2020

Community Health Benefits Report

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

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Mt. Ascutney Hospital and Health Center (MAHHC), demonstrates our vision to improve the lives of those we serve through our community health initiatives. This report is a summary of the work MAHHC and our community partners have accomplished to improve the health and well-being of the communities in our region. We have used the 2018 Community Health Needs Assessment (CHNA) as our guide in the process.

INTRODUCTION

Our last Community Health Needs Assessment (CHNA) was completed in 2018. This assessment identified community health concerns, priorities and opportunities for the MAHHC service area which covers a geographic area of 13 municipalities in Vermont and New Hampshire. Our CHNA was conducted in conjunction with a 5 hospital collaborative which included Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, New London Hospital, and Valley Regional Healthcare.

The Community Health Implementation Plan (CHIP) serves as our guide to transform data received in the CHNA to improve health within the populations we serve, that leads to action. Our CHIP was approved by the MAHHC Board of Trustees in December 2018.

We began our Community Health Implementation Plan in 2019 after convening a multisector planning team and organizing two Community Health Summit's in Windsor and Woodstock Vermont. These Summits were designed to educate our community about the findings within the needs assessment and to involve agencies and citizens as an Accountable Community for Health (ACH) in a collaborative plan to improve the health status of our communities. MAHHC is the lead organization for our regional Accountable Community for Health. This aspirational model demonstrates accountability for the health and well-being of the entire population in our geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors.

An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care.

It also supports community-wide prevention efforts across our defined geographic area to reduce disparities in the distribution of services to promote health and wellness.

Our commitment in 2020 was to continue to address each of the top health priorities identified within the CHNA. You will find our efforts recounted on the pages that follow.

Of note, we chose to design a "deeper dive" to radically transform our efforts with a technique called Collective Impact. Collective Impact brings people together, in a structured way, to achieve social change. The four initial workgroups of 2019 included Strengthening Families, Alcohol and Substance Misuse, Housing and Senior Health. In 2020 we added, to our four initial CHIP workgroups, two additional workgroups to address Food Security and Spiritual Health. A COVID-19 Response Team was also created in 2020.

Each of these workgroups were structured to lay the foundation of 5 Core Elements including: Identifying a Problem Statement, conducting a Root Cause Analysis, developing an Aim Statement, selection of Best-Practice Strategies and designing pre-established Results-Based Accountability evaluation metrics. Each workgroup was also required to incorporate community members with first-hand experience who have been impacted by the issue being addressed. Each of the initial workgroups completed their 5 Core Elements in 2020 and have begun to implement their Best-Practice Strategies.

March of 2020 brought a worldwide COVID-19 pandemic into our lives. We responded to this devastating and life changing public health emergency by leading our community partners in the creation of a Windsor Area COVID-19 Relief Response Team. Our staff also joined a multi-sector Woodstock Area Relief effort. The work related to preventing, protecting and treating our community has been extensive and is detailed within this report.

Please direct comments or questions to Jill Lord, RN, MS, Director of Community Health, Mt. Ascutney Hospital and Health Center, 289 County Rd., Windsor, VT 05089, 802-674-7224, jill.m.lord@mahhc.org.

WINDSOR HSA COMMUNITY COLLABORATIVE

Accountable Community for Health, because we are stronger together.

Governance and Vision

Leadership Partners
Convene • Listen
Align • Advocate
Support • Evaluate

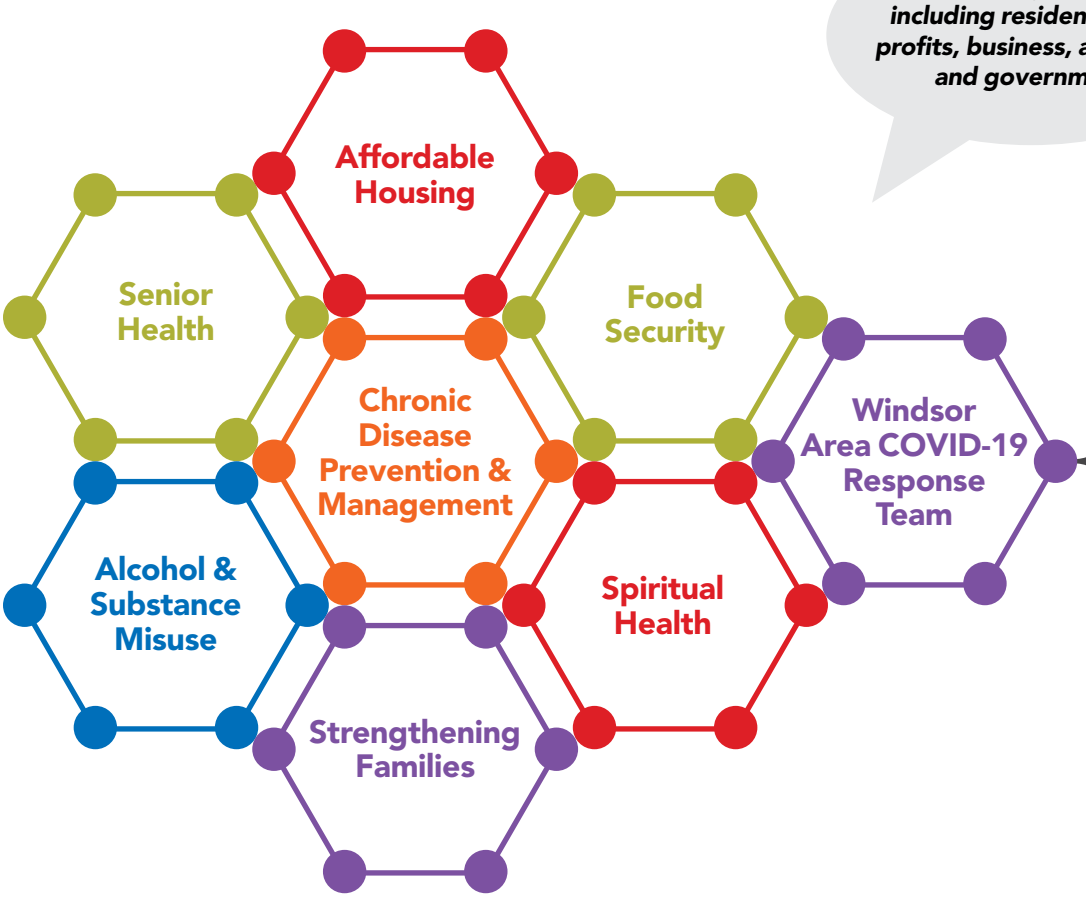
Backbone Organization
Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Our Community Vision:
- Well Nourished
- Well Housed
- Mentally Healthy
- Physically Healthy
- Financially Secure
- Socially Connected and Valued

Our Community Mission:
- Increase quality of health care
- Improve patient experience
- Contain the costs of care
- Promote health equity

Driver:
- Community Health Needs Assessment

Community partners including residents, non-profits, business, agencies, and government



CORE ELEMENTS
- Problem Statement
- Root Cause Analysis
- Aim Statement
- Best Practice Strategies
- Results-Based Accountability

Adapted from Listening to the Stars: The Constellation Model of Collaborative Social Change. Tonya and Mark Surman, 2008

CHIP PARTNERS LIST

Substance Misuse

- Mt. Ascutney Hospital and Health Center
- Artistree
- HCRS
- HIV/HCV Resource Center
- Mt. Ascutney Prevention Partnership
- OHC
- Second Wind Foundation
- Southern Vermont Area Health Education Center
- State Senate
- Stat-Eval
- The Family Place
- TLC Nursing
- Trinity Evangelical Church
- Turning Point Recovery Center- Springfield
- Two Rivers Ottauquechee Regional Planning Commission
- United Ways VT & VT-211
- Valley Court Diversion Program
- Vermont Department of Health

Strengthening Families

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

Housing

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

Chronic Disease Prevention & Management - RiseVT

- Mt. Ascutney Hospital and Health Center
- Community Health Committee, MAHHC
- Green Mountain Retired Seniors Volunteer Corps
- Hartland residents (2)
- Hartland Select Board
- Hartland, Recreation
- MAHHC volunteer
- Mt. Ascutney Prevention Partnership
- OneCare
- RiseVT Windsor County
- SEVCA-Windsor County Head Start
- Southern Windsor County Regional Planning Commission
- Springfield Office, VT. Department of Health
- Two Rivers Ottauquechee Regional Planning Commission
- West Windsor resident
- Wild Women of Windsor
- Windsor County Mentors
- Windsor Food Shelf
- Windsor residents (3)
- Windsor Rotary
- Windsor Schools

Chronic Disease Prevention & Management - Hypertension

- Mt. Ascutney Hospital and Health Center
- SASH

Chronic Disease Prevention

- Mt. Ascutney Prevention Partnership

Chronic Disease Prevention & Management - Diabetes

- Mt. Ascutney Hospital and Health Center
- SASH

Spiritual Health Workgroup

- Area Churches
- Chaplain

Seniors

- Mt. Ascutney Hospital and Health Center
- Aging in Hartland
- Granite United Way
- Green Mountain RSVP Coordinator
- HCRS
- OHC
- OneCare VT
- Ottauquechee Health Foundation
- SASH
- Scotland House
- Senior Solutions
- Seniors Together
- Thompson Senior Center
- UU Church Woodstock
- Vermont Department of Health
- Vermont-211
- Volunteers in Action
- VISTA
- VNH

