology. Investigate scale.	• Improved access to mental health services and patient outcomes.
Continue collaboration between Primary Care and Lebanon School District (support emergency medication prescriptions, immunizations for vulnerable populations, provide school protocol and pediatric population consultation). Work with community partners to understand value and models. Explore expanded support across other school districts in partnership with DH system.	• Improved collaboration; access to clinical expertise and education for Lebanon Schools. • Spread of effective models within service area.
Evaluation partnerships and coalition engagement and sustain those that are providing measurable improvements to community health. Examples of regional organizations include TLC Recovery Center, West Central Behavioral Health (NH), Health	• Improved coordination and access to services provided by community organization. • Facilitates innovation and enhanced impact.

Strategy	Outcomes
Care and Rehabilitation Services of VT, Public Health Council of the Upper Valley, Upper Valley Counseling Associates, fitness centers/recreation, Arts & Humanities, DH system Injury Prevention Center – gunlock and suicide prevention team, ALL Together and Open Door, etc.	
Offer bike helmets to patients in Primary Care, Emergency Department and community in partnership with DH system-Injury Prevention Center and community organizations.	• Increased biking in the community and the number of patients who bike. • Improved safety and environmental stewardship.
Maintain APD Nature Trails available to patients, staff and local community.	• Improved access to recreation and enhanced environmental stewardship.
Screen teenagers, young adults and adult patients in primary care for substance use and refer patients to local community Behavioral Health resources. Continue to investigate programs to meet needs in partnership with DH system and community organizations.	• Prevention, early identification and intervention.
Make available and educate APD providers and staff on Medical Assisted Therapies for substance use disorder, including appropriate language and available services. Address barriers for Naloxone distribution and provide education to patients, staff and community (Behavioral Health).	• Reduced rates of substance use disorder; positively impact outcomes to prevent overdose.
Continue to invest in APD campus upgrades with continued focus on improving access and belonging to vulnerable populations (i.e., Disability, Age and Recovery Friendly, LGBTQIA+ and BIPOC)	• Increased access to care and care experience especially for vulnerable populations.

4) Community Health Need: Services for older adults including opportunities for social interaction and supports for aging in place

Strategy	Outcomes
Enhance collaboration and alignment between APD, APD Lifecare and community partners with a focus on seniors.	• Increased alignment, coordination and impact in the area of senior care. • Improved clinical services and support to APD Lifecare residents.
Invest in APD's volunteer services infrastructure. In collaboration with APD Lifecare, consider a specific focus on re-energizing the "Elder Friends" program, which provides support and companionship to vulnerable elders.	• Increased ability to provide support and care to community; community programming and opportunities for social interactions for seniors interested in giving back. • Increased opportunity for community resident to give back.
Maintain Senior Care Team's home-based primary care program for frail elderly (defined as 85 years +) in the local community.	• Increased clinical care access and support to home-bound frail elderly patients, families and care partners. • Supports aging in place and end of life (Advance Directives, Power of Attorney, etc.)
Maintain Emergency Room Call Back Programs for seniors (70 years+) discharged from the Emergency Room in partnership with community organizations.	• Reduced hospital readmissions and impact on APD Emergency Department. • Improved support during transitions from hospital to home.
In partnership with DH system and community organizations, transition hosting of "Elder Forum," a networking/ educational forum for health and human services organizations focused on the seniors and aging to APD Lifecare	• Increased coordination; learning and innovation in the space of seniors and health needs.

5) Community Health Issue: Cost and affordability of health care services and health insurance

Strategy	Outcomes
In collaboration with community partners, support patients with navigating marketplace health insurance during Open Enrollment and NH Medicaid enrollment. Seek opportunities to enhance support and learn from community partners.	• Better educated and informed consumers of health insurance • Selection of insurance products that better meet consumers needs and budget • Improved ability to access healthcare services
Screen uninsured and underinsured APD patients for APD and NH Health Access Network (financial application), support application process as needed and track emerging needs.	• More patients identified as uninsured and underinsured and enrolled in insurance plans; • Improved access, patient experience and reduced costs.
Offer Prescription Assistance Program to uninsured and underinsured patients needing help paying for medications. Assist patients with applications for manufacturer assistance programs for patients to pay for and receive necessary medications. Scale successful interventions within DH system.	• Increased treatment plan compliance; improved outcomes.

6) Community Health Need: Health and human service workforce shortages and challenges navigating the health care system

Strategy
APD does not intend to engage in large/robust strategies to address health and human workforce shortages for reasons which include resource constraints, lack of expertise to effectively address needs, other facilities in community are better equipped to address need. APD acknowledges that workforce shortages uniquely impact access to care and will continue to look for innovative ways to improve access knowing that workforce shortages are going to continue both regionally and nationally. APD will continuously evaluate and adjust compensation in accordance with DH system policies and procedures.

APD will continue to assist employees who are managing non-work-related stressors including navigating challenges associated with housing, transportation, childcare, legal issues, and/or mental health concerns (ie; Social Drivers of Health). APD will execute on additional aspects of the 2025 Strategic Plan, which calls for engagement with the APD workforce to support education and career development.

