

COMMUNITY HEALTH BENEFITS REPORT

2022



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At MAHHC our purpose is to improve the lives of those we serve, with a significant part of this work being accomplished through our community health initiatives. This report highlights the work that our Community Health Department and community partners have accomplished in the 2022 fiscal year. The activities reported on address the priority concerns identified in the 2021 Community Health Needs Assessment.

INTRODUCTION

It is with gratitude and thanks that the MAHHC Community Health Department, our regional Windsor Health Service Area Community Collaborative, and our Community Health Implementation Plan Network invite you to join us in celebrating our accomplishments of the last fiscal year.

The following pages cover our activities from October 1, 2021 through September 30, 2022.

While impossible to cover everything, we hope that this in-depth report provides the reader with enough detail about the array of programs and services we offer to our community.

Our Structure

MAHHC is the lead organization for our regional Accountable Community for Health called the Windsor Health Service Area Community Collaborative (Windsor HSA). This aspirational model demonstrates accountability for the health and well-being of the entire population in our geographic area and is 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. *(Graphical representation of our Accountable Community for Health found on page 3.)*

In addition to the Windsor HSA, since 2019, we have intentionally built a network of Community Health Implementation Plan (CHIP) workgroups addressing 50+ Health, Food Security, Housing, Spiritual Health, Strengthening Families, and Substance Use. Accomplishments and future direction for each group is found at the end of their respective sections in this report.

For a more in-depth account about our processes and structure within Community Health at MAHHC, please visit our website: mtascutneyhospital.org/about/community-health-needs.



IN DEDICATION

This year's Community Benefits report is dedicated to Jill Lord, RN, MS. Jill worked at MAHHC for over 30 years in administrative nursing roles and as the Director of Community Health. She retired in January of 2023.

"Jill cares deeply for our local communities and led healthcare reform efforts on a state level. She was also instrumental in creating many of the programs outlined in this report.

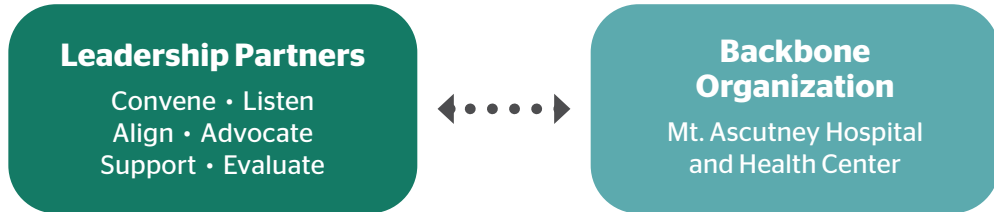
To you, Jill, we are grateful!"

- Community Health Department and Staff of MAHHC

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



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

WINDSOR HSA COMMUNITY COLLABORATIVE PARTNERS

WINDSOR HSA COMMUNITY COLLABORATIVE LEADERSHIP PARTNERS

- Aging In Hartland
- Bayada
- Blueprint for Health
- Cedar Hill Continuing Care Community
- Clara Martin Center
- Couch Family Foundation
- Dartmouth Trauma Interventions Research Center
- FCP Live-In
- Gifford Health Care
- Health Care and Rehabilitation Services
- Historic Homes of Runnemedede
- Mt. Ascutney Hospital and Health Center
- Mt. Ascutney Prevention Partnership
- Ottauquechee Health Center
- Ottauquechee Health Foundation
- OneCare Vermont
- Scotland House
- Senior Solutions
- 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
- Volunteers in Action
- Windsor Southeast Supervisory Union
- White River Family Practice
- Windsor Community Health Clinic