Chronic Disease Prevention & Management - Falls Prevention

- Mt. Ascutney Hospital and Health Center
- Bayada
- Historic Homes of Runnemede
- Mertens House
- SASH
- Thompson Senior Center
- VNH
- Volunteers in Action
- Windsor EMS
- Woodstock EMS
- Woodstock Terrace

Chronic Disease Prevention & Management - Care Coordinator

- Mt. Ascutney Hospital and Health Center
- Bayada
- DCF
- HCRS
- SASH
- Windsor Central Supervisory Union
- Windsor Southeast Supervisory Union
- Senior Solutions
- Twin Pines Housing
- VNH

Windsor Area Covid-19 Response Team

- Mt. Ascutney Hospital and Health Center
- Citizens of Windsor
- Volunteers in Action
- Windsor Churches
- Windsor Improvement Corp.
- Windsor Resilience Committee
- Windsor Town Government

Food Insecurity Workgroup

- Mt. Ascutney Hospital and Health Center
- Change the World Kids
- Citizens
- Mt. Ascutney School District
- North Chapel Unitarian Universalist Church
- Ottauquechee Health Foundation
- Rachel's Kitchen
- RiseVT
- Sustainable Woodstock
- Upper Valley haven
- Vermont Food Bank
- Windsor Food Shelf
- Woodstock Food Shelf

VT POPULATION HEALTH MODEL (4 QUADRANTS OF HEALTH)

The VT population health four-quadrant model helps us to strategically plan and implement programs to keep the well, well. The graphic here demonstrates the interventions and support provided so that each population group is continually moved towards wellness. Using this approach, we are addressing prevention at every stage, even in highly complex-care patient groups. We have historically prioritized prevention of illness and this model helps us to continue to focus on prevention across the continuum of care.

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
- CHIP Addressing Community Health Needs
- DULCE
- Family Wellness Program
- Mt. Ascutney Prevention Partnership
- (CHIP) Workgroups
- Flossbar
- Rides to Wellness
- Summer Picnic Series
- RiseVT

MAHHC COMMUNITY HEALTH MEETS PEOPLE WHERE THEY ARE AND HELPS THEM MOVE TOWARD GREATER HEALTH AND WELLNESS.

QUADRANT 2

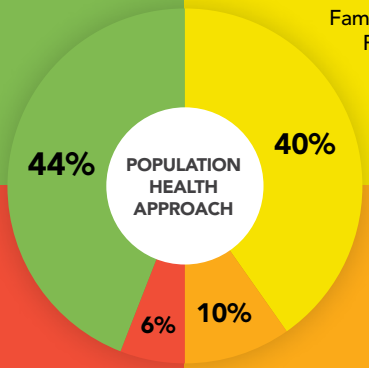
EARLY ONSET CHRONIC ILLNESS & RISING RISK

(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
- CHIP 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
- CHIP 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
- CHIP 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

As an Accountable Community for Health we could not accomplish our work without community partners.

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
Windsor Connection Resource Center	Steve Henry, Service Coordinator – **0.5**	Susan Whittemore, Service Coordinator – **0.5**	Carol Rice – **Per Diem**				
Family Wellness Program	Courtney McKaig, Wellness Coach – **1.0**	Katrin Tchana, MSW, Family Wellness Therapist – **0.5**	Alice Stewart, Evaluation – **0.01**				
RiseVT	Alice Stewart, RiseVT Program Manager – **0.37**	Courtney Hillhouse, Communications Specialist – **0.10**					
Mt. Ascutney Prevention Partnership	Melanie Sheehan, Reg. Prevention Program Mgr – **0.90**	Courtney Hillhouse, Community Outreach – **0.775** Elizabeth Kelsey, Communications Specialist – **0.8**	Alice Stewart, Grant Implementation Team Leader – **0.62**				
Blueprint Self-Management	Sarah Doyle, Coordinator – **0.5**						
Windsor Community Health Clinic (self-management programs)	Samantha Ball, Coordinator – **1.0**	Kristi Clark, Assistant Coordinator – **0.3**					
Housing and Support Services	Bess Klassen-Landis – **0.22**						
Support and Services at Home	Rita Rice, RN – **0.17**						
Volunteers in Action	Anna Caputo – **0.9**	Scottie Shattuck – **Per Diem**	Martha Zoerheide – **Per Diem**				
Blueprint Community Health Team	Carla Kamel – **1.0** Liz Sheehan, RN – **1.0**	Amy Swarr, RN – **1.0**	Jenna Austin, MSW – **1.0**				
Blueprint Spoke Team	Paula Buckley, RN – **1.0** Gail Mears, Spoke Counselor – **1.0**						

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.

COVID-19 Response

The COVID-19 pandemic placed our region and the whole world in a public health emergency. Fortunately, over the years we have built a strong and trusted network of community partners. MAHHC relied on key stakeholders and agencies to help us mount a swift and effective response to mitigate the effects of COVID-19, protect the vulnerable in our communities, marshal community resources and continue to live our mission of "improving the lives we serve."

This work is summarized as follows:

BUILDING ON A STRONG AND TRUSTED NETWORK OF COMMUNITY PARTNERS:

MAHHC led the formation of the Windsor Area COVID-19 Response Team.

Mission: The Windsor Area COVID-19 Response Team is a coalition of professionals and citizens dedicated to helping the community meet the challenges of COVID-19 in a way that promotes the health and well-being of the community while keeping people safe and helping them have access to necessary services.

Membership: Representatives from Mt. Ascutney Hospital and Health Center, The Windsor school system, Windsor town government, Volunteers in Action, The Windsor Improvement Corporation, The Windsor Resilience Committee, The Windsor churches, the citizens of Windsor, the Windsor and Hartland Food Shelves.

Subcommittees/Workgroups:

- MAHHC Leadership to form in Windsor area
- Communication
- Food Security
- Economic Security
- Family Wellness - Child Care and Mental Health

COMMUNICATION

Purpose: to educate, share resources, promote health and reduce risk of infection, decrease social isolation and promote compassionate support.

- Created a website for citizens to express needs and developed a workflow to meet the needs, and to recruit support and mobilize community volunteers (75 as of 10-13-20)

sites.google.com/view/windsorvt-covid19

- Implemented daily dissemination of education and resources through website, social media, Front Porch Forum, town newsletter, electronic distribution networks
- Began developing a system of street captains for local communication network
- Developed a compassionate support outreach of phone calls and pen pals to all local nursing homes and assisted living, as well as elders and socially isolated individuals

ECONOMIC SUPPORT

Developed a workflow and an algorithm between the website, Volunteers in Action and the Community Health Team (CHT) linking financial needs with traditional resources such as Economic Services and SEVCA and then to grant resources:

- Procured $20,000 in funding from Dartmouth-Hitchcock and private Foundations for a pool of funding to support local needs
- Combined resources with Woodstock Relief Fund ($130,000) and worked with Vermont Community Foundation, and Ottauquechee Health Foundation to increase awareness of resource available and connect with those in need
- Mobilized the CHT social workers with Volunteers in Action and our Windsor Community Health Clinic (free clinic at MAHHC) to assess and meet the pressing needs for social determinants of health

FOOD - DECREASE RISK OF FOOD INSECURITY AND HUNGER IN A TIME OF CRISIS. (SEE PAGE 15)

As COVID-19 struck our community in February/March 2020, it became extremely important to increase our efforts to decrease risk of food insecurity and hunger at the time of the crisis. By mobilizing community action networks and through a Windsor Area COVID-19 Response Team, we were able to achieve the following:

- 750 meals a day during the school year and 160 meals a day during the summer
- Supported schools in packing and distribution of food
- Supported Meals On Wheels with volunteers and alternate sources of food from two restaurants in town
- Supported food shelves with volunteers and food drives
- Conducted outreach, linking three farms to four food shelves for increased supplies of local milk, eggs, and cheese. Also arranged for milk supplies from The Haven and Vermont Food Bank
- Facilitation of resources with the Vermont Food Bank
- VeggieVanGo served an average of 307 families each month, a 105% increase
- Working with RISE VT to promote gardens – partnered with Windsor Community Garden to establish a new garden at the library and rehabilitate raised beds at the Windsor Connection Resource Center (WCRC), worked with the Windsor Food Shelf to distribute porch garden kits to 25 families, supported community composter initiative in Hartland
- Worked with local restaurants, schools and food shelves, individual/agency philanthropy to provide meals to those in need

FAMILY WELLNESS-CHILD CARE & MENTAL HEALTH

- Assessed increased signs of distress/stress of families
- Provided outreach through Family Wellness Program phone support
- Created a video re: coping and support services
- Created a flyer and did a mailing to all pediatric families re: self-care, coping and infection prevention
- Organized three prevention of suicide trainings working with HCRS – Kate Lamphere - provided training and capacity building for approximately 100 hospital and community partners
- Promoted HCRS Warm Line
- Convened a meeting of VDH, regional recreation departments and summer camps–Dr. Breena Holmes provided education and the participants had an opportunity to have questions answered and receive encouragement and appreciation for their support of families
- Supervised VT AHEC Intern McKenna Brinkman to assess regional summer camp capacity, and provided weekly updates for networks of available openings for families. Hosted by the UV Strong Child Care Committee website

LESSONS LEARNED...

