



COMMUNITY HEALTH BENEFITS REPORT 2021

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At Mt. Ascutney Hospital and Health Center (MAHHC), our purpose is 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.

INTRODUCTION

In collaboration with multiple organizations and agencies, MAHHC Community Health meets the definition of an Accountable Community for Health, or ACH. This means that, as a health system, we take care of the sick but we also work to ensure opportunities for residents in our region to be physically healthy, mentally healthy, socially connected and valued, financially secure, well nourished and well housed. You can see our structure and how we do this in the graphic on page 3.

So, what is our process? Every three years, we complete a Community Health Needs Assessment. These assessments help us to identify 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 survey is conducted in conjunction with a 5-hospital collaborative which includes Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, New London Hospital, and Valley Regional Healthcare.

After doing the assessment, we take the results and create a Community Health Implementation Plan. Using the data from the needs assessment, the improvement plan is our map to how we can address the top priorities and invest in health improvement for the populations we serve.

This 2021 Community Health Benefits Report highlights our activities to address the top health concerns highlighted in our 2018 Community Health Needs Assessment. Our efforts are recounted in this report.

And, what is our structure? MAHHC is the lead organization for our regional Accountable Community for Health called the Windsor Health Service Area Community Collaborative—see graphic on next page. 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. We understand that the health of a population is a product of multiple factors including medical care, public health, genetics, behavior, social factors, economic circumstances and environmental factors.

To take on the work of Population Health in this way, we have chosen a design to radically transform our efforts with a technique called Collective Impact. Collective Impact brings people together, in a structured way, to achieve social change. In 2019, we formed four initial workgroups including Strengthening Families, Alcohol and Substance Use, Housing and Senior Health. In 2020, we added two additional workgroups to address Food Security and Spiritual Health and also added the Windsor area COVID-19 Response Team.

Each of these workgroups has 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 finished identifying their 5 Core Elements in 2020 and began implementing best-practice strategies in and throughout 2021.

Again, the graphic following this introduction shows how each of the workgroups are connected to and interact with our medical-based and community-based chronic disease prevention efforts. By working together, our communities evolve and our mission and vision is realized.

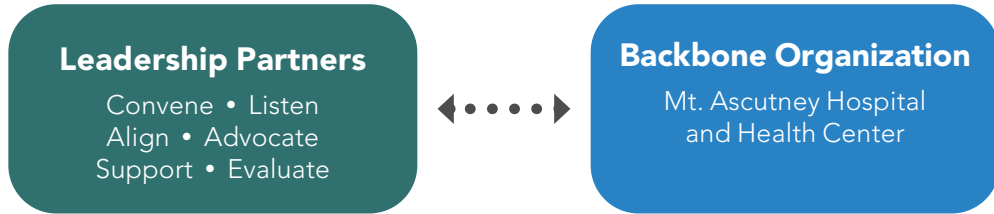
Lastly, where do we go from here? In 2021, we completed a new comprehensive Community Health Needs Assessment. This needs assessment consisted of a paper and online survey which reached 1,241 individuals from the communities that we serve. It also consisted of multiple focus groups to vulnerable populations such as those experiencing food insecurity, opioid use disorder, individuals in recovery and seniors. Data from validated health and human service outcome metrics was analyzed. The compilation and thematic analysis of all of this information culminates in our 2021 Community Health Implementation Plan and serves as a guide for our work in the 3 years forward as we continue to utilize a collective impact strategy to improve the lives of those we serve.

Page 3 includes the graphical representation of our Accountable Community for Health.

WINDSOR HEALTH SERVICE AREA COMMUNITY COLLABORATIVE

Accountable Community for Health, because we are stronger together.

Governance and Vision



Our Community Vision:

- Well nourished
- Well housed
- Mentally healthy
- Physically healthy
- Financially secure
- Socially connected and valued

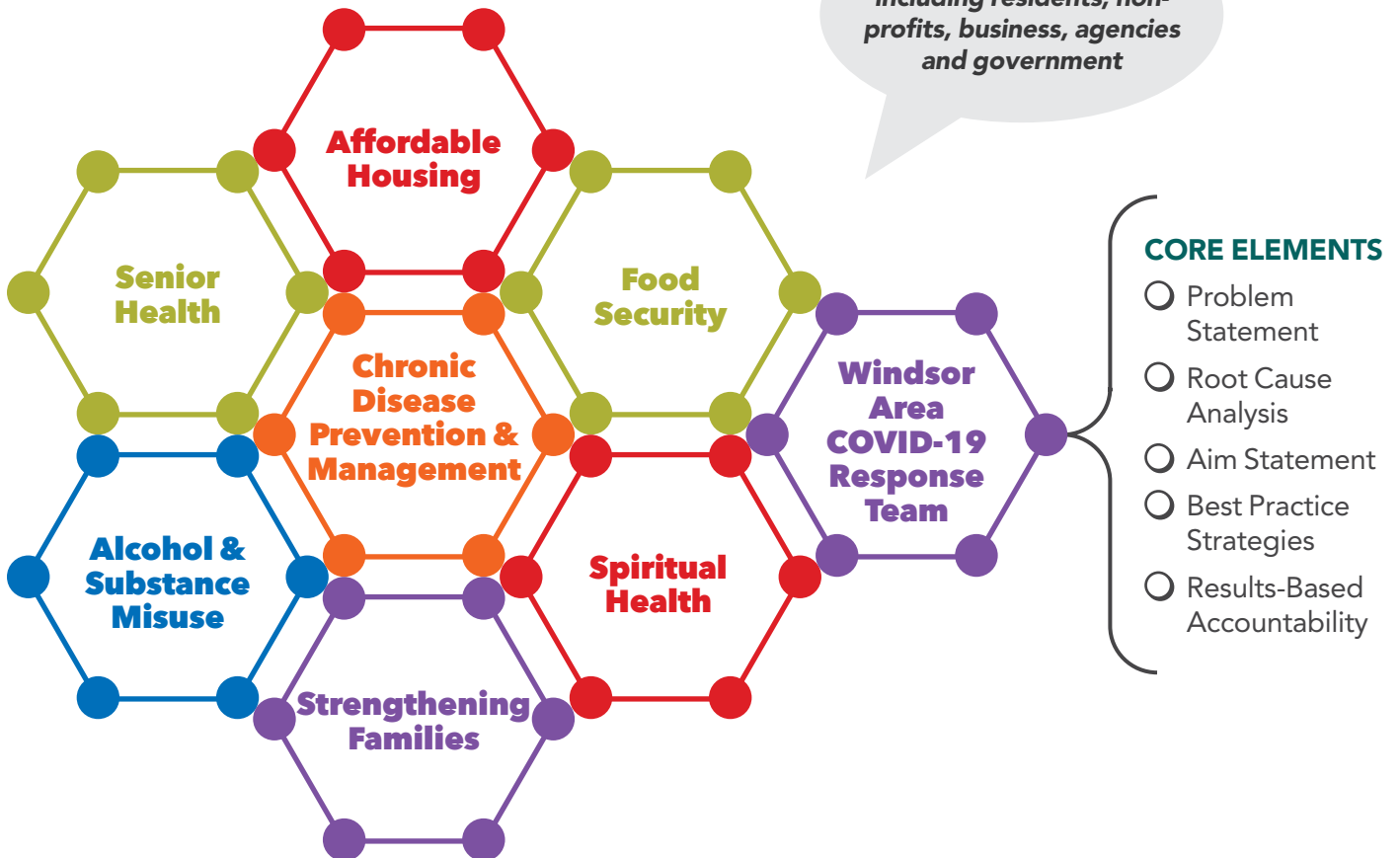
Our Community Mission:

- Increase quality of healthcare
- 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



WINDSOR HSA COMMUNITY COLLABORATIVE NETWORK

WINDSOR HSA COMMUNITY COLLABORATIVE LEADERSHIP PARTNERS

- Aging In Hartland
- Bayada
- Blueprint for Health
- Cedar Hill Continuing Care Community
- Couch Family Foundation
- Clara Martin Center
- Dartmouth Trauma Interventions Research Center
- Health Care and Rehabilitation Services
- Historic Homes of Runnemed
- Mt. Ascutney Hospital and Health Center
- Mt. Ascutney Prevention Partnership
- Windsor Community Health Clinic
- Volunteers in Action
- Ottawaquechee Health Center
- Ottawaquechee Health Foundation
- OneCare Vermont
- Senior Solutions
- Scotland House
- Springfield Area Parent Child Center
- Southeastern Vermont Community Action
- Southern Vermont Area Education Center
- Support and Services at Home
- The Family Place
- Twin Pines Housing Trust
- Upper Valley Haven
- Vermont Department of Health
- Vermont Agency of Human Services
- Visiting Nurse and Hospice for VT and NH
- Windsor Southeast Supervisory Union
- White River Family Practice