7) Community Health Need: Social drivers of health and well-being such as access to affordable housing, healthy foods and affordable child care

"Drivers of health are the conditions in which individuals are born, age, work, and live and how these factors can influence health, wellness and quality of life" DHAPD 2025 CHNA 3.06.2025.pdf The drivers of health include "primarily nonmedical factors" that can have an impact on health outcomes that have traditionally been outside the direct influence of hospitals. These factors include access to housing, food, safety, community infrastructure (i.e. fundamental services such as transportation, schools and parks) and education. The National Academy of Medicine notes that approximately 80 - 90% of "modifiable" health outcomes are attributed to social drivers of health leaving only 10 - 20% determined by clinical interventions NLH_CHIP 2024 Executive Summary SDoH 201 for Health Care: Plan, Do, Study, Act - PMC 2021.

Effectively impacting the social drivers of health is beyond the scope of a small, community hospital acting along; however, APD remains committed to partnering with others in the DH system and in our communities to develop sustainable, cost effective solutions.

Strategy	Outcomes
Access to healthy foods	
As able, donations of prepared foods from APD Kitchen to community partners such as LISTEN Community Services, Pop Up Health Clinics (hosted by DHMC/ Community Nurses) and City of Lebanon Seasonal Winter Shelter. Investigate if strategy can be scaled to APD Lifecare.	• Reduced food insecurity experienced by community and the wasting of food.
Scale successful food programs across DH system sites with support from DH Food Champions Collaboration and Center for Advancing Health Equity (CARHE).	• Successful food programs that effectively support food insecure patients and families are sustained at APD. • Enhanced efficiency of DH system Community/Population Health resources.
Collaborate with community partners such as, Hartford Community Coalition (provides free summer lunch program for low-income children), Upper Valley Haven, LISTEN Community Services,	• Reduced food insecurity experienced by low-income school age children during the summer and for all community residents experiencing food insecurity.

Strategy	Outcomes
and Willing Hands in close collaboration with DH system.	
Screen all Primary Care patients ages 0- 18 years of age for food insecurity during annual wellness visit, and all Emergency Room patients 70 years and older. For patients who screen positive for food insecurity and request support offer non-perishable food bags, APD Alice Café Meal Cards, Farmers Market vouchers and automated eDH (APD electronic medical record) referral to Women, Infant and Children (WIC) in certain patient populations.	• Improved identification of food insecurity in APD patient population, improved access to urgent need resources and federal programs.
Review and continuously improve APD's in-patient and outpatient-Alice Café -menu with affordable and healthier food choices. Continue to make Alice Café available to community residents.	• Reduced number of unhealthy food options on APD's menu and improved access to nutritious and low-cost food for APD employees and community residents.
Housing	
Strategy	**Outcomes**
Screen adult patients (18 years +) for housing needs using Primary Care Adult Screener and assist patients in need requesting support with applications for local resources (e.g. Twin Pines, Section 8 Housing Program).	• Reduced housing as a barrier to clinical care.
Bi-annual participation in point-in-time Housing Count led by the City of Lebanon, LISTEN Community Services and Upper Valley Haven.	• Supports funding, advocacy and monitoring of programming for the unhoused population.
Continue collaboration with Housing First Meeting run by the City of Lebanon.	• Enhanced collaboration, innovation and local housing strategy.
Transportation	
APD does not intend to develop strategies to address transportation as a community health need for reasons which include resource constraints, lack of expertise to affectively address needs, other facilities in community are better equipped to address need. APD will remain in conversations with Advance Transit and transportation planning efforts within our region to enhance advocacy efforts and collection of meaningful data in partnership with DH system and community partners. APD will continue to assist patients with Advance Transit ACCESS AT applications who meet medical criteria to request medical transportation rides to and from appointments. ACCESS AT is Americans with Disabilities Act (ADA) complimentary paratransit service intended to make transportation available to everyone.	

Childcare	
APD does not intend to develop strategies to address the childcare need for reasons which include resource constraints, lack of expertise to affectively address needs, other facilities in community are better equipped to address need.	
Literacy /Education	
Strategy	**Outcomes**
Continue participation in the Reach Out and Read Program for children and young adults and support navigation of educational system.	• Improved knowledge of importance of early literary in children and young adults and improved access to literature.
Maintain free library on APD campus.	• Improved access to literature and awareness of the importance of literacy.

Acknowledgements: Dartmouth Health system members Our Members | Dartmouth Health in Community/Population Health, Regional institutions and foundations, JSI, R.C. Brayshaw & Company, LLC, internal APD community health stakeholders, community organizations and residents.

References:

Charitable hospitals - general requirements for tax-exemption under Section 501(c)(3) | Internal Revenue Service

Requirements for 501(c)(3) hospitals under the Affordable Care Act – Section 501(r) | Internal Revenue Service

Community health needs assessment for charitable hospital organizations - Section 501(r)(3) | Internal Revenue Service

DHAPD 2025 CHNA 3.06.2025.pdf

Glossary | Coproduction Collaboratory

Co-production in research – UKRI

Home | Alice Peck Day Life Care

APD FY24 FINAL Community Benefits Report with Addendum.pdf

Collaborative Care Model

Social Determinants of Health 201 for Health Care: Plan, Do, Study, Act - PMC

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