Crisis – Our community can mobilize quickly and effectively to utilize a neighbor helping neighbor approach to meet financial, social, educational, nutritional and mental health needs. The existing infrastructure of our Windsor HSA Community Collaborative/Accountable Community for Health and trusted community partnership's made our response successful.

Recovery – Our community is resilient. We can continue to screen, clean and keep space in between while resuming necessary care and services.

Sustainability – Our community can analyze and sustain strengths and lessons learned from the COVID-19 pandemic. Examples of sustainability efforts include the power of trusted relationships, continuation and evolution of Telehealth and telecommunication, implementation of effective infection prevention strategies, the ability to share resources and work collaboratively.

Access to Mental Health

Improving the mental health status of our community is a critical component of our plan. MAHHC made significant investments in 2020 to design and implement a trauma - informed care educational series for hospital staff and community partners. We worked with "Project Launch" at Dartmouth-Hitchcock as well as Health Care and Rehabilitation Services (HCRS).

FOCUSED, NEW 2020 ACTIVITIES INCLUDE:

- Designed and implemented 6 trauma-informed care classes in 2020; 196 individuals participated.
- Worked with Windsor High School to promote UMatter suicide prevention "gatekeeper training."
- Provided a support group for parents who have experienced the death of a child.
- Worked with Family Wellness Program to deliver a COVID-19 coping strategies plan to all families in our pediatric program.
- Worked with the pediatric program and HCRS to improve communication and strengthen services.
- Our Family Wellness Therapist developed a Mental Health Access Team. Since starting in January 2020, access to this service has increased over 30% and the number of visits has more than doubled. (read more about the Family Wellness Program on pg. 7)
- Taped "For Your Health" Television show re: Helping Families with Coping during COVID-19. Show can be found here: youtu.be/JLQuDgnqEsU
- Welcomed new Psychiatrist Dr. Biesheuvel.

EXISTING INITIATIVES THAT WERE ENHANCED AND MAINTAINED IN 2020 INCLUDE:

- Added two full-time psychiatrists providing services as part of the Patient-Centered Medical Home (PCMH).
- Continued contractual agreement for monthly pediatric psychiatry consultation.
- Embedded HCRS clinician available in our PCMH 3 days a week (remote March through September).
- Provided 1 Wellness Recovery Action Plan (WRAP) self-management class.
- Provided 288 mental health counseling sessions at the Windsor Connection Resource Center.
- Continued staff support through Chaplaincy services.

Alcohol & Substance Misuse

MAHHC has progressively implemented best-practice approaches to prevent and reduce alcohol and substance misuse since the mid-1990s. We have continued this effort in 2020.

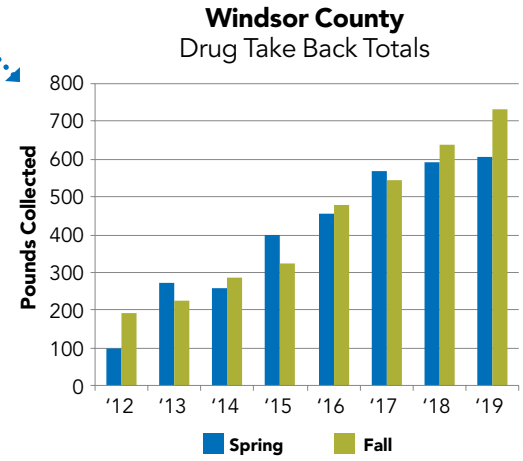
COMMUNITY-BASED PREVENTION

The Mt. Ascutney Prevention Partnership (MAPP) is a community-based public health coalition operated under the auspices of Mt. Ascutney Hospital and Health Center. MAPP was designed to focus on prevention. To build and maintain healthy communities, a comprehensive approach beyond education is needed. While education increases awareness and helps individuals make better choices, it only affects the individuals who receive it. MAPP focuses on broader, environmental strategies which improves lives by transforming communities at the population level. Our 2020 activities include:

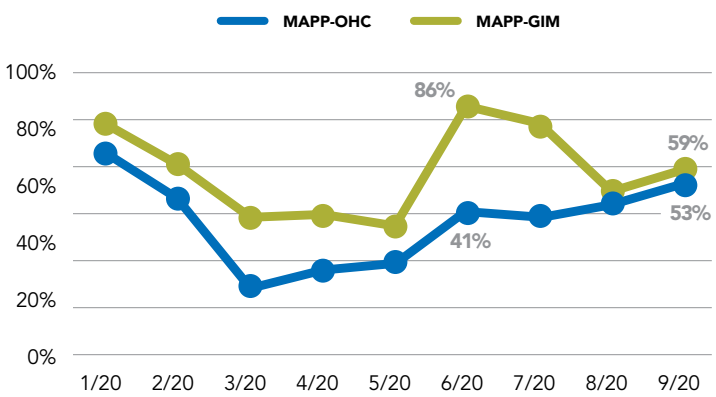
- Subawarded ~ $253,000 to 11 community organizations to implement prevention strategies at the local level. Sectors included Restorative Justice, School districts, Recovery Centers, Training agencies, Law Enforcement, Healthcare. There was equal distribution of resources across the social ecological model, from individual to policy level approaches.
- Provided funding for Windsor Southeast Supervisory Union (WSESU) to conduct a Collaborative Problem Solving (CPS) readiness assessment across the district with over 150 leadership and staff. CPS is a best-practice approach to overcoming social emotional learning challenges with children. Kids do better if they can! Building these essential skills is an "upstream" substance misuse prevention approach.
- Supported the adoption of town health chapter template for 3 towns and continue to facilitate health chapter process in 5 other towns.
- Co-created Health Policy Clearinghouse with local Regional Planning Commission– a resource for decision makers, towns, schools, planning commissions, etc. to view best-practice policy solutions to building local cultures of health and prevent substance misuse.

Mt. Ascutney PREVENTION PARTNERSHIP **www.mappvt.org**

- Designed a data dashboard for use by partner organizations and communities to access local, relevant population health indicators for the purposes of health planning and / or grant writing. Visit: app.resultsscorecard.com/Scorecard/Embed/66478
- Researched data related to disparities in the region to complete a thorough needs assessment. From the needs assessment, programs are planned around equity. Report found here:
- Continued efforts to decrease access to dangerous, addictive medications by:
  - Maintaining mail-back envelope supplies in over 30 kiosks set up at various community locations in 2019. From October 2019 to June 2020, 161 mail-back envelopes were returned to the state from the White River Junction Health office catchment area.
  - Supporting October 2019 Drug Take Back efforts (Spring event cancelled due to COVID-19), 735# of prescription drugs collected. This is a record amount collected since first event in 2012.



Percentage of Patients (New Patients, Annual Exams, Well Visits) **Who Received SBIRT Screening**



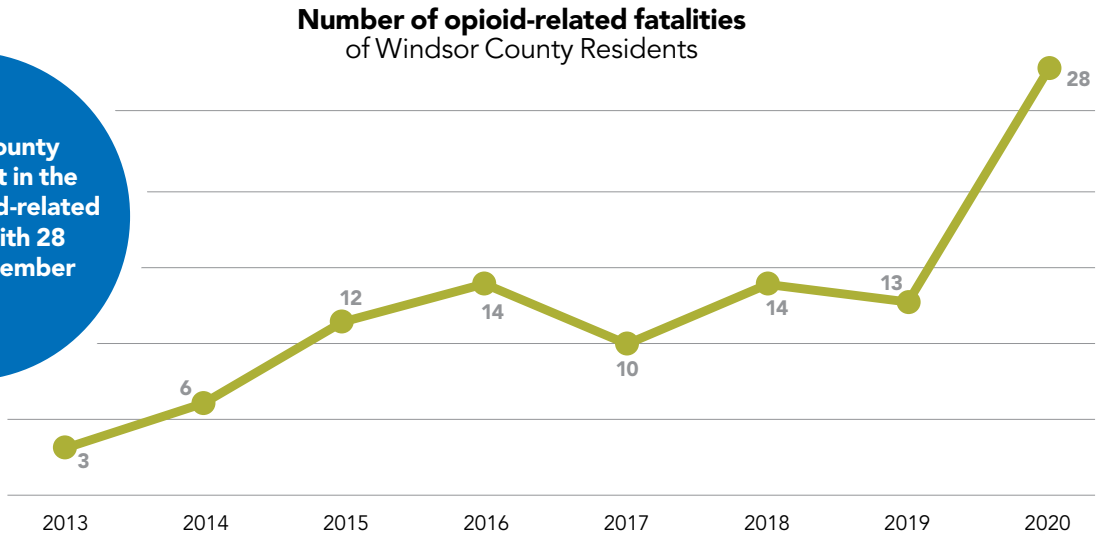
MEDICAL-BASED PREVENTION, TREATMENT AND RECOVERY

- 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 4 years.
- Windsor County has a second lowest rate of prescriptions of benzodiazepines and stimulus medications for 4 years.
- We have implemented substance use Screening Brief Intervention and Referral to Treatment (SBIRT) in the clinic.
- In 2020, 2217 individuals were screened and referred to treatment as indicated. This is an over 450% increase from 2019.