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) NETWORKS

FOOD SECURITY

- Mt. Ascutney Hospital and Health Center
- Mt. Ascutney School District
- Windsor Southeast Supervisory Union
- Senior Solutions
- Vermont Department of Health WIC program
- Ottawaquechee Health Foundation
- RiseVT
- Windsor Community Dinner
- Vermont 211
- Mount Ascutney Regional Commission Upper Valley Haven
- Vital Communities
- Willing Hands
- Two Rivers-Ottawaquechee Regional Commission
- Vermont Food Bank
- Reading-West Windsor Food Shelf
- Windsor Food Shelf
- Woodstock Food Shelf
- Sustainable Woodstock
- Change the World Kids
- North Universalist Chapel Society, Woodstock

HOUSING

- Mt. Ascutney Hospital and Health Center
- Aging in Hartland
- Alice Peck Day Hospital
- Granite United Way
- Health Care and Rehabilitation Services
- Housing Project Manager
- Mount Ascutney Regional Commission
- 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
- Sharing Housing, Inc.
- Southern Vermont Area Health Education Center
- Springfield Supportive Housing
- St. Paul's Episcopal Church
- Thompson Senior Center
- Twin Pines Housing Trust
- Two Rivers Ottawaquechee 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

SENIORS

- Mt. Ascutney Hospital and Health Center
- Aging in Hartland
- Granite United Way
- Green Mountain RSVP
- Health Care and Rehabilitation Services
- Ottawaquechee Health Center
- OneCare Vermont
- Ottawaquechee Health Foundation
- Support and Services at Home
- Scotland House
- Senior Solutions
- Seniors Together
- Thompson Senior Center
- North Universalist Chapel Society, Woodstock
- Vermont Department of Health
- Vermont-211
- Volunteers in Action
- VISTA
- Visiting Nurse and Hospice for VT and NH

STRENGTHENING FAMILIES

- Mt. Ascutney Hospital and Health Center
- Building Bright Futures
- Couch Family Foundation
- Dartmouth-Hitchcock Medical Center
- Health Care and Rehabilitation Services
- MoonRise Therapeutics
- Mount Ascutney Regional Commission
- Ottawaquechee Health Foundation
- Springfield Area Parent Child Center
- The Family Place
- Town of Hartland
- Two Rivers Ottawaquechee Regional Commission
- United Ways VT & VT-211
- Upper Valley Haven
- North Universalist Chapel Society, 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

SUBSTANCE USE

- Mt. Ascutney Hospital and Health Center
- Artistree
- Health Care and Rehabilitation Services
- HIV/HCV Resource Center
- Mt. Ascutney Prevention Partnership
- Ottawaquechee Health Center
- Second Wind Foundation
- Southern Vermont Area Health Education Center
- VT State Senate
- The Family Place
- TLC Nursing
- Trinity Evangelical Free Church
- Turning Point Recovery Center of Springfield
- Two Rivers Ottawaquechee Regional Commission
- United Ways VT & VT-211
- Valley Court Diversion Program
- Vermont Department of Health
- CT Valley Addiction Recovery
- Windsor Police & EMS

SPIRITUAL HEALTH

- Mt. Ascutney Hospital and Health Center
- Ascutney Union Church
- VNA & Hospice of the Southwest Region
- Mt. Ascutney Prevention Partnership
- Old South Church
- Trinity Evangelical Free Church
- St. Francis of Assisi Church
- Hartland Universalist Unitarian Church
- Volunteers in Action

CHRONIC DISEASE PREVENTION & MANAGEMENT

MT. ASCUTNEY PREVENTION PARTNERSHIP & RISE VT

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

CARE COORDINATION

- Mt. Ascutney Hospital and Health Center
- Bayada
- Blueprint for Health
- Connecticut Valley Addiction Recovery
- DULCE
- Department of Children, Youth and Families
- Family Wellness Program
- Green Peak Alliance
- Hartland Community Nurse
- Health Care and Rehabilitation Services
- OneCare Vermont
- Senior Solutions Services and Support at Home
- Springfield Parent Child Center
- The Family Place
- Windsor Central Supervisory Union
- Windsor Southeast Supervisory Union
- Visiting Nurse and Hospice for VT and NH

VERMONT POPULATION HEALTH MODEL (4 QUADRANTS OF HEALTH)

The Vermont 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.



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 Meg Stern – 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, Community Outreach – 0.10					
Mt. Ascutney Prevention Partnership	Melanie Sheehan, Reg. Prevention Program Mgr. – 1.00	Courtney Hillhouse, Community Outreach – 0.775	Alice Stewart, Grant Implementation Team Leader – 0.62				
Blueprint Community Health Team	Carla Kamel – 1.0 Jenna Austin, MSW – 1.0	Amy Swarr, RN – 1.0 Samantha Ball – 0.1	Jennifer Joy, RN – 1.0				
Blueprint Spoke Team	Sharon Jones, RN – 1.0 Gail Mears, Spoke Counselor – 1.0						
Blueprint Self-Management	Sarah Doyle, Coordinator – 0.5						
Windsor Community Health Clinic (self-management programs)	Samantha Ball, Coordinator – 0.9	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 Smith – 1.0	Scottie Shattuck – Per Diem	Martha Zoerheide – Per Diem				

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 organizational structure during the reported time period (10/1/20-9/30/21).

ISSUE

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 purpose of “improving the lives we serve.”

In 2021, we entered in both the recovery phase of COVID-19 and saw the spike of the Delta variant. Community-based concerns regarding the critical housing shortage leading to increased homelessness, work force shortages, increased evidence of substance use disorder and its impact on individuals and families, and rising mental health issues consumed our healthcare, family wellness, Community Health Team and community partners response. We actively engaged in care coordination, linkage to resources, education and support of families and individuals impacted.

CONFRONTING THE CRISIS—CLINICAL CARE

Under the direction of Mt. Ascutney Hospital’s CEO and CMO Joseph Perras, MD, and the senior leadership team and staff, significant effort and accomplishments were made to prepare the Hospital and clinics to care for our community during the COVID-19 crisis. These improvements included establishment and ongoing resources of the respiratory clinic, screening, immunization clinics, testing on site, patient education, structural and workflow changes internally to minimize risk and excellence of clinical care for patients. Please see our most recent edition of our [Peak Health](#) newsletter for a comprehensive description of this work.

PROGRAMS

WINDSOR AREA COVID-19 RESPONSE TEAM

MAHHC led the formation of this Response Team in early 2020 to help our community meet the challenges that came with the pandemic.

These 2021 updates include the efforts of the Response Team as well as MAHHC staff who ran testing and vaccine clinics.

PROGRESS



- 23 individuals contributed approximately **6,172 hours of support.**
- The Team worked with schools, school nurses, assisted living, homeless, those experiencing substance use disorder and mental health issues.
- Hospital respiratory clinics kept responsive to the flexing needs.
- State COVID-19 vaccine clinic was established for vaccinations.



ECONOMIC SUPPORT

We developed a workflow and an algorithm between the website, Volunteers in Action and the Community Health Team linking financial needs with traditional resources such as Economic Services, Southeastern Vermont Community Action (SEVCA) and then to grant resources.



- Procured \$40,000 in funding from Dartmouth Hitchcock Medical Center and private foundations for a pool of funding to support local needs.
- Combined resources with Woodstock Relief Fund (\$130,000) and worked with the Vermont Community Foundation and the Ottauquechee Health Foundation to increase awareness of resources available and to connect them with those in need.
- Mobilized the Community Health Team social workers with Volunteers in Action and our Windsor Community Health Clinic (free clinic at MAHHC) to assess, meet the pressing needs for social determinants of health, and refer to community partners such as Southeastern Vermont Community Action, Health Care & Rehabilitative Services and Vermont Economic Services.

FOOD - DECREASE RISK OF FOOD INSECURITY AND HUNGER IN A TIME OF CRISIS

As COVID-19 struck our community in early 2020, it became extremely important to increase our efforts to decrease risk of food insecurity and hunger at the time of the crisis.



- Supported Meals On Wheels with volunteers and alternate sources of food from two restaurants in town.
- Supported food shelves with volunteer food drives, donations, medical staff and others.
- Facilitated resources with the Vermont Food Bank.
- VeggieVanGo served an average of 307 families each month.
- RiseVT promoted gardening work with the Windsor Food Shelf to distribute porch garden kits to families.
- Worked with local restaurants, particularly with The Windsor Diner and area food shelves to provide meals to those in need. Food distributions occurred primarily through VeggieVanGo, Meals on Wheels and the Upper Valley Eats Program.





A COMMUNITY THAT IS...

**PHYSICALLY
HEALTHY**

ISSUE

Access to quality health services is essential for preventing, managing and reducing diseases for everyone. This is one of the many topics we strive to address. Access to primary care was identified as one of the top priority community health needs.