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) NETWORKS

FOOD SECURITY

- AmeriCorps VISTA
- Building Bright Futures
- Hartford Community Coalition
- Mount Ascutney Regional Commission
- Mt. Ascutney Hospital and Health Center
- Ottauquechee Health Foundation
- Reading-West Windsor Food Shelf
- RiseVT
- Senior Solutions
- Two Rivers-Ottawuechee Regional Commission
- Upper Valley Haven
- Vermont 211
- Veterans Affairs Hospital
- Vermont Department of Health
- Vermont Food Bank
- Vermont Student Assistance Corporation
- Vital Communities
- VT Sustainable Jobs Fund WIC program
- WIC Program
- Willing Hands
- Windsor Central Supervisory Union
- Windsor Community Food Shelf
- Windsor Community Garden
- Windsor Southeast Supervisory Union
- WISE
- Woodstock Food Shelf

HOUSING

- Agency of Human Services
- Aging in Hartland
- Alice Peck Day Hospital
- AmeriCorps VISTA
- Dartmouth College
- Granite United Way
- Health Care and Rehabilitation Services
- 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 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

50+ HEALTH

- Agency of Human Services
- Aging in Hartland
- Aging in Place
- Aging Resource Center
- AmeriCorps VISTA
- Bayada
- Community Nurse Connection
- Connected At Home
- Dartmouth College
- Friends Helping Friends
- Granite United Way
- HireAbility VT
- Health Care and Rehabilitation Services
- Lake Sunapee VNA
- Mt. Ascutney Hospital and Health Center
- Ottauquechee Health Center
- OneCare Vermont
- Ottauquechee Health Foundation
- Public Health Council of the Upper Valley
- Support and Services at Home
- Scotland House
- Senior Solutions
- Thompson Senior Center
- North Universalist Chapel Society Woodstock
- Upper Valley Community Nursing Project
- Vermont Department of Health
- Vermont-211
- Volunteers in Action
- Visiting Nurse and Hospice for VT and NH

STRENGTHENING FAMILIES NETWORK

- AmeriCorps VISTA
- Blueprint for Health
- Building Bright Futures
- Couch Family Foundation
- Dartmouth Health
- Dartmouth Trauma Interventions Research Center
- Gifford Health Care
- Health Care and Rehabilitation Services
- MoonRise Therapeutics
- Mount Ascutney Regional Commission
- Mt. Ascutney Hospital and Health Center
- Ottauquechee Health Foundation
- Springfield Area Parent Child Center
- The Family Place
- Town of Hartland
- Two Rivers Ottauquechee 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
- Windsor Central Supervisory Union
- Windsor County Head Start
- Windsor Rotary
- Windsor Southeast Supervisory Union
- WISE

WINDSOR COUNTY SUBSTANCE USE DISORDER COLLABORATIVE

- Agency of Human Services
- AmeriCorps VISTA
- Better Life Partners
- Clara Martin Center
- Connecticut Valley Addiction Recovery
- Dartmouth College
- Dartmouth Health P2P
- Divided Sky Foundation
- H2RC / HIV/HCV Resource Center
- Health Care and Rehabilitation Services
- Mt. Ascutney Hospital and Health Center ED
- Mt. Ascutney Prevention Partnership
- Ottawaquechee Health Center
- Hartford Community Restorative Justice Center
- Second Wind Foundation
- Southern Vermont Area Health Education Center
- 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
- Upper Valley Haven
- Valley Court Diversion Program
- VCCI Nurse
- Vermont Department of Health
- Vermont Department of Health Overdose Response Strategy
- Vermont Recovery Network
- Vermont State Senate
- VT Dept of Substance Use
- Windsor Police & EMS
- Windsor Select Board
- Woodstock EMS

SPIRITUAL HEALTH

- AmeriCorps VISTA
- Ascutney Union Church
- Hartland Universalist Unitarian Church
- NH Healthy Families
- Mt. Ascutney Hospital and Health Center
- Mt. Ascutney Prevention Partnership
- Old South Church
- Trinity Evangelical Free Church
- Turning Point Recovery Center of Springfield
- St. Francis of Assisi Church