PREVENTION OF OVERDOSE DEATHS

Windsor County has been recognized as a high risk area for overdose deaths. Please see graph for the number of opioid-related fatalities and Windsor County. We have aggressively implemented Best-Practice Strategies to combat this devastating phenomena. These strategies and programs have been implemented working with strong community partners, MAHHC leadership and expertise and grant support.

Windsor County is the highest in the state for opioid-related fatalities, with 28 through December 2020.



OVERDOSE PREVENTION TRAINING

Summit participants identified trauma experienced by those administering Narcan that led to their reluctance to carry and administer Narcan. A team formed consisting of leadership from MAHHC and HIV/HCV Resource Center. This team began to design an educational booklet to be attached to Narcan boxes to provide critical education to those who administer Narcan. This booklet was previewed by those in active use and pharmacists throughout the state. Input was incorporated and the booklet is now being readied for production.

The MAHHC and HIV/HCV team organized a WebEx to train those who distribute Narcan in a train the trainer format so that they could provide essential training to those carrying Narcan. The first 90 minute WebEx PowerPoint and training was provided to Recovery Coaches from Wilder and Springfield, as well as members of the Hartford Police Department. A video about preventing overdose death was also created and can be found at the following link: youtu.be/uvEOjxLSqT4

MAHHC has become a naloxone distribution site for the community placing life-saving medication in the hands of friends and relatives whose loved ones otherwise may have died from an overdose.

OUTREACH AFTER OVERDOSE

Recognizing that those who have experienced one overdose are at higher risk for a second overdose and fatality. MAHHC has worked with teams of Police/EMS Departments, Recovery Coaches and mental health professionals in Hartford, Windsor and Springfield to launch a modified Police Assisted Addiction and Recovery Initiative (PAARI Project) in each community. Teams have formed and workflows are being created so that when an overdose occurs the Police/EMS notify mental health professionals who in turn notify Recovery Coaches. A team consisting of a combination of Police/EMS/Counselor/Recovery Coach provides outreach after the overdose to the affected person and family. Empathy, resources, support and linkage to treatment is offered to both the patient and the family. Each of these community level teams are in various stages of formation. Each is committed to work together to provide systematic support and linkage to treatment after an overdose.

RAPID ACCESS TO MEDICATION ASSISTED THERAPY (RAM)

Administration of Suboxone is a recognized best practice for the treatment of opiate addiction. MAHHC has led an effort to organized teams of Emergency Departments and treatment providers in Windsor and Springfield to assess for addiction in the Emergency Department, initiate Suboxone in the Emergency Department and refer to a treatment provider for ongoing medication and counseling. The goal of this project is rapid access to medication and treatment at the first sign of readiness. MAHHC Emergency Department began RAM in 2019 under the leadership of Dr. Perras and Dr. Marasa. Much of this year was spent helping Springfield Hospital prepare for initiation of the program.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP;
ALCOHOL AND SUBSTANCE MISUSE 2020 UPDATES

The Alcohol and Substance Misuse CHIP workgroup met 11 times from October 2019 – September 2020. In that time frame, stakeholders:

- Assessed barriers to engaging in substance misuse treatment from survey results from over 25 persons with lived experience.
- Engaged in scientific process for selecting the top 4 barriers identified: pathways (not enough access to treatment), stigma (guilt, shame, etc.), life circumstances (competing priorities), and ambivalence (hard to change).
- Selected 2 concrete strategies to overcoming barriers: Integrate a recovery presence at community events and create a formal anti self-stigma communications campaign.
- Completed evaluation plan process to identify Results-Based Accountability (RBA) measures to evaluate: How much did we do? How well did we do it? Is anyone better off?
- Worked with partners in recovery to disseminate over 5,000 "Overcoming Isolation" Recovery support flyers at 8 local food distribution sites, 11 farmer's markets interacting with 1,669 local families during the pandemic.
- Contracted with professional marketing agency and procured funding to design the campaign.
- Began planning and implementation of a communications campaign designed to overcome self-stigma as a barrier to treatment. Visit; www.weareworthwhile.org.

worthwhile
I am more than my disorder.

CHIP CORE ELEMENTS

PROBLEM STATEMENT	Substance misuse (all substances) treatment options are underutilized by the adult population.
ROOT CAUSES	The components contributing to the adult population underutilizing 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	Decrease the following barriers to substance misuse treatment for adults in the Windsor HSA within 3 years: availability of services, stigma (guilt, shame, etc.), life circumstances & competing priorities/chaos, and ambivalence with regard to recovering.
BEST PRACTICE STRATEGY(IES)	Develop communication campaign that messages self worth to overcome self-stigma around Substance Use Disorder. Overcoming social isolation of recovery by integration of the recovery community with the general public at community events (role modeling that recovery can still be socially fun!)
RESULTS BASED ACCOUNTABILITY **(RBA)/DATA COLLECTION**	Communication Campaign: # of people who receive the message, % of reshares of social media posts, % of people new to recovery or treatment who were influenced to take action by our campaign, % of people who view the campaign who show a change in how they view addiction. Recovery Integration at Community Events: # of events that we add a recovery presence to, % of towns that have public events that participate in our initiative, % of event hosts who report satisfaction with the experience, # of event hosts that take action to become more recovery friendly.

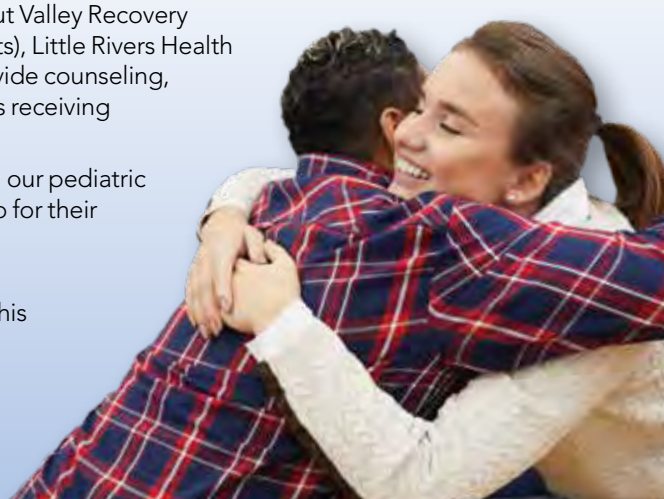
TREATMENT

MAHHC has been a member of **Vermont's Hub and Spoke Program** for treating opioid use disorder since its inception. MAHHC is the administrative entity in the Hub and Spoke Program for our pediatric program and Dr. Smith patient's Ottauquechee Health Center (8 Medicaid patients), Connecticut Valley Recovery Services (82 Medicaid patients), Bradford Psychiatric Services (48 Medicaid patients), Little Rivers Health Care (33 Medicaid patients). We hire and support nurses and counselors who provide counseling, education, care management, access to primary and preventative care for patients receiving Medication Assisted Therapy (MAT) of Suboxone and Sublicaide.

Our pediatric MAT program is a small but mighty effort that serves 5-6 mothers in our pediatric clinic. These mothers receive medication, counseling and a therapeutic playgroup for their children. The participants have been stable in this program since 2015.

Chronic Pain Consult Team has continued to stand at the ready to provide consultation to providers in the care and management of chronic pain patient's. This team received 1 consult in 2020.

Our Blueprint for Health Self-Management programs offered a successful Chronic Pain Self-Management Program in 2020.



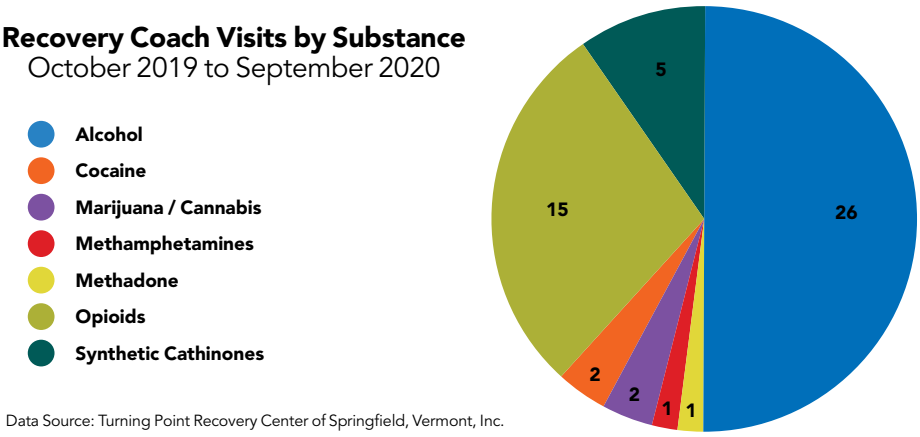
SUBSTANCE MISUSE PARTNERS

- Mt. Ascutney Hospital and Health Center/OHC
- Artistree
- HCRS
- HIV/HCV Resource Center
- Mt. Ascutney Prevention Partnership
- Second Wind Foundation
- Southern Vermont Area Health Education Center
- State Senate
- Stat-Eval
- The Family Place
- TLC Nursing
- Trinity Evangelical Church
- Turning Point Recovery Center - Springfield
- Two Rivers Ottauquechee Regional Planning Commission
- United Ways VT & VT-211
- Valley Court Diversion Program
- Vermont Department of Health

RECOVERY COACHES

MAHHC entered in an agreement with Springfield Turning Point Recovery Center to link patients to Recovery Coaches 7 days a week 24 hours a day. Once the patient consents, the Recovery Coach meets with the patient in the Emergency Department. They also follow the patient to provide support in the first 10 days and beyond after the Emergency Department visit. Recovery Coaches have provided real and meaningful support to our patients struggling with addiction. The graph below detail the outcomes of their work in 2020.