PROGRAMS

QUALITY IMPROVEMENT INITIATIVES

COMMUNITY HEALTH TEAM

Works with community partners to coordinate care and provide interventions. This team works across the continuum from preventative care to very high-risk chronic care patients.

SELF-MANAGEMENT PROGRAM

Workshops teaching important skills in living with and managing chronic conditions are offered to prevent disease, reduce complications and improve quality of life.

PROGRESS



- Mt. Ascutney Hospital and Health Center celebrated our 11th year anniversary as a NCQA recognized Patient-Centered Medical Home™.
 - Efforts led by Leesa Taft, DNP, ARNPC, working with team of primary care and quality improvement staff.
 - Recognition held by both Windsor and Woodstock Clinic locations.



- MAHHC has provided leadership for regional implementation of care coordination with community partners of:
 - Blueprint for Health, OneCare VT, Support and Services at Home, Senior Solutions, Visiting Nurse and Hospice of VT and NH, Bayada, DULCE, Heath Care and Rehabilitative Services, and VT Chronic Care Initiative.
- Meet weekly with community partners to share resources, problem-solve, and coordinate care.

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



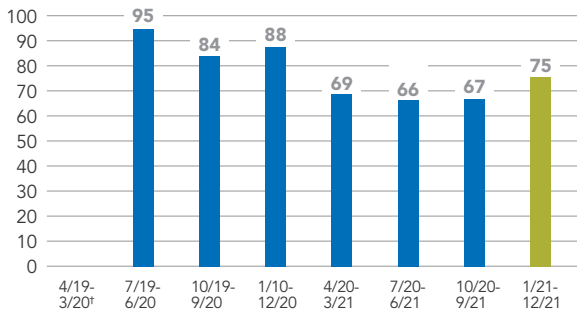
- Workshops provided this year included Diabetes Self-Management Program, Diabetes Prevention Program, Chronic Disease Self-Management Program, Chronic Pain Self-Management Program and Tobacco Cessation Program. In 2021:
 - 17 groups were held
 - 144 participants
 - 86% course completion

QUALITY IMPROVEMENT INITIATIVES

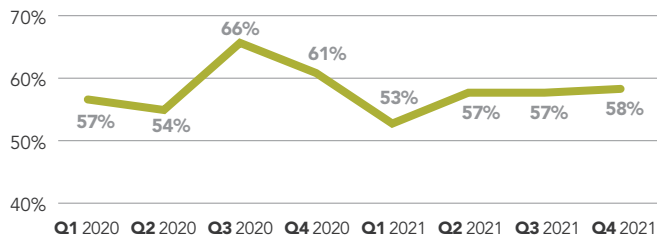
Part of access to primary care is ensuring that the services provided are hitting quality measurements. In Primary Care at MAHHC, our providers and staff, data analysts and quality improvement staff form teams with outside partners to tackle areas that will help improve care for a high percentage of our patients. In 2021, we had quality improvement initiatives in the areas shown (right).

Data from these initiatives shown below.

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



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



COVID-19 RELATED AND COMMUNITY OUTREACH

“The Primary Care team is dedicated to meeting the needs of our patients and our community. Last year we were able to respond not only to evolving patient needs, but also to the demands of the pandemic by establishing and maintaining both adult and pediatric respiratory clinics, adult and pediatric vaccination clinics and establishment of a new walk-in clinic in coordination with the Emergency Department. All of this required great flexibility and commitment of our staff, while still providing high quality care to our patients.”

- Leesa L. Taft, DNP, ARNP, FNP-BC, Medical Director of Primary Care



HYPERTENSION / HIGH BLOOD PRESSURE CARE

- Community care nurses report success in helping most patients to meet their high blood pressure goal within one to two visits.
- Monthly data shows improvement of 11% from January – June 2021.
- New high blood pressure self-management workshops are being offered; the program coordinator is working with medical providers on a systematic referral process for this new, essential resource.

DIABETES CARE

- Ivan Levin, MD is leading this quality improvement process and working with clinic providers to implement it.
- Community Care Nurses have best practice order sets for labs, patient education and follow-up.

IMMUNIZATIONS

In 2021 an internal team including the Director of Community Health, our clinic data analyst, clinic practice manager, and the VT Department of health began meeting to address poor immunization rates in Windsor county. By performing data analysis, the following was found:

- Windsor County vaccination rates fall 5.5% points behind statewide 7-series immunization rates by county.
- Both MAHHC and OHC outperform the statewide immunization rates for DTAP, Polio, MMR, Hib, HepB, Varicella, Pneumonia and HepA.
- The statewide percentage points for all of these vaccines hovers around 80-88%, where MAHHC and OHC show immunization rates between **88% - 100%**.



- Due to COVID-19, a Respiratory Care Clinic was created to help patients with respiratory symptoms receive the care they need.
- Planned and coordinated 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.

o 999 children and adults were vaccinated in this effort.

ISSUE

Cigarette smoking is the leading cause of preventable death in the U.S., accounting for nearly 1 in 5 deaths. After years of declining cigarette use, rates rose during the COVID-19 pandemic. Given the rise in smoking rates, coupled with the youth vaping epidemic, tobacco and nicotine use prevention and cessation continue to be a key focus of our work.

PROGRAMS

MT. ASCUTNEY PREVENTION PARTNERSHIP (MAPP)

MAPP has continuously received and implemented a Vermont Department of Health Tobacco Control 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 and other emerging products has brought significant challenges in the world of public health.



Mt. Ascutney
**PREVENTION
PARTNERSHIP**



**YOU CAN QUIT.
WE CAN HELP.**

MT. ASCUTNEY HOSPITAL TOBACCO CESSATION COACHING

The cessation program is part of the My Healthy VT self-management workshops and 802 quits.

For more information visit:

myhealthyvt.org | 802quits.org

PROGRESS



- Continued to distribute items designed to build awareness of vaping quit resources to MAHHC Pediatrics Clinics staff, schools, recreation departments, multi-unit housing, Early Childcare Center, Healthcare and Rehabilitative Services, Turning Point Recovery Center of Springfield as well as the Windsor Pride event.
- As a result of student feedback, items to promote vaping quit resources were updated.
- Created and distributed a vaping assessment to the schools in Windsor Central Supervisory Union and Windsor Southeast Supervisory Union.
- Continued to partner with regional planning commissions around town health chapters.
- Partnered with the Vermont Department of Health to recognize two area Early Childcare Centers for their 3-4-50 Gold Status.
- 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.
- Facilitated check-in meetings with two school student assistance professionals to get updates on emerging products and to offer resources.
- Partnered with Windsor Black Lives Matter group to share messaging on health disparities in vulnerable populations through a virtual 5K.



- Due to COVID there were no tobacco classes, however there were 32 tobacco related referrals that were contacted throughout the year.



A COMMUNITY THAT IS...

**MENTALLY
HEALTHY**

ISSUE

Alcohol and substance use disorder can have a devastating impact on individuals, families and communities. This has been a topic identified as a priority need in each Community Needs Assessment done since 2015. MAHHC has progressively implemented best-practice approaches to prevent and reduce alcohol and substance use and we have continued this effort in 2021. There is still work to be done, as we are seeing some increasing trends related to the COVID-19 pandemic.

MAHHC has hosted both AA and Al-Anon meetings for more than 25 years. The pandemic required that we suspend these groups on-site in March 2020. Both Springfield and Upper Valley Turning Point Recovery Centers provided virtual AA meetings from March 2020 onward. Meetings will remain as currently provided for the near future.

PROGRAMS

COMMUNITY-BASED PREVENTION

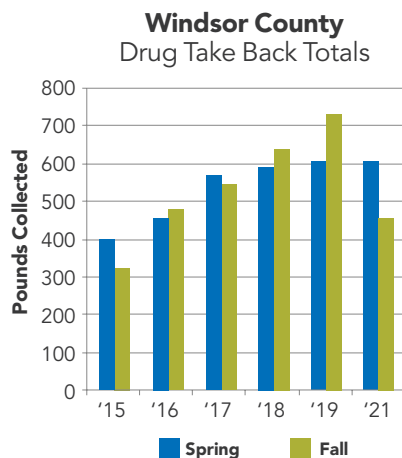
The Mt. Ascutney Prevention Partnership (MAPP) is part of the Community Health Department at MAHHC. MAPP was created in 1998 to focus on prevention. We help strengthen community connections and build environments that promote health and value well-being for all. Our goal is to promote health with a particular focus on prevention of substance misuse and equitable access to improve physical health, ensuring that individuals feel valued by their community.