CHRONIC DISEASE PREVENTION & MANAGEMENT

MT. ASCUTNEY PREVENTION PARTNERSHIP & RISE VT

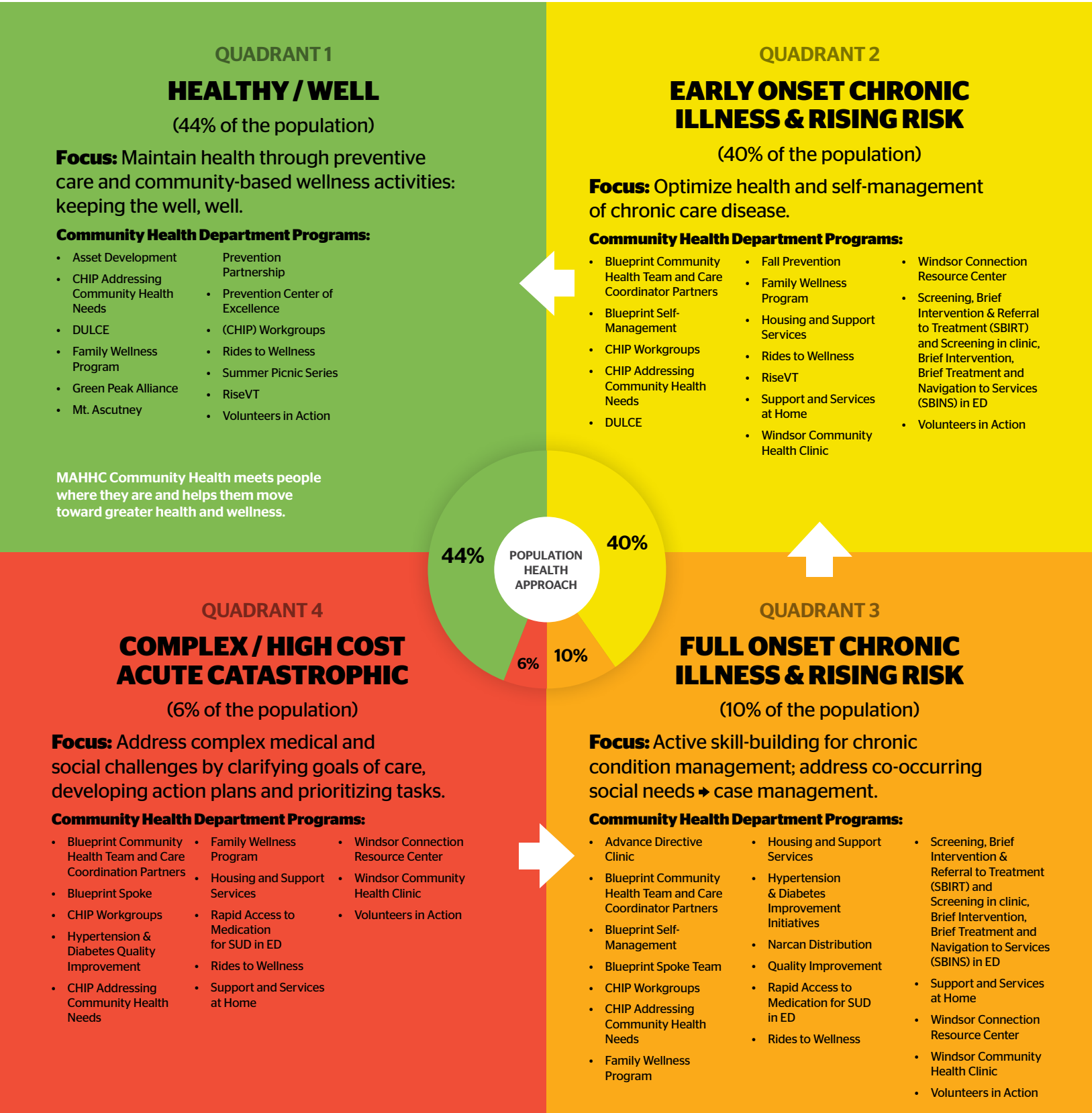
- Mt. Ascutney Hospital and Health Center
- Community Health Committee, MAHHC
- Retired Hartland residents (2)
- Hartland Select Board
- Hartland, Recreation
- MAHHC volunteer
- Mount Ascutney Regional Commission
- OneCare Vermont
- Southeastern Vermont Community Action
- Seniors Volunteer Corps Springfield 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