Recovery Coach Visits by Substance
October 2019 to September 2020



Data Source: Turning Point Recovery Center of Springfield, Vermont, Inc.

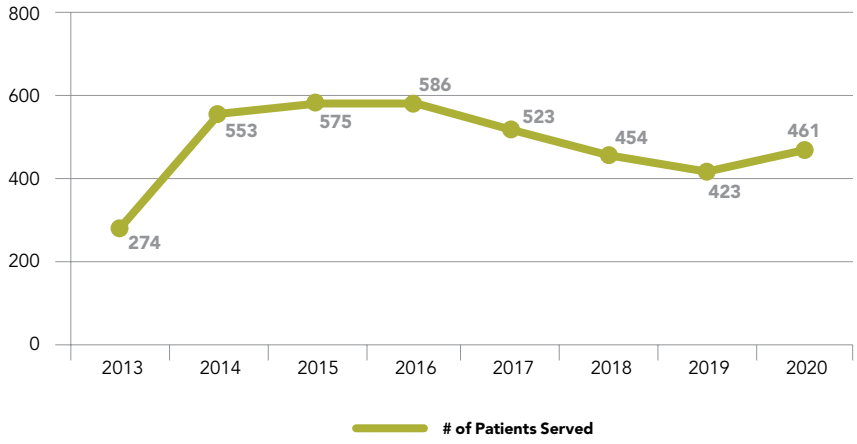
- After intervention, out of 52 visits, 23 continued to follow up (44%)
- Of those able to be reached for follow up, 18 were still in recovery (78%)
- Of those still in recovery, 13 continued to stay involved with Turning Point (72%)

MAHHC has hosted AA and Al-Anon meetings for more than 25 years. These meetings were suspended in March 2020 related to COVID-19. Both Turning Point Recovery Centers of Springfield and the Upper Valley provided virtual AA meetings from March onward in 2020.

Access to Affordable Health Insurance and Prescription Medication

- Increased access to health insurance by partnering with the Thompson Senior Center to offer twice monthly in person assistance to answer questions, review coverage and process enrollments.
- Received COVID-19 relief funding from the Vermont Community Foundation to help with needs of the community impacted by the pandemic.
- Partnered with a new dental practice, Area Dental Services in Claremont, NH to accept vouchers and assist our patients.
- WCHC received funding from DHMC for COVID-19 relief for patients, we have been able to help patients with multiple needs with these funds.
- WCHC was open and available to help navigate the Vermont Health Connect Emergency Special Enrollment Period. Staff were able to help those losing their jobs or decreasing hours to sign up for insurance through the state.
- Through generous funding from Byrne Foundation, WCHC provided medication, dental, equipment, and transportation vouchers to eligible patients.

WCHC # of Patients Served



Windsor Community Health Clinic

Connecting a Young, Working Vermonter with Medications and Health Insurance

In the spring, the Windsor Community Health Clinic (WCHC) was contacted by one of the clinic providers to come speak to a patient in crisis. The patient had been suffering from many health issues and because of this was let go from his job. As fall out from losing his job, he also lost his insurance and was declining medical testing due to the costs. We were able to meet with him that day and get him enrolled onto VT Medicaid to cover his previous medical bills and his future testing needs. After the medical needs were addressed, we became aware that he had not been purchasing much food due to his financial situation and also had pretty severe dental needs. WCHC, MAHHC's social worker and the Ottauquechee Health Foundation (OHF) staff all partnered together to address all of his needs. An application for food stamps and fuel assistance was completed, dental funding was secured through an OHF and WCHC dental grant, all of his teeth were pulled, and a set of dentures were purchased for him. He is now receiving the full support of our "medical home" and receiving his needed care. He has a strong and supportive medical team that he can reach out to if he is having any issues. He is doing so much better and has hopes to return to work in the future!

Strengthening Families

Comments from families describing how they benefited from the Family Wellness Program:

> *Empathic listening - very helpful. [it] Changes the whole dynamic with [a] child once they feel like their voice is being heard. Collaborative problem solving - amazing how kids can offer their own solutions!"*

> *Observing [my child] rather than questioning and naming feelings have worked wonders."*

> *Great program - thank you so much! Always appreciative of how much time the [Coach] spent with us, and the obvious amount of preparation that went into each meeting."*

The Strengthening Families (SF) initiative is a comprehensive, Collective Impact approach to overcome poverty and family stress by increasing skills and capacity for positive relationships in the family unit. There are multiple programs contributing to this effort: the Family Wellness Program, DULCE, and the SF Community Health Implementation Plan (CHIP) workgroup.

Other community-based efforts, such as PATCH (direct service provision) and Asset Development (helping youth feel valued) contribute greatly to this initiative. 2020 updates for each program included here.

FAMILY WELLNESS

The Family Wellness Program (FWP) at MAHHC embeds a Family Wellness Coach and Family Wellness Therapist in the Pediatric Clinics of MAHHC and OHC. It provides a continuum of care anchored in health promotion and prevention with the family unit as the focus, and is offered universally to all families. Family Wellness Program principles:

Emotional Behavioral Health is the Foundation of All Health

Health Runs in Families

We Can Change Our Brains through Wellness Practices

FWP TEAM:

Family Wellness Coach (FWC) - works to keep the well, well; and to protect families who are at risk for developing emotional, behavioral health issues, as well as group parenting workshops.

Family Wellness Therapist (FWT)- treats families whose emotional, behavioral health has been impacted in a way that prevents positive family functioning. Participating families receive individual education and counseling.

OUR DATA SHOWS...

- The Family Wellness Coach saw 116 individual families (9% increase) in 239 sessions (2% increase)
- The Family Wellness Therapist saw 116 individual patients (34% increase) in 532 sessions (58% increase); some sessions held via Telehealth due to COVID-19
- The Family Wellness Program served a total of 232 patients, in a total of 771 sessions

From an early Fall 2020 survey of 35 families, 100% report they either Agreed or Strongly Agreed:

✓ **Their experience with the Family Wellness Program was valuable.**

✓ **They learned positive ways to interact and guide behavior for their children.**

✓ **They were able to get an appointment in a time frame that worked for them.**

✓ **Stated they would recommend the Family Wellness Program to other families.**

STRENGTHENING FAMILIES (SF) COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

Over the past year, extensive work has been done by a diverse multi-sector Strengthening Families workgroup. This workgroup identified as its Aim to enhance Social Connectedness, which is one of the 5 Protective Factors of Strengthening Families Framework (SFF) from Center for the Study of Social Policy.

Using a Collective Impact approach and the lens of community capacity, the SF workgroup identified two strategies to address Social Connectedness: regional coordination of Circle of Security and Strengthening Family Play Group. Two action teams emerged from the workgroup to implement these strategies. The SF workgroup intentionally works to maintain sector engagement to ensure broad perspectives are included in the process of the CHIP. In 2020:

- The Regional Circle of Security facilitators are working collaboratively to:
  - Schedule the series in the region, on a rotating schedule
  - Establish a learning collaborative, a Reflective Practice, for facilitators
  - Create shared marketing approach
  - Intentionally maximize the series for social connectedness
  - Use a shared participant evaluation tool and data collection system
  - Ensure sustainability
- The SF Family Play Groups were offered weekly in the Woodstock area prior to COVID-19 and by Zoom and socially-distant walking groups during the pandemic. A Windsor Walks Play Group began in September 2020, taking advantage of "Windsor Walks" (see pg. 15) trail loops and outdoor activities sponsored by the Windsor Children's librarian.
- SF CHIP workgroup leadership sponsored a back-to-school clothing drive, serving 270 families.

CHIP CORE ELEMENTS

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 connectedness of caregivers in the MAH service area within the next 5 years.

BEST PRACTICE STRATEGY(IES)

Approaches will include:

I. Implementing *Strengthening Families* in Vermont towns in the HSA

II. Coordinating a series of Circle of Security parenting education offerings in this region (VT & NH)

RESULTS BASED ACCOUNTABILITY (RBA)/DATA COLLECTION

Data Development Plan

I. How much - # of unique playgroups offered per time period, # of towns in which playgroups are offered, and # of towns from which people participate.