For more information, visit: mappvt.org



Mt. Ascutney
**PREVENTION
PARTNERSHIP**

MAPP supported April and October 2021 Drug Take Back events. Graph shows number of pounds of medications collected:



PROGRESS



- **Subawarded ~ \$138,000** to 10 community organizations to implement prevention strategies at the local level. Ongoing maintenance of subawarding processes, monitoring of grantee performance and updating resource page mappvt.org/PNGgrant.
- Community health leadership and staff involved in local planning related to retail cannabis, given that local communities have opted to host this new market.
- Contracted expertise to support a local school district in setting up Restorative Practices policies/procedures related to be consistent in using substance use or substance misuse prevention.
- Our work with local Regional Planning Commission and Two Rivers Ottauquechee Regional Commission (TRORC) was highlighted at Vermont Youth Cannabis Conference.
- Prevention policy outreach regarding health promotion in 3 towns.
- Cannabis retail policy support in 6 towns, providing multiple presentations; policy support to local business in 1 town.
- Partnered with TRORC to maintain Health Policy Clearinghouse—a resource for decision makers, towns, schools, planning commissions and others to view best-practice policy solutions to building local cultures of health and prevent substance misuse.
- Updated health disparity data report.
- Maintained supply of medication return envelopes in over 30 kiosks across region. More than 324 envelopes have been returned from the White River Junction Health District office area, a 44% increase from 2020.

MEDICAL-BASED PREVENTION,
TREATMENT AND RECOVERY

CLINIC-BASED PROGRAMMING

The following updates reflect our medical clinic's commitment to holistic care. This includes screening for substance use and adhering to best practices regarding narcotic prescribing.



- Quarterly tracking of the Vermont Prescription Monitoring System and data from the Vermont Department of Health:
 - Windsor County has had the lowest rate of opioid analgesic prescriptions in the state for the past 5 years.
 - Windsor County has had the second lowest rate of benzodiazepine prescriptions and stimulant medications for the past 5 years.
- We have continued to conduct personal safety and substance use screening using a comprehensive 3-page tool called Screening Brief Intervention and Referral to Treatment (SBIRT):
 - The screening asks about personal safety such as seatbelt use and also quickly identifies if use of substances are at a risky level.
 - Our responses and recommendations to the screening match the level of personal use patterns reported.
 - All new and annual exam patients in both MAHHC and OHC clinics received SBIRT screening, representing 78%-97% of patients at MAH and 48% - 89% of patients at OHC.
- **2,217 individuals were screened** and referred to treatment as indicated.

MEDICAL-BASED PREVENTION,
TREATMENT AND RECOVERY

RAPID ACCESS TO MEDICATION-ASSISTED THERAPY (RAM)

Administration of Suboxone is a recognized best practice for the treatment of opiate addiction. 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.



- MAHHC Emergency Department has become a naloxone distribution site for the community, getting a life-saving intervention out into the community.
- MAHHC has led an effort to organize teams of Emergency Departments and treatment providers in Windsor and Springfield to assess for addiction and initiate Suboxone in the Emergency Department.
- In addition to Suboxone, patients also receive a timely referral to a treatment provider for ongoing medication and counseling.
- Springfield Hospital Medical Care Systems added the rapid access to medication protocol in their Emergency Department.

Narcan Education	Rapid Administration of Medication (RAM) through the Emergency Dept.
24 Doses of Narcan were Administered in the ED for FY21	7 initiated for FY21

RECOVERY COACHES

MAHHC works with Turning Point Recovery Center of Springfield to provide Recovery Coaching in the Emergency Department. Patients can be linked to coaches 7 days a week, 24 hours a day. With patient consent, the recovery coach meets with the patient in the Emergency Department and then follow up 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.



- 46% of coaching was for opioid use, 45% for alcohol, 7% for methamphetamine and 2% for cannabis.
- 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 Recovery Center of Springfield (72%).

TREATMENT

MAHHC has been a member of Vermont's Hub and Spoke Program for treating opioid use disorder for patients with Medicaid since its inception. MAHHC is the administrative entity in the Hub and Spoke Program for 193 patients across:

- o Ottauquechee Health Center and Pediatric Parents Support Programs
- o Connecticut Valley Addiction Recovery
- o Bradford Psychiatric Services
- o Little Rivers Health Care

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 Sublocade.



- Our pediatric parent MAT program serves 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 3 consults in 2021.
- Our Blueprint for Health Self-Management programs offered a successful Chronic Pain Self-Management Program in 2021:
 - o 4 Chronic Pain workshops were provided.

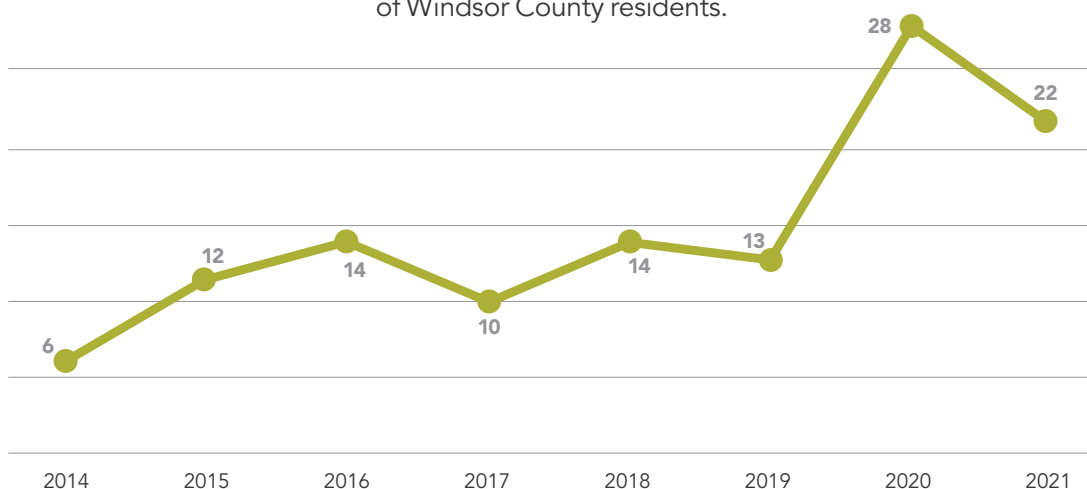
COMMUNITY-BASED EFFORTS TO PREVENT OVERDOSE DEATHS

Windsor County has been recognized as a high-risk area for overdose deaths. 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.



- In 2021, Jill Lord, RN, presented at the Vermont Fire Chief Conference regarding the opioid crisis. She provided data and action as outlined within this report.

Number of opioid-related fatalities
of Windsor County residents.



OVERDOSE PREVENTION

Training Narcan can be compared to CPR as an essential method to save lives related to opioid overdose. We have also learned trauma experienced by those administering Narcan led to their reluctance to carry and administer Narcan.

In 2021, a team was formed to take on the important work of community-based Narcan education, training and distribution. The team consisted of leadership from MAHHC and The HIV/HCV Resource Center.



- The MAHHC and HIV/HCV team designed and published an educational booklet to be attached to Narcan boxes to provide critical education to those who administer Narcan:
 - The booklet was previewed by those with active substance use, the Vermont Department of Health and pharmacists throughout the state.
 - The booklet is being used in county-wide harm reduction bags with Narcan distribution.
 - To date, 1,742+ booklets have been distributed. (You may obtain a booklet by emailing jill.m.lord@mahhc.org).
 - Credit is given to Dartmouth Health and the Vermont Department of Health for public expenses.
- The MAHHC and HIV/HCV team organized an online training for those who distribute Narcan. This was done in a “train the trainer format” so that they could provide essential training to others carrying Narcan.
- The first 90-minute WebEx PowerPoint and training has been made widely available.
- A “For your Health” video about preventing overdose death was also created and can be [found here](https://youtu.be/9HwP4iS5usQ).
- We continue to coordinate relevant drug trend information to community partners by working with New England High Intensity Drug Trafficking Agency.

OUTREACH AFTER OVERDOSE

Recognizing that those who have experienced one overdose are at higher risk for a second overdose and subsequent 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 connection to treatment is offered to both the patient and the family.
- Each of these community level teams—Hartford, Springfield, and Windsor—are in various stages of formation. Each is committed to work together to provide systematic support and linkage to treatment after an overdose.

Overdose to Action - FY21 Outreach After Overdose

Total # of individual referrals	57
Total # of outreach attempts	61
Total # of coaching efforts	39
Total # of leave behind/harm reduction kits given	108
Total # of engaged with Recovery	12
Total # intake for or completion of treatment	7
Total # accepted additional referrals	39
Total # of contacts with family members	9
Total # refused help/appointment set, no show	5
Total # could not locate or contact	17

Recovery coach outreach after overdose metrics from 2021 are as follows:

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP; ALCOHOL AND SUBSTANCE USE

The Alcohol and Substance Misuse CHIP workgroup met 12 times from October 2020 – September 2021. In that time frame, stakeholders:



- Continued ongoing promotion of the We Are Worthwhile communication campaign: Spotify radio, social media, printed materials, bus stop posters, community partner organization distribution and public transportation sign planning. (Visit: www.weareworthwhile.org).
- As COVID-19 restrictions were lifted, a total of 12 Recovery Inclusive Community Events (RICE) events were hosted since April 2021.
- Worthwhile and RICE tabling at the country club July 4th Fireworks, farmers markets (3 towns), community running event, outdoor music festival, VeggieVanGo food distribution events, youth events and candlelight vigil.
- Events hosted in multiple towns, representing a 46% coverage of the catchment area.