- Aging in Hartland
- Bayada
- Better Life Partners
- Blueprint for Health
- Connecticut Valley Addiction Recovery
- DULCE
- Department of Children, Youth and Families
- Family Wellness Program
- Good Neighbor Health Clinic
- Hartland Community Nurse
- Health Care and Rehabilitation Services
- Mt. Ascutney Hospital and Health Center
- Mt. Ascutney Prevention Partnership
- OneCare Vermont
- Scotland House
- Senior Solutions
- Services and Support at Home
- Springfield Area Parent Child Center
- The Family Place
- Twin Pines Housing Trust
- Upper Valley Haven
- Windsor Central Supervisory Union
- Windsor Southeast Supervisory Union
- VT Chronic Care initiative
- Vermont Dept. of Health
- Volunteers in Action
- Visiting Nurse and Hospice for Vermont and New Hampshire
- White River Family Practice

VERMONT POPULATION HEALTH MODEL

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

Mt. Ascutney Hospital and Health Center Board of Trustees

Community Health Committee

Chief Executive Officer - Joseph L. Perras, MD

Director of Community Health - Jill Lord, RN, MS

MAHHC Community Health Department

"As a community partner who serves on the Community Health Committee, it's wonderful to be part of these collaborative health initiatives. Again and again I am reminded that being healthy and whole involves us all!"

- Pastor Paul Voltmer, Community Health Committee Member

PROGRAM	STAFF - FTE			Q1	Q2	Q3	Q4
Windsor Connection Resource Center	Carrie Thornton, 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	Sarah Zwickelmaier, MSW, Family Wellness Therapist: 0.5	Alice Stewart, Evaluation: 0.01				
RiseVT	Alice Stewart, RiseVT Program Manager: 0.37						
Mt. Ascutney Prevention Partnership	Melanie Sheehan, Regional Prevention Program Manager: 1.00	Alice Stewart, Grant Implementation Team Leader: .62	Jemima Roberts, Preventions Outreach Specialist: 0.5				
Blueprint Community Health Team	Carla Kamel: 1.0 Jenna Austin, MSW: 1.0	Amy Swarr, RN: 1.0 Samantha Ball: 0.1 Kristi Templeton-Clark, Community Health Worker: 0.5 FTE	Jennifer Joy, RN: 1.0				
Blueprint Spoke Team	Sharon Jones, RN: 1.0						
Blueprint Self-Management	Sarah Doyle, Coordinator: 0.5						
Windsor Community Health Clinic	Samantha Ball, Coordinator: 0.9	Jemima Roberts, Assistant Coordinator: 0.4	Kathleen Castellini: Per Diem				
Volunteers in Action	Amanda Jordan Smith: 1.0	Susan Enser: 0.5					

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 (10/1/21-9/30/22).

ISSUE

Health Equity is a focus of our work in communities as a means to overcome preventable differences (health disparities) in the burden of disease, injury, or access to care. Many populations experience health disparities including racial and ethnic groups, LGBTQI+ persons (lesbian, gay, bisexual, transgender, queer, intersex, or other), and persons living with substance use or mental health conditions, physical or developmental disabilities, and/or persons with limited language proficiency.

To achieve health equity, we must recognize and acknowledge beliefs previously taken for granted about health, the healthcare and public health systems, and society (particularly how it is set up to advantage some and disadvantage others). This work requires focused efforts and ongoing societal efforts to address injustices, overcome economic, social, and other obstacles to health improvement. Strategies that support Diversity, Equity, Inclusion, and Belonging (DEIB) are pathways to achieving health equity.