I. How well - % of returning families

I. Is anyone better off - % of participants reporting improvement in the Strengthening Families Protective Factors

II. How much - # of families/households served by COS series

II. How well - % of participants that are satisfied/very satisfied with the series

II. Is anyone better off - % of participants that report they are still using strategies learned in a series 3 months later, and % of participants reporting an enhanced relationship with a supportive person 3 months later

DULCE – A PRIMARY PEDIATRIC CLINIC MODEL

DULCE: **D**evelopmental **U**nderstanding and **L**egal **C**ollaboration for **E**veryone. With this unique approach, a Family Specialist is paired with families of newborns through their 6th month. Having a newborn is a very exciting and exhausting time in a family's life, and the Family Specialist is tasked with helping families consider all the facets of possible needs and promote family wellness. Family Specialists are embedded in the Pediatric clinics of both MAHHC and OHC.

- DULCE implementation began November 2019
- DULCE served 90 families across both clinics, with a participation rate of 80%
- Partners in this endeavor include Vermont Department of Health, OneCare Vermont, the Springfield Area Parent Child Center, VT Legal Aid, and The Family Place.

"The DULCE Program has really helped our family to navigate the challenges that have come with the addition of a new baby to our family. I struggled with PPD/PPA after having Leo, and the resources and support of the DULCE Program have tremendously helped prevent those issues from arising again with Adi. Since becoming a mom I've often felt like I have the weight of the world on my shoulders, and having someone to connect me with resources that can help us overcome the obstacles we face has been a lifesaver for me."

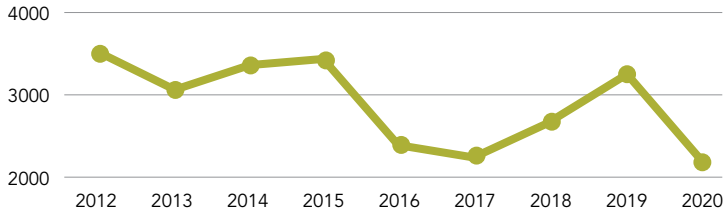
– J.D.

PATCH

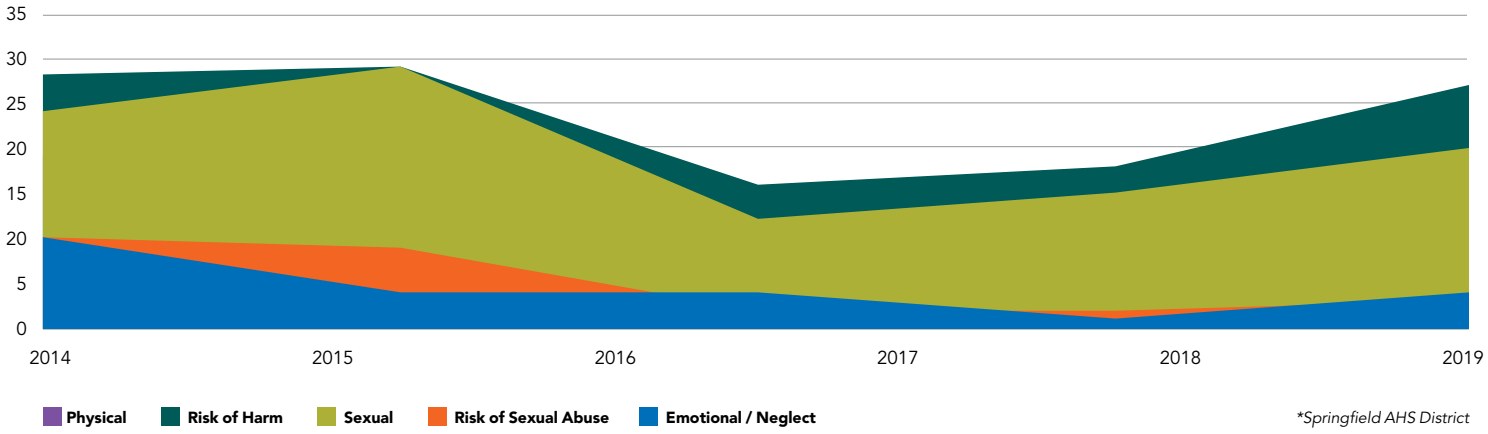
MAHHC provides the leadership for PATCH, a collaboration of Health and Human Services providers who provide services in the Windsor area and through the Windsor Connection Resource Center (WCRC).

The Windsor Connection Resource Center completed a full year of servcie and remained open during the COVID-19 pandemic. Staff and providers engaged in the proper screening, cleaning, and other prevention meausres so that access to essential services was not hampered.

# of People Served by WCRC



Child Abuse & Neglect: Substantiated Reports, by Type*



**Springfield AHS District*

STRENGTHENING FAMILIES PARTNERS

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

DEVELOPING ASSETS

Sled Dog Disco is a Windsor-based group of community members and MAHHC staff who work to create asset development activities and build a flourishing community.

The group has two identified themes for the focus of their work:

Families ·····▸ Connected **Teenagers ·····▸ Valued**

Major activities this year included:

Because of stressors caused by COVID-19, the annual Windsor School Supply Drive was expanded to all WSESU schools and moved from a supplies donation model to financial donations. Sled Dog Disco worked with each school to develop supply lists and coordinate distribution to families.

The drive resulted in 64 individual and business donations from Windsor, Hartland, Weathersfield, West Windsor, and NH.

A total of $6,683 was raised to purchase all needed school supplies for 455 students who qualify for free/reduced lunches.

Mascoma Bank and Old South Church provided administrative support and volunteers from the Windsor Rotary Club helped with moving and sorting supplies.

Supplies were purchased and sorted age appropriately. Asset development and health promotion messaging was included in each student bag.

Community Health and the MAPP also coordinated the second annual Ascutney Mountain Promise Community *New Year's Eve Noon Countdown Family Celebration.*

Access to Primary Care

In 2020:

- Despite COVID-19, we saw only a 4% drop in self-management workshop completion rates compared to 2019.
- Primary Care has met the goal of new patients establishing care within 30 days of a request. Current service is maintaining at 29 days.
- Due to COVID-19, a Respiratory Care Clinic was created to help patients with respiratory symptoms receive the care they need.
- Planned and organized both clinic and community-based flu clinics, for October 2020 launch. Vaccines were given in the clinics as well as in 9 area schools, 6 assisted living facilities and a food shelf.

QUALITY IMPROVEMENT INITIATIVES

Mt. Ascutney Hospital and Health Center celebrated its 10th year anniversary as a NCQA recognized Patient-Centered Medical Home™. Being a Patient-Centered Medical Home means that we meet or exceed all of the required standards of best practice for primary care. This recognition is currently held by both primary care units at MAHHC in Windsor, and its Ottauquechee Health Center in Woodstock.

Access to primary care was identified as one of the top priority community health needs. Much work has been done to increase access to primary care. Dr. Leesa Taft, DNP, ARNPC, Medical Director for primary care led to NCQA recognition process working with the team of primary care and quality improvement staff.

Our Community Health Team continues to work with community partners to provide care coordination and interview interventions which will improve the quality of care in the continuum of care from very high risk chronic care patients to preventative care. MAHHC has provided leadership for regional implementation of care coordination with community partners of Blueprint for Health, OneCare Vermont, SASH, Senior Solutions, VNH, Bayada, DULCE, HCRS, and VCCI.

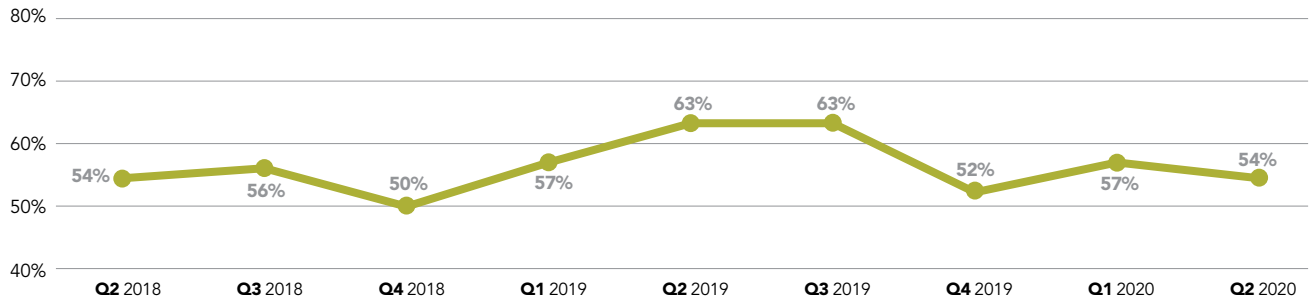
As a result of these efforts, 27% of patients attributed to OneCare VT are care managed by MAHHC Community Health Team, exceeding OneCare's goal of 15%.

Self-care 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 workshops provided this year included: Diabetes Self-Management Program, Diabetes Prevention Program, Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, Wellness Recovery and Action Plan.