In 2021, at the second annual Recovery Gala organized by the Springfield Turning Point Recovery Center, Joseph Perras, MD, was selected as an award recipient for systematic improvement in the area of substance use disorder. Melanie Sheehan was awarded recognition for innovation. Leesa Taft, MSN, DNP, APRN, was given honorable mention for leadership and expertise.

COMMUNITY WORKING TOGETHER IN ACTION

To tackle issues as serious and devastating as substance use disorder, overdose and/or overdose death, collaboration across many groups is desperately needed. The chart below demonstrates all that has happened in 2021 across multiple partnerships. Despite all of the good work, overdose deaths continued to rise in 2021. MAHHC convened an Overdose Death Summit – a series of 2 meetings in June. The purpose was to discuss and plan strategies that can help to reverse the overdose trend. Attendees broke out into groups to plan strategies related to: eliminating wait times for detox and residential treatment, harm reduction/peer distribution of Narcan, expanding capacity for recovery coaching/peer support, and increasing safe housing for vulnerable persons at risk of relapse.

Windsor County Efforts to Prevent Opioid Fatalities

PREVENTION

- Community-level grants (\$253,000)
- Environmental strategies/Town Policy efforts
- Increase drug disposal efforts (Drug Take Back, Envelopes)
- Health/wellness/prevention messaging
- Collaborative Problem Solving for School District
- Date Dashboard planning, grants and evaluation
- Health Disparities Needs Assessment and report
- Prevention digest and “For Your Health?” TV shows

INTERVENTION & TREATMENT

- Data monitoring, dissemination, outcomes reporting
- Systematic SBIRT training
- Creation of Narcan Education booklet & distribution of CPR Masks
- Outreach After Overdose (Police, Fire, EMS, HCRS, Recovery) Hartford, Windsor, & Springfield
- Hartford Overdose Awareness Vigil
- Rapid Access to MAT in ED
 - Springfield, Windsor, VA
- “We are Worthwhile” anti-self stigma campaign
- Mobile Syringe Services Programs
- Chronic Pain Consult Team (Windsor) and Workshops

RECOVERY

- Recovery Coaches in ED
 - Springfield, Windsor
- Recovery Ready Workforce initiatives
- Rides to Recovery, Springfield
- NA, AA, and Family Groups - Springfield, Hartford areas
- Turning Point Recovery Centers - drop in/safe haven
- Youth Based Recovery Services, Springfield
- Recovery Inclusive community events, outreach at food sites
- Point of access for “We are Worthwhile” campaign

*This summary of current activities was presented at the Vermont Department of Health Roundtable discussion in May 2021.

“Windsor County has one of the highest rates of fatal and non-fatal overdose death in the State. It is vital and necessary that we work together from our different areas of expertise on how to serve our community better. This workgroup is part of the solution. The connections we are making are helping us to help our clients. In this work, we get to do better and our clients get better!”

~ Co-Chair Astrid Bradish Hoyt

**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 Health Service Area 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!)

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.

**RESULTS BASED
ACCOUNTABILITY**

(RBA)/DATA COLLECTION

ISSUE

Improving the mental health status of our community is a critical component of our plan. MAHHC made significant investments in 2021 to design and implement trauma-informed care through the development of a Resiliency Leadership Team.

PROGRAMS

RESILIENCE LEADERSHIP TEAM

Formed to shepherd the cultural transformation to a trauma informed care environment that builds resilience both among staff and patients. The mission is:

To improve the lives of those we serve by establishing an environment which identifies and responds to the need to feel safe and supported while giving and receiving care.

MAHHC CLINICAL SETTING

PROGRESS



- Established membership to include expertise in trauma-informed care.
- Established agreed upon mission and vision.
- Conducted baseline assessments.
- Implemented goals for education and support to build capacity of staff to provide trauma-informed care as a strengths-based approach.
- Worked with “Project Launch” at Dartmouth Health as well as Health Care and Rehabilitation Services (HCRS).



- 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).
- Established process for group visits.
- Strengthened relationships with VT Department of Children and Families amid staff shortages.



WINDSOR CONNECTION RESOURCE CENTER



- 288 mental health counseling sessions were provided at the center.

CHRONIC DISEASE SELF-MANAGEMENT



- Provided 1 Wellness Recovery Action Plan self-management class.

CHAPLAINCY SERVICES



- Continued support for staff and patients.

MENTAL WELLNESS CLINIC

(PART OF FAMILY WELLNESS PROGRAM, SEE PAGE 23)

The purpose of this clinic is to provide timely, easily accessible coaching and psychoeducation to pediatric patients who present with anxiety and depression and are unable to access recommended services because of lack of availability of psychotherapy and/or psychiatric services. This program is not meant to replace services, rather it is provided as a complementary resource for patients who are waiting for care, or unwilling or unable to access usual treatment.



- Started as time limited pilot from May 24 - September 24. The decision was made to continue the work.
 - Set up anxiety/depression screening protocol.
 - Developed best practice, patient education materials on managing symptoms.
 - Coaching visits on mindfulness, introduction to cognitive behavioral therapy, and introduction to technology apps that help with symptom management.
 - Follow up support phone calls.
-



A COMMUNITY THAT IS...

**SOCIALLY
CONNECTED
AND VALUED**

ISSUE

Poverty and family stress has tremendous impacts on the health and wellness of individuals and families. Our Strengthening Families initiative is a comprehensive, Collective Impact approach that increases emotional and behavioral health skills and capacity for positive relationships in the family unit.

Emotional behavioral health is the foundation of all health.

Health runs in families.

We can change our brains through wellness practices.

PROGRAMS

FAMILY WELLNESS

The Family Wellness Program 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 TEAM

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

PROGRESS



- The Family Wellness Program served **379** patients in **1,109** sessions.
- The Family Wellness Coach had visited with **141** children / caregivers (18% ↑) in a total of **244** sessions.
 - 74% of visits with children under 3 were return appointments
- The Family Wellness Therapist met with **238** individual patients (49% ↑) in **865** sessions (62% ↑).
 - Some sessions held via Telehealth due to COVID-19.

FAMILY WELLNESS COACH

- Consulted and advocated for universal and family-based practice at regional meetings of UV Strong Child Care Committee, Early Childhood Service Delivery Integration, Whole School Community Child (& Family) Health Committee of Windsor Southeast Supervisory Union, Building Bright Futures Councils – Springfield & Northern Windsor/Orange County.
- Provided leadership for Strengthening Families Network Action Teams.
- Provided leadership for monthly Pediatric Mental Health provider meeting.
- Funding for our wellness coach was gratefully received from the Couch Family Foundation.

FAMILY WELLNESS THERAPIST

- Leadership provided within the MAHHC system to offer group therapy.
- Provided clinical Supervision for Mt. Ascutney Hospital Community Health Team master of social work to advance towards licensure.
- Provided recruitment and supervision of University of Vermont social worker candidate intern.



DULCE – A PRIMARY CARE CLINIC MODEL

DULCE is a unique collaboration between the Pediatric Clinics at OHC and MAHHC and area Parent-Child Centers. It is a universal approach to supporting families at unique times in parenthood. A DULCE Family Specialist joins pediatricians during well child visits from newborn through six months. During visits the family specialist uses a New Born Observation tool to promote attachment and completes an early screening for possible areas of need and connects families to community resources as indicated. This program is entering its 3rd year within the MAHHC Pediatric Clinic.

DULCE

- **55** Families engaged in the DULCE element of Pediatrics at the OHC.
- **68** families engaged in the DULCE element of Pediatrics at MAHHC.
- Developed and enhanced process maps to address social determinants of health.
- Offered 4th Trimester group to address the unique needs of young parents during the pandemic.

"I have no idea what our lives would look like if it weren't for the never-ending support offered through this (DULCE) program and The Family Place. We have faced significant challenges with the health of our son in the last 9 months and have found numerous outlets to help us get through this difficult time. There is so much available to families that they wouldn't otherwise know about and we are forever grateful for this resource. Sue has been with us on this journey every step of the way and has gone above and beyond, someone before now I would have only considered a friend or acquaintance. This program has made us feel safe, heard and supported in every way possible especially now when so many of us as parents to young children have very limited access to most things without having to risk the safety of their health. We feel as though we have been accepted into a very large family. Ours now has the opportunity to thrive in the face of the chaos that is our life at present. We are so thankful for this resource."

- Courtney & Stephen Panoushek

STRENGTHENING FAMILIES NETWORK

Over the past year, the two action teams that emerged from Strengthening Families Network:

1. Circle of Security: The Circle of Security strategy pivoted with ease to a virtual format and was able to expand implementation.
2. Playgroup connections: Collaboration across the Parent-Child Centers and Family Wellness Program, families were offered bi-monthly Regional Zoom Playgroup, with a variety of topics and activities through volunteer partners from December through April.