Our work to address DEIB emphasizes the importance of addressing all people inclusively and respectfully. Much of this work is grounded in Human-Centered approaches. While all of our programs incorporate this foundational concept, some program highlights and progress in 2022 include:

PROGRAMS

MT. ASCUTNEY PREVENTION PARTNERSHIP



- MAPP presented data on health disparities to the Windsor Justice, Equity, Diversity, Inclusion group as well as the Mt. Ascutney School District Board. Both presentations led to interest to increase supports for LGBTQI+ and Students of Color.
- Strategically planned communications around recommendations according to the [American Medical Association Language, Narrative, and Concepts guide to Advance Health Equity](#).*
- Made available the Harvard Implicit Bias (implicit.harvard.edu/implicit/takeatest.html) test resource with 100 % of employees.

FOOD SECURITY WORKGROUP



- Continued to develop non-stigmatizing social media messaging to reduce barriers to accessing important food resources.
- Continued to develop digital display media for the Windsor food shelf television, containing audio content for greater accessibility for low literacy or failing eyesight.

VOLUNTEERS IN ACTION (VIA)



- Invested in mechanized knitting for volunteers unable to knit in traditional ways (allowing for peer interaction and increased volunteerism).
- ViA Program Lead participated in many local and regional equity meetings and conferences; also lent expertise in revamping written content for readability, accommodations, inclusive language as well as advising on image choices for publications.

WINDSOR COUNTY SUBSTANCE USE DISORDER COLLABORATIVE (WCSUDC)

Our philosophy of care:

"In the work that we do related to SUD, we are guided by making everyone feel like they matter to our community. We meet people where they are in their lives, and we treat them with dignity as human beings, understanding that SUD is a disease, not a moral failure. Our approach to care recognizes that none of us is perfect, and we are committed to expanding this philosophy of SUD care throughout our community."



- Continued the development and expansion of the weareworthwhile.org stories campaign, to overcome self-stigma as a barrier to treatment.
- Partnered with local Physicians hosting an Addiction Summit to discuss the perpetuating impact that stigmatization against substance users has on continued use. We Are Worthwhile physician ambassadors (those who promise to treat persons with substance use with dignity and respect) were recruited.

* Reframing paradigms is essential to addressing health disparities. It requires a focus away from individuals and individual behaviors to a health equity focus on the well-being of communities, as shaped by social and structural drivers.



A COMMUNITY THAT IS...

**PHYSICALLY
HEALTHY**

ISSUE

Access to quality health services is essential for preventing, managing and reducing diseases across the population. Improved 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 12th 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 provides ongoing 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, Aging in Place/Community Nurses, DULCE, Heath Care and Rehabilitation Services, and VT Chronic Care Initiative.
- Met weekly with community partners to share resources, problem-solve, and coordinate care.
- The Community Health Team, as care coordinators, worked with an average of 328 patients per quarter. As a team, by sharing resources and holding care conferences, they addressed patient needs such as access to healthcare, food, housing, finances, and education.



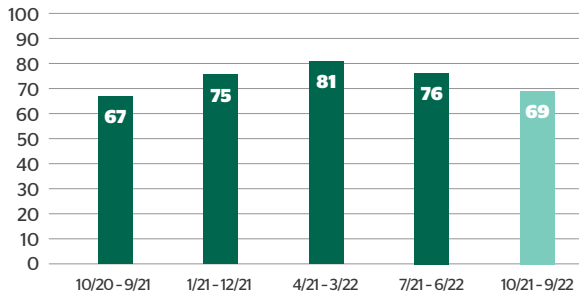
- Workshops provided this year included Diabetes Self-Management Program, Diabetes Prevention Program, Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, Hypertension, and Tobacco Cessation Program.
 - 18 different groups
 - 165 total participants
 - 55% course completion

QUALITY IMPROVEMENT INITIATIVES