HYPERTENSION CARE

- Providers are following best practice guidelines in caring for patients.
- Our Collaborative Care Nurses (CCNs) have developed disease management protocols and patient education. Providers referred to CCNs for follow-up.
- Chronic disease self-management classes are offered.
- Kathleen Meyer RN led a Green Belt Quality Improvement Project to improve hypertension.

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



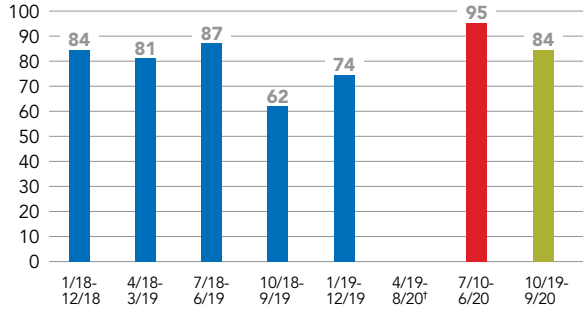
DIABETES CARE

- Dr. Levin has led a quality improvement process after developing a best-practice algorithm and process. He worked with Brenna Heighes, our data analyst, to identify and disseminate accurate outcomes data for the providers.
- In 2020, the providers were able to use dynamic work lists to identify their patients out-of-control and provide out reach for interventions in many of the chronic care conditions.

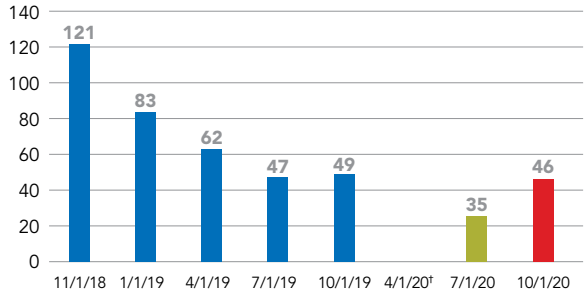
Skill building workshops trends

	# 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%
2020	10	90	76%

A. Number of patients with diabetes whose most recent A1c was >9.0% across MAHHC



B. Number of patients with diabetes with no A1c test in one year, across MAHHC



† Reflects lack of reported data due to COVID-19

Senior Health

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) 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 workgroup was formed.

SENIOR PARTNERS

- MAHHC/OHC
- Aging in Hartland
- Granite United Way
- Green Mountain RSVP Coordinator
- HCRS
- OneCare VT
- Ottauquechee Health Foundation
- SASH
- Scotland House
- Senior Solutions
- Seniors Together
- Thompson Senior Center
- UU Church Woodstock
- Vermont Department of Health
- Vermont-211
- VIA
- VISTA
- VNH

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

- Developed a Quick Guide refrigerator magnet with phone numbers for seven local health-related resource agencies.
- Developing a Senior Services and Aging-in-Place Resource Directory.
- Provided start-up grant money for a community nurse position within a local aging-in-place non-profit group.
- Convened a community forum series to provide information and education on various aspects of developing aging-in-place initiatives.
- Senior Health Workgroup has expanded to include participants from most all towns within the HSA.

SASH – SUPPORT AND SERVICES AT HOME & **HASS –** HOUSING AND SUPPORT SERVICES

The SASH Program includes a Wellness Nurse stationed within community housing in Windsor. Despite staffing challenges, in 2020:

- The Wellness Nurse served over 100 patients with assessments, education, monitoring and care coordination.
- Blood pressure clinics were held as well as a flu clinic this year.

The HASS Coordinator is a MAHHC employee who has worked to decrease social isolation by providing one-on-one care, outreach, as well as classes and events in the beginning of the year. After COVID-19 began, the coordinator initiated a multisector program to transition Olde Windsor Village to a virtual environment working with Housing Vermont, Stewart Properties, Senior Solutions and leadership from MAHHC.

CHIP CORE ELEMENTS

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 MAHHCservice area within the next 3 years.
BEST PRACTICE STRATEGY(IES)	Aging in place groups across the region are in various stages of development - Aging in Hartland being the model for many. Each town needs to figure out what is right for its own town and how best to meet the needs of its citizens. Aging in place groups will look different in each town. Each group that is fledgling or new could be assisted with a road map to figure out next steps in the their evolution. Also, we want to connect with the Upper Valley Nursing Project.
RESULTS BASED ACCOUNTABILITY **(RBA)/DATA COLLECTION**	**How much:** # of existing and new groups collaborating with this network **How well:** % of groups that report that their group is more connected/supported and therefore more able to serve seniors **Is anyone better off:** # of seniors who know to access/find resources

Affordable Housing

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

Stable and affordable housing is an important factor that impacts health. The 2018 needs assessment identified housing as a priority area.

HOUSING PARTNERS

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

> *"A friend had a large house that he was going to tear down. It had been owned by his parents and needed fixing up, so the price was affordable. We created 10 rooms for rent at $600 per month with shared common spaces."*
>
> **– Local Landlord**

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 workgroup was formed.

MAHHC CHIP Affordable Housing Group FY2020 Update

- Identified 13 potentially actionable Root Causes for the lack of affordable homes in our communities by interviews with public and private service providers and municipal leaders.
- Created Results-Based Analysis metrics to track engagement with potential landlords, the number of new units created through those engagements, and the utilization of those new units in meeting community needs for affordable homes.
- Conducted a Community Readiness Assessment by interviewing key respondents in MAHHC service area communities to identify potential partners, opportunities, and obstacles for creation of additional rentals in existing homes.
- Mapped the assets of MAHHC service area communities related to this effort, including the presence of property management companies, realtors working with rental units in homes, the current number of homes and rental units in each community, and community recognition of an affordable housing challenge as expressed in their town plans.
- Launched landlord interview effort to gather stories and build peer network among people who are successfully meeting their economic and social needs by renting to others at affordable rates.

CHIP CORE ELEMENTS

PROBLEM STATEMENT	There is a mismatch between the amount of housing that is available and affordable, and the number of people seeking 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.
BEST PRACTICE STRATEGY(IES)	Creation of new units within existing structures by way of safe home sharing practices, renting rooms, and creating accessory apartments.
RESULTS BASED ACCOUNTABILITY (RBA)/DATA COLLECTION	**How much: #** of successful community education workshops we conduct around home sharing; **How well:** % of short and long term rentals that are meeting identified needs of the target population(s), % of potential landlords who tell us their initial concerns about becoming a landlord were addressed **Is anyone better off:** # of additional residential rental units that become occupied by the target population(s), % of residents within the target population who find their needs are accommodated by the newly available rental units

Dental Care

DENTAL CARE IS IMPORTANT TO YOUR HEALTH!

In fact, your mouth is the gateway to your body for eating and nutrition, how you look and how you are perceived and can confidence in yourself. Many people are not regularly seen by a dentist.

MAHHC worked to help increase access to dental care through our Windsor Community Health Clinic. With the help of a generous donation from Dorothy Byrne Foundation, our 2020 activity includes:

- 36 individuals were helped to find dental care
- $20,057.23 in dental vouchers given to assist those in need of funding for dental care
- We assisted patients in applying for various other dental need funding resources
- 25 persons received services from the mobile Floss Bar in 2019 before COVID-19 temporarily shut down (services include exams, cleanings, xrays, and teeth whitening)

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

**Due to COVID-19, we were unable to run a dental clinic in 2020.*

Nutrition/Access to Affordable, Healthy Food, and Increasing Physical Activity

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

Food security, exacerbated by COVID-19, has long been an area of focus. In 2020, a multisector workgroup was formed to apply a collective impact approach to increasing access to healthy, affordable food.

FOOD SECURITY PARTNERS

- MAHHC
- Vermont Food Bank
- Windsor Food Shelf
- Reading-West Windsor Food Shelf
- Woodstock Food Shelf
- Ottauquechee Health Foundation
- Windsor Community Dinner
- Sustainable Woodstock
- Unitarian Universalist Church, Woodstock
- Change the World Kids
- Vermont Department of Health WIC Program
- Mt. Ascutney Regional Commission
- Two Rivers-Ottauquechee Regional Commission
- Upper Valley Haven
- Windsor Southeast Supervisory Union
- Windsor Central Supervisory Union

> *We are fortunate to be co-chairing such a broad-based and collaborative group of stakeholders. They bring their varied perspectives, deep experience, and creative and curious minds to work on the food security challenges our region faces. Together, we are working to create full access for families and residents in our region to all available community, state, and federal resources that can supplement their food budgets."*
>
> – **Nan Pariseau & Alice Stewart,** Windsor Food Shelf and MAHHC

Prior to COVID-19, Community Health at MAHHC (along with our community partners) continued many outreach activities related to food security and helping the most vulnerable in our region.

- Volunteers in Action (VIA) hosted **57 Community Meals**
- **307 Meals** provided by Meals on Wheels and ViA
- VeggieVanGo was onsite monthly to distribute free produce, **serving roughly 150 families per month prior to COVID-19 and 307 families duringCOVID-19**

FOOD SECURITY

Community Health Implementation Workgroup

MAHHC and our community partners have been working to address food security for many years. When the Vermont Food Bank conducted an assessment of food security in Woodstock and approached MAHHC about working together in March 2020, our Director of Community Health recognized the opportunity to build on the foundation of both our prior work and the Collective Impact structure of the other CHIP workgroups. She reached out to involve stakeholders across our service area and the Food Security CHIP Workgroup is the result.