Both teams have worked to build capacity, plan, implement, and create data collection and evaluation plans. All to work towards its Aim to enhance social connectedness, one of the 5 Protective Factors of Strengthening Families Framework from Center for the Study of Social Policy.

Windsor Playgroup Connections struggled to connect after COVID-19 shutdowns in November 2020.

CIRCLE OF SECURITY

- **24** more facilitators were trained, with an additional 5 agencies/programs now represented in the new trainee group.
 - 9 Memorandum of Understanding documents signed as part of being trained, solidifying agreement to be involved in the regional approach.
- A Regional Calendar for 2022 is in development, allowing for inter-agency referrals and increased access to services.
- Strengthening Families Network and Project Launch at Dartmouth Hitchcock Medical Center have collaborated on a data collection tools to track outcomes on social connectedness:
 - 100% of participants were likely or very likely to reach out to the Facilitators if help or advice was needed.
 - 76% of participants would reach out to another parent from the group if help or advice was needed.

PLAYGROUP CONNECTIONS

- In person, outdoor Woodstock Playgroup Connections resumed with walks, playgrounds, and at a farm through connection with MoonRise Therapeutics.
- Developed Playgroup Standards Document, a tool to develop or assess a playgroup based on best practice, with examples and resources for support.
- Data collection and evaluation tools, completed with evaluation consultant.
- With initiative and design contributions from of a parent member, a Strengthening Families Network logo was created, and can be adapted for both Playgroup Connections and Circle of Security.

PATCH

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

The center is open Monday through Friday connecting citizens with services. Their salaries are required to be raised through grant funding and donations each year. This is done through a series of grant requests. We are grateful for town support, The Byrne Foundation and the United Way.



- The WCRC continued to serve the Windsor area during the COVID-19 pandemic while taking precautions to keep people safe.
- WCRC staff and partner agency staff facilitated a mix of in person and virtual services including job skills training and support, counseling services, recovery coaching, financial help and access to laundry and showers.
- Remarkable changes were seen in 2021 related to the intensity of work needed to support people in our area experiencing homelessness.

DEVELOPING ASSETS/"SLED DOG DISCO"

Sled Dog Disco is the name chosen for a group of MAHHC staff and others from the community who have worked together to create asset development activities in our community in an effort to build a flourishing community.



- The Annual Windsor Southeast Supervisory Union (WSESU) School Supply Fundraising Drive continued this year. Sled Dog Disco worked with each school to develop supply lists and coordinate distribution to families:
- The drive resulted in 60 individual and business donations from VT and NH towns surrounding Mt. Ascutney Hospital.
 - More than \$5,000 was raised to purchase all needed school supplies for 347 students who qualify for free/reduced lunches. MAHHC donated water bottles for 175 Windsor students.
 - 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 for each student.
 - A handout for parents was included, promoting ways to build assets within the family.
 - Other activities were curtailed this year due to COVID-19.

OUR FAMILY WELLNESS DATA SHOWS...

Surveys over the past three years indicate 95% families 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.

QUOTES

PARENT COMMENTS FROM FALL 2021 FAMILY WELLNESS SURVEY

Q: How has Family Wellness benefited your family?

A: "Eased stresses, focused us on what is needed, eased anxiety. Mental health is very important to us."

Q: Please tell us about the approaches you tried and how they worked (or didn't work) for your family...

A: "(We) Used more visual guides like schedule charts and emotions pictures. It helped my son to get through his day without being so overwhelmed and got him to start talking about his feelings more."

Q: Any comments about the Family Wellness Program that you would like to share?

A: "Family Wellness Coach thinks beyond current behavioral issues and gives you preventative advice to shape your relationship with your child for the most positive outcomes. When I talk to her after venting about a frustrating experience with my kids and she is NEVER judgmental and very strategic about the advice and tools she provides."



STRENGTHENING FAMILIES NETWORK

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 MAHHC service area within the next 5 years.

BEST PRACTICE STRATEGY(IES)

Approaches will include:

- I. Implementing *Strengthening Families* in Vermont towns in the Health Services Area.
- II. Coordinating a series of Circle of Security parenting education offerings in this region (VT & NH).

Data Development Plan

- | | |
|---|--|
| <ol style="list-style-type: none"> 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. | <ol style="list-style-type: none"> II. How much - # of families/households served by Circle of Security 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. |
|---|--|

RESULTS BASED ACCOUNTABILITY

(RBA)/DATA COLLECTION

ISSUE

As our population ages, we're working to provide the resources our neighbors need to safely stay in their homes and communities. MAHHC and our partners in the community have worked to improve healthcare and living for our elders in many ways in 2021.

PROGRAMS

MAHHC COMMUNITY HEALTH LEADERSHIP AND CASE MANAGEMENT

Many of the projects to address seniors in our area involve key partners such as inpatient case management, the Community Health Team and others.

One particular project worth highlighting included connecting seniors with technology. In 2020 and 2021, MAHHC spearheaded a collaboration between Ever North, Stewart Properties, Senior Solutions, HASS, MAHHC, and SASH to improve quality of life for the residents of Windsor Village through introducing computer technology and Wi-Fi. By building an electronic infrastructure residents can now participate in telehealth, decrease social isolation, and engage in self-management group classes, etc.

SASH (SUPPORT AND SERVICES AT HOME) & HASS (HOUSING AND SUPPORT SERVICES)

The SASH Program includes a wellness nurse stationed within community housing in Windsor.

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.

PROGRESS



- Restarted a weekly Advance Directive Clinic, which provides free individualized support for individuals to complete and disseminate their advance directive.
- For the 2020 tax year, we worked with Southeast Vermont Community Action to provide tax assistance to 250 area residents.
- Continued to provide leadership and support to Scotland House Adult Daycare:
 - Provided oversight on their Board of Directors and linkage to community resources.
 - Ensured that Scotland House survive the COVID-19 pandemic and doors reopened in 2021.
- Provided start-up grant money for a community nurse position within a local aging-in-place non-profit group in Reading/West Windsor.
- Distributed 12 free computers to residents of Windsor Village through Senior Solutions and the SASH programs.



- Despite staffing challenges in 2021, the wellness nurse served more than 100 patients with assessments, education, monitoring and care coordination.
- Blood pressure clinics were continued as well as a flu clinic this year.
- SASH coordinator worked with 4 residents on how to use technology to decrease social isolation and improve access to telehealth.
- The wellness nurse worked with the SASH coordinator to serve an average of 80 patients:
 - Organized monthly blood pressure check and education clinics.
 - Provided heart-healthy recipes with demonstrations.
 - Served as a link between clients and their primary care providers as well as the Community Health Team.

VOLUNTEERS IN ACTION

Volunteers in Action provides services for individuals who are older and/or disabled, (especially those lacking familial support close by). Many of our services support opportunities to stay at home and maintain independence while aging. Services include:

- Delivering nutritious food in collaboration with the Meals on Wheels program and local foodbanks and the Everyone Eats program.
- Providing medical appointment rides at no-cost.
- Offering a hand around the home with errands.
- Providing friendly visiting.

Volunteers in Action empowers people to help each other while maintaining dignity and bolstering a sense of community and belonging. Some of our volunteers have since transitioned to receiving services rather than providing them, and we are honored to help them as they once helped others.



- Helped to organize and coordinate a 65-person “neighbor helping neighbor” Windsor Area COVID-19 Response Team that responded to emergency requests, e.g., pet care for the hospitalized, grocery pick-up for those quarantining and much more.
- Throughout the entire pandemic, our courageous and generous volunteers have continued to bag and deliver Meals on Wheels with no interruption in service.
- Our Creative Crafting Circle of volunteers spent, on average, 20 hours per month (since restarting in June 2021) knitting hearts and garments for comfort for those hospitalized and their families at MAHHC.

COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP (CHIP)



- Several hundred Senior Health Quick Guide resource magnets have been distributed throughout the service area.
- A series of informational/educational sessions was presented with information on various topics of starting and maintaining an aging-in-place organization. This series was well received by participants. One of the topics of the series was about community nursing and included representatives from the Upper Valley Nursing Project.
- Senior Health Workgroup has expanded to include participants from most all towns within the HSA.

PROBLEM STATEMENT	Seniors are not accessing services that are available to them.
ROOT CAUSES	There is a lack of knowledge around resources among seniors.
AIM STATEMENT	To increase the connection of seniors to needed resources in the MAHHC service 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 their evolution. Also, we want to connect with the Upper Valley Nursing Project.
RESULTS BASED ACCOUNTABILITY	<p>How much: # of existing and new groups collaborating with this network;</p> <p>How well: % of groups that report that their group is more connected/supported and therefore more able to serve seniors;</p> <p>Is anyone better off: # of seniors who know to access/find resources.</p>
(RBA)/DATA COLLECTION	

DEFINITION OF SPIRITUAL HEALTH

Spiritual health is the aspect of our well-being that refers to the values, the relationships, and the meaning and purpose of our lives. It includes a person's sense of being a part of something bigger than themselves. Spiritual health can help a person cope with issues that arise with physical and mental health regardless of circumstance.

ISSUE

Spiritual health is an important aspect of overall health.

Research demonstrates that spirituality and religion positively impact health and wellness across the continuum of care. In prevention, treatment, and the experience of severe and recurrent substance use disorder and mental illness, both primary and co-morbid outcomes are improved when the patient and their family receive spiritual and religious support. Understanding the critical intersections of spirituality, substance use disorder and mental health can increase the overall effectiveness and quality of treatment across an individual's continuum of care.

To find out more, visit: spiritualitymindbody.tc.columbia.edu/our-work/mental-health--wellness/

PROGRAMS

COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) WORKGROUP

PROGRESS



- Spirited health newly recognized as a priority issue. Indicators of isolation and spiritual health were part of the 2021 Community Health Needs Assessment for baseline measurement and to track progress over time.



- Multisector workgroup formed in late 2020.
- Outlined 5 core elements (see below).
- Began planning spiritual health asset mapping project. Interviews will be conducted and analyzed in 2022. The information gathered will serve as the basis of an improvement plan.

PROBLEM STATEMENT

There is lack of hope and interconnectedness in our community.

ROOT CAUSES

Lack of faith leading to over-emphasis of the 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 MAHHC Service Area in the next 3 years.

BEST PRACTICE STRATEGY(IES)

Conduct a spiritual health asset mapping project, identifying gaps and applying best practices to address.

of interviews conducted.

of things that come out of the assessment that lead to actionable steps.

% of interviews that provide in-depth versus superficial information (quality information).

of workgroup members or participating organizations who take action (who steps up to own part of the plan).

RESULTS BASED ACCOUNTABILITY

(RBA)/DATA COLLECTION



A COMMUNITY THAT IS...

**FINANCIALLY
SECURE**

Increasing Access to Affordable Health Insurance, Dental Care, and Prescription Medication

ISSUE

We believe that everyone should be able to receive needed health and dental care services ranging from the prevention of disease and promotion of health to the treatment of illness and injury. We also believe that having a regular relationship with a doctor and dentist is an important part of quality healthcare.

The Windsor Community Health Clinic was established to serve members of our community who are not covered by Medicaid, Vermont Health Access Plan or private insurance, and who do not have the financial resources to pay for health or dental care services. While the creation of the Affordable Care Act (Obamacare) was an effort to make insurance accessible to more families and individuals, costs are still high and residents still end up forgoing health and dental insurance.

Dental Care was a top need identified in our 2018 needs assessment. Many people are not seen by a dentist which impacts not only physical health (as the mouth is the gateway to the body) but also how people are seen and people feel about themselves, impacting self-confidence.

PROGRAMS

WINDSOR COMMUNITY HEALTH CLINIC

A member of Vermont's Free and Referral Clinics. We are an integrated service within Primary Care at MAHHC and a member of the Community Health Team—providing care coordination and patient advocacy to better serve the needs of our patients.

SCHOOL AND COMMUNITY-BASED DENTAL OUTREACH

Services providing access to dental care in the school setting was significantly impacted by COVID-19 in 2021. We plan to resume services in 2022.

PROGRESS



- Collaborated with the Thompson Senior Center and Ottauquechee Health Foundation to assist patients with health insurance and any other needs they may have.
- Recognized as a leader in Vermont Health Connect enrollments; staff members were interviewed for WCAX Channel 3 News.
- **Served 328 patients in 2021.**
- Partnered with multiple dental practices to be able to treat more patients:
 - One in Manchester, NH, is urgent care based and can often see patients "same day" for extractions.
- With continued Byrne Foundation funding, we continued to provide high-cost dental care and high-cost medications.



- Through generous donations from Northeast Delta Dental, MAHHC provided toothbrushes and toothpaste to the following:

◦ Senior Solutions (48)	◦ Bellows Falls/Parks Place (50)
◦ Hartland Elementary School (96)	◦ Transitional Living in Springfield (12)
◦ Stafford Commons, West Woodstock and Mellishwood (48)	◦ The Haven Homeless Shelter (144)
◦ Bradford Psychiatric Associates (25)	◦ Springfield Justice Center and Springfield Supported Housing (144)

ISSUE

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services including healthcare appointments, and more challenges to leading independent, healthy lives. Transportation is a strong emphasis within our community health work. We take two approaches. One is to bring services more centrally to the Windsor area. This is done through the work of the Windsor Connection Resource Center through which we bring a myriad of essential health and human services into Windsor. The second approach is to provide transportation to those in need. As displayed in this table, about 6% of households in the MAHHC service area report not having a vehicle available.

Area	Percent of Households with No Vehicle Available
MAHHC Service Area	6.3%
Vermont	6.9%
New Hampshire	5.1%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

In the 2021 Community Health Needs Assessment, transportation was arranged as the fourth highest priority at 22% when answering the question, “which of the following programs are services would you use if it were more available in your community.” In addition, 64% of residents and 81% of community leaders felt that town, county and state officials need to take action to promote public transportation.

PROGRAMS

MAHHC LEADERSHIP AND STAFF

PROGRESS



- Community Health director participates in the Springfield Area Working Communities Challenge (SAWCC) subgroup for transportation. This Transportation Subcommittee has gathered information surrounding resources and areas of need in the region and identify opportunities for funding support. SAWCC also:
 - o Connects community members, social service agencies and employers to existing resources.
 - o Continues to gather information around gaps in resources.
 - o Continues researching potential new areas to provide transportation support.
- Volunteers in Action coordinator represents our region at the Elderly and Disabled transportation meeting to advocate for our clients' needs.
- Community Health director has also participated in the Vermont Micro-Transit Feasibility Study with the Vermont Transportation Agency attempting to promote increased transportation resources within our area.
- A MAHHC team working with community partners such as the Windsor Police Department and Trinity Evangelical Free Church developed a system for bringing those experiencing homelessness to the Upper Valley Haven shelter during the winter.



VOLUNTEERS IN ACTION (ViA)

Volunteers in Action provides services for individuals who are older and/or disabled, (especially those lacking familial support close by). A key service is providing medical appointment or other rides at no-cost.

We maintain a robust network of volunteers who donate their time helping neighbors.



- Delivered 350 meals on wheels, driving 18,000 miles.
- Gave 134 volunteer rides, driving 1,750 miles.

RIDES TO WELLNESS (R2W)

We developed and distributed a roadmap or algorithm to educate the community and community partners about the various options for transportation. Overall the surveys about Rides to Wellness showed a positive impact of the program. An important component of the project was to raise awareness of available options both among healthcare providers and among patients.



- Rides to Wellness program survey results show that:
- 92% of respondents saying that Rides to Wellness met their needs "very well." None of the respondents said that it did not meet their needs.
 - 82% of respondents said that they were "very likely" to recommend R2W to friends or family who face transportation barriers to medical service, and another 15% said they were "somewhat likely."
 - 81% of respondents said that they know more about transportation options because of R2W.
 - 82% of respondents agree with the statement that "they were better off health wise or in other ways because of R2W".
 - 65% of respondents said that before R2W they had canceled or rescheduled an appointment in the past year because of a lack of transportation.
 - 68% of respondents indicated that they would have skipped, canceled or rescheduled the appointment for which they received the R2W benefit, had R2W not been available.

WINDSOR COMMUNITY HEALTH CLINIC



- Distributed gas cards and arranged transportation for those in need served by our free clinic including uninsured and underinsured members of the community.



A COMMUNITY THAT IS...

**WELL
NOURISHED**

Increasing Food Security, Access to Healthy Food and Opportunities for Physical Activity

ISSUE

Research shows that up to 80% of our health outcomes are determined by social and environmental factors that occur outside the boundaries of a traditional healthcare setting. Supporting health and wellness in our communities has been a focus of our efforts over many years. We specifically work to create environments of health particularly around ensuring access to healthy food options and increasing options for being physically active.

Food security is a long-standing and pressing problem. An estimated 10% of Windsor County households experienced food insecurity pre-COVID-19. During the pandemic, demand for food security resources increased dramatically. We are diligently working with partners across the region to establish a sustainable, equitable network of food security resources.

PROGRAMS

VOLUNTEERS IN ACTION (ViA)

Volunteers in Action provides services for individuals who are older and/or disabled, (especially those lacking familial support close by). A key service is providing medical appointment or other rides at no-cost.

We maintain a robust network of volunteers who donate their time helping neighbors.



RISE VERMONT

Only 20% of our health is determined by clinical healthcare. RISE is a statewide initiative with regional efforts to work on policies and programs that implement health behavior change interventions and address the social, economic, and physical environment factors that impact health.

The core of the RISE VT at MAHHC is working with community partners to realize the potential and take action to create environments that improve health and wellness. We make investments in local projects that take action through our Amplify grants.



PROGRESS



- Our Meals on Wheels volunteers delivered **more than 350 meals per week** over an estimated **18,000 total miles collectively.** (Throughout the entire pandemic, our courageous and generous volunteers have continued to bag and deliver Meals on Wheels with no interruption in service).
- Partnering with the Vermont Foodbank to help our neighbors facing food insecurity by our volunteers helping to distribute fresh produce to **more than 330 households per month** through the VeggieVanGo program.



- With Windsor Food Shelf, co-led the Porch Garden Project to distribute supplies and starter plants to 100 food shelf client families:
 - Participating food shelves: Hartland, Weathersfield, Reading-West Windsor.
 - Plants and supply donations procured from Cedar Mountain Farm, Deep Meadow Farm, Crossroad Farm and Honey Field Farm.
- Provided RISE "Amplify" Grant funding to:
 - Expand the Windsor Community Garden and establish raised beds at Children's Place Preschool in Windsor.
 - Purchased a digital display board for Windsor Food Shelf to help low literacy or elderly patrons access information about available resources in the region.
 - Provide a free sled giveaway through the Hartland Recreation Department to encourage outdoor time during the pandemic.



- Hosted a Southern Vermont Area Health Education Center intern to develop a series of slides with audio for the food shelf display.
- Partnered with the Windsor Recreation Department, Windsor Food Shelf and Black Lives Matter Windsor VT to co-sponsor a RISE to 5K program and host a virtual 5K-Race to Health Equity.
- Continued to maintain and promote the previously established “Windsor Walks” loops. A series of walks around Windsor that vary in length and range, from flat ground to hills, and from sidewalks to the shores of Lake Runnemedede. Partners included the Town of Windsor and the VT Department of Health.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

MAHHC and our community partners have been working to address food security for many years. The Vermont Food Bank conducted an assessment of food security in Woodstock and approached MAHHC about working together in March 2020. Stakeholders were engaged across our service area and the Food Security Community Health Implementation Plan workgroup is the result.



- Regular, monthly Food Security workgroup meetings, met 12 times.
- Supported a messaging campaign to reduce barriers to accessing food resources, including VeggieVanGo, local food shelves, and the Special Supplemental Nutrition Program for Women, Infants, and Children.

“We are working toward the day when there is an equitable system for addressing food security. When everyone is aware of the food resources available to them and is accessing those resources, because stigma and other barriers are removed.”

- The CHIP Food Security Workgroups

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.
- Identify gaps and barriers to food access in our region by conducting a food resources inventory. Use the results to develop and implement a plan for increasing access to nourishing and culturally appropriate food. Include in the plan what will be done, who will do it and by when.



A COMMUNITY THAT IS...

**WELL
HOUSED**

Coordinating Housing Stabilization, Expanding Opportunities, and Addressing Homelessness

ISSUE

Housing and homeless needs continue to rise in our area. There is a shortage of available properties and housing advocates say typical Vermont incomes are not high enough to afford renting, buying, or building a home. The situation has been burdensome for years, but was severely worsened by the pandemic where an influx of new residents created greater scarcity of properties and folks impacted by loss of income are having trouble making ends meet.

PROGRAMS

MT. ASCUTNEY HOSPITAL COMMUNITY HEALTH LEADERSHIP

Efforts are bolstered (or sustained if Byrne is sole funder) supported through generous grant support from the Byrne Foundation. We rallied key stakeholders bringing together churches, healthcare providers, town officials and volunteers, to organize a community support program for the homeless during the winter.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP

PROGRESS



- Organized a community team to address the rising needs of homelessness in our area:
 - Purchased tents and camping supplies.
 - Produced and disseminated a housing resource guide, homeless resource guide, and disseminated outreach posters directly to those experiencing homelessness.
 - Organized a system of transportation for those experiencing homelessness to hotels and shelters.



- Completed and reviewed Sharing Housing Inc.'s self-paced courses to understand and communicate the benefits of home sharing, the steps to create a successful Homeshare situation and the support needed for each step of the process.
- Conducted outreach to recruit potential Homeshare hosts in support of the first Thompson Senior Center Homeshare match.
- Hosted conversation with the Gibson Senior Center of the Mount Washington Valley about their emerging Homeshare program to exchange plans and perspectives.
- Collaborated with Community Health Implementation Plan seniors group and with Aging in Hartland to learn about existing networks for outreach, and explored partnership for outreach planning.
- Worked with John Snow International to develop and update results-based accountability measures suited to Homeshare project plans.
- Conducted landlord interviews and shared stories of people who met their economic and social needs by renting to others at affordable rates or through homeshare.
- Facilitated presentation of Homesharing Program by the Thompson Senior Center at the Vital Communities Housing Breakfast.
- Participated in and helped promote Keys to the Valley framework for the range of housing needs and solutions in our region.
- Engaged in a number of community outreach efforts for homeshare and rental education; 6 outreach efforts to 170+ people.

“Large-scale development is needed, but it’s simply not enough to meet our needs. In some cases, we homeowners have to become developers, too.”

- Jason Rasmussen, Director of Planning at Mount Ascutney Regional Commission



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 homeshare and 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

How much: # of community outreach efforts for homeshare and rental education.

How well: % of outreach effort that lead to further exploration of rental or homeshare.

Is anyone better off: # of potential landlords/homesharers who tell us their initial concerns about becoming a landlord/homesharer were addressed.

(RBA)/DATA COLLECTION

“We have a housing crisis, and it is getting worse. It is not a small problem. Tens of thousands of individuals and families in the region struggle to afford their home, while others lack access to needed in-home supportive services. Some remain without permanent shelter, fear eviction or reside in unsafe conditions.”

WINDSOR COMMUNITY HEALTH CLINIC SERVED **328 PATIENTS**

\$10,923

GIVEN OUT IN
Medication Vouchers

112

Miles Driven (7 Rides)
BY RIDES TO
WELLNESS PROGRAM



25 Dental Vouchers

GIVEN OUT
TOTTALLING \$19,689

**567
Toothbrushes**
DISTRIBUTED



WINDSOR COMMUNITY
RESOURCE CENTER AND
PATCH TEAM SERVED

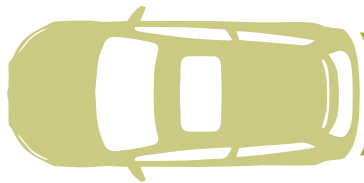
1929 Clients



VeggieVanGo SERVED

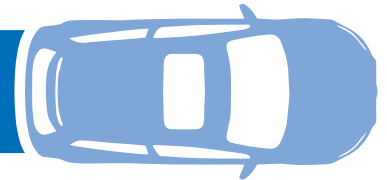
**3889 Families/
Households**

**VOLUNTEERS
IN ACTION:**



Gave 134 Volunteer Rides
DRIVING 1,750 MILES

Delivered 350 Meals on wheels
DRIVING 18,000 MILES



SELF-MANAGEMENT, CHRONIC DISEASE CLASSES

17

Groups Held

144

Registrants

86%

Completed the Course

Appendix II: CHNA Community Health Costs and Funding Sources

MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

CHNA COMMUNITY HEALTH COSTS AND FUNDING SOURCES

October 1, 2020 – September 30, 2021

Description	Total Cost	Grants, Trusts, Foundations, Private Contributions	MAHHC (Hospital Subsidized)
MAHHC - Community Health Infrastructure	\$48,031	\$5,596	\$42,435
Access to Mental Health	\$73,325	\$20,502	\$52,823
Alcohol and Drug Misuse Including Heroin and Use of Pain Medications - Prevention, Treatment, and Recovery	\$756,857	\$735,950	\$20,907
Access to Affordable Health Insurance, Cost of Prescription Drugs	\$153,417	\$145,471	\$7,946
Family Strengthening: Including Poverty and Childhood Trauma	\$221,821	\$203,535	\$18,286
Access to Primary Care Services	\$470,254	\$418,798	\$51,455
Healthcare for Seniors	\$27,905	\$25,265	\$2,640
Affordable Housing	\$1,839	\$0	\$1,839
Access to Dental Care	\$20,375	\$19,580	\$795
Smoking, Tobacco Use, Vaping	\$63,415	\$62,621	\$795
Transportation	\$18,970	\$5,310	\$13,660
Nutrition/Access to Affordable Food; Access to Physical Activity	\$51,888	\$28,790	\$23,098
COVID - 19	\$25,374	\$15,129	\$10,245
Spiritual Health	\$31,474	\$705	\$30,769
	\$1,959,634	\$1,681,942	\$277,691

*Not included in the above funding is over \$26,000 of in-kind support from partners and agencies contributing resources to our Community Health Improvement Plan networks.