MAHHC has contributed to improving this issue during 2020 in the following ways:

- Facilitated a cross-sector COVID-19 Food Task Force for Windsor and surrounding towns.
- Through RiseVT, 7 Amplify grants were provided to promote capacity building and access to healthy foods, including the healthy snack and drink "Swap It" project at Hartland Elementary, a milk machine for Windsor schools, porch garden kits for Windsor Food Shelf clients, support for two Windsor Community Garden sites, community composters for each village in Hartland, and a produce exchange in Hartland.

ENCOURAGING PHYSICAL ACTIVITY

Through RiseVT Amplify grants, MAHHC provided funding this year for:

- Yoga and mindfulness series at Children's Place Preschool (Head Start)
- Equipment for aerobic bingo bowling and pickleball for the Windsor Southeast Supervisory Union in-service
- COVID-19-Safe Rise to 5K program in partnership with Windsor Recreation and the Windsor Foodshelf
- At Home Olympics contest to encourage physical activity by families during the COVID-19 shutdown
- Free bike helmets for pediatric patients
- Play equipment to support gross motor development at World of Discovery Child Care Center in Weathersfield

MAHHC partnered with RiseVT, the Town of Windsor, and the Vermont Department of Health on Windsor Walks, a series of walking loops around Windsor. The walking loops vary in length and range from flat ground to hills, and from sidewalks to the shores of Lake Runnemede.

CHIP CORE ELEMENTS

PROBLEM STATEMENT	Our community is facing food insecurity across all age cohorts.
ROOT CAUSES	Lack of knowledge and skills can perpetuate food insecurity and leads to shame associated with accessing community resources that provide food to people.
AIM STATEMENT	Increase access to nourishing food for all people in our communities over the next 3 years.
BEST PRACTICE STRATEGY(IES)	Apply message framing principles to market food security resources to area residents, with the intent of increasing awareness and reducing barriers to access

Smoking/Tobacco Use/Vaping

POLICY EFFORTS:

Building upon previous work with the town of Windsor, MAPP presented at a town Select board meeting. The result was adoption of a smoke/vape-free town-owned parks and land policy, which went into effect September 1, 2020.

TRORC Two Rivers-Ottauquechee REGIONAL COMMISSION

In 2020, we worked with Two Rivers-Ottauquechee Regional Commission (TRORC) to develop an online, searchable Health Policy Clearinghouse that includes sample policies and other resources, many of them centered on smoke-/vape-free environments. To view this resource, visit: trorc.org/healthpolicyclearinghouse

Through our partnership with TRORC, we continued efforts to support towns in "planning for health." As a result of our work, the following towns have adopted a health chapter in their town plans:

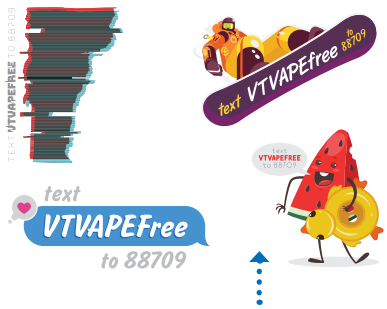
Plymouth • Bridgewater • Royalton * • Bethel *

** Plan adopted in 2020 and includes recommendations related to smoke/vape-free policies*

The MAPP has continuously received and implemented a VT Department of Health Tobacco Prevention grant since 1998. This has resulted in steep declines in tobacco use among youth over many years. Sadly, the invention of e-cigarettes/vaping has brought significant challenges in the world of public health.

MAPP's activity related to tobacco and vaping prevention in 2020 includes:

- In August 2019, we launched a weekly vaping digest in response to the surge of EVALI (vaping associated lung disease) cases reported nationally. The digest was a way to keep school, community, and health care partners abreast of the number of cases reported and other latest news regarding risks of vaping. As time went on, the digest expanded to include additional prevention resources and became a monthly prevention digest.
- Created visual, locked display case of older and newer styles of vaping devices for the purpose of educating school personnel and parents. Circulation of the case put on hold due to COVID-19. However, display case information was adapted to share with partners digitally and posted online via social media channels.
- With the onset of COVID-19, MAPP created a handout on the signs of nicotine withdrawal and how to access cessation services.
- Partnered with Hartland Elementary Health Teacher to design smoking/vaping research and reporting activity for middle school students. The students presented their findings to other students and staff.



- Designed and ordered **stickers**, pens, hand sanitizers, and cell phone wallets designed to build awareness of vaping quit resources, particularly among teens. Items were distributed to several area schools and are popular.
- Continued to participate on the Hartland and Windsor School Wellness Committees and the Whole School, Whole Child, Whole Community Supervisory committee where prevention information and education is shared.
- Worked with MAHHC Tobacco Cessation Coach to increase connections with our providers to ensure they have the latest information on vaping trends and resources available, particularly for youth seen by the Pediatrics Department.

Outcomes: The Windsor County (WC) data profile produced by VT's Alcohol and Drug Program division shows that WC rates of cigarette and vaping use in the past 30 days for high school students is statistically better than the state at 17% vs. 21% respectively. WC is also better than the State for rate of students who start smoking before age 13 (5%) and for parents who believe it is wrong or very wrong for children to smoke (88%).

Access to Transportation

PROGRAM STATISTICS:

Volunteers in Action ~ 2020	
# rides given	543
# miles driven	4,930

Rides to Wellness ~ 2020	
# rides given	155
# miles driven	1,233

Our Volunteers in Action (VIA) are in their 23rd year of connecting neighbors with needs to people who care. They also provide transportation to those in need. In 2020, VIA continued the "Rides to Wellness" Program, providing medical rides for local community wellness. Other transportation services include essential shopping trips and non-medical appointments. The VIA transportation service was heavily impacted by COVID-19. Rides were given from October 2019 through March 2020 and then were temporarily discontinued.

In addition to the help of VIA, our Windsor Community Health Clinic also provides gas cards to those in need through the generosity of a donation from Dorothy Byrne.

Spiritual Health

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

Work will continue to complete the Core Elements including selection of a Best-Practice Strategy and Results Based Accountability.

SPIRITUAL HEALTH PARTNERS

- Volunteers in Action
- Trinity Church
- Mt. Ascutney Prevention Partnership
- MAHHC Chaplaincy Program

The leadership of our Community Health Implementation Plan recognized that spiritual health was a gap in the priority of issues we have been addressing. Recognizing that spiritual health is an important aspect of overall health, a multisector workgroup was formed which consisted of a local pastor and member of our Community Health Committee, the coordinator of Volunteers in Action, our Regional Prevention Coordinator and Director of Community Health. This committee, formed late in 2020, has begun the work delineating the 5 core elements of our community health workgroups. To date the team has identified the core elements listed below.

CHIP CORE ELEMENTS

PROBLEM STATEMENT	There is lack of hope and interconnectedness in our community.
ROOT CAUSES	Lack of faith leading to over emphasis of self. Approaches for including people most affected by the issue – Relationship building and a neighbor to neighbor approach.
AIM STATEMENT	To foster a greater spiritual awareness for the Mt. Ascutney Hospital Service Area in the next 3 years.

Data Trends Graphs

As part of this annual report, we have historically provided data trend graphs to show the impact of our work on data trends over time. Due to VT Department of Health needs in response to COVID-19, 2019 VT Youth Risk Behavior Survey data for our local school districts (and other state-wide data) is not available at the time of this report. We have full intentions of updating all trend graphs in the 2022 report, next year. We appreciate your patience and understanding.

Data trends can be seen as part of our 2019 report at:

mtascutneyhospital.org/about/community-health-needs

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

CHNA COMMUNITY HEALTH COSTS AND FUNDING SOURCES

October 1, 2019 – September 30, 2020

Description	Total Cost	MAHHC (Hospital Subsidized)	Grants, Foundations, Trusts, Private Contributions
MAHHC - Community Health Infrastructure	180,104	$30,872	$149,233
Access to Mental Health	$45,665	$45,665	–
Alcohol and drug misuse including heroin and misuse of pain medications - Prevention, Treatment, and Recovery	$785,416	$19,911	$765,504
Access to Affordable Health Insurance, Cost of Prescription Drugs	$94,002	$8,773	$85,229
Strengthening Families: Including Poverty and Childhood Trauma	$165,699	$10,717	$154,982
Access to Primary Care Services	$604,194	$40,985	$563,210
Healthcare for Seniors	$43,337	$8,580	$34,757
Affordable Housing	$9,527	$8,277	$1,250
Access to Dental Care	$21,446	$8,320	$13,126
Smoking, Tobacco Use, Vaping	$69,138	–	$69,138
Transportation	$27,078	$21,751	$5,327
FOOD INSECURITY: Nutrition/access to affordable food; Access to Physical Activity	$42,636	$21,751	$20,885
COVID - 19	$89,583	$63,188	$26,395
Spritual Health	$32,878	$32,878	–
	$2,210,704	**$321,668**	**$1,889,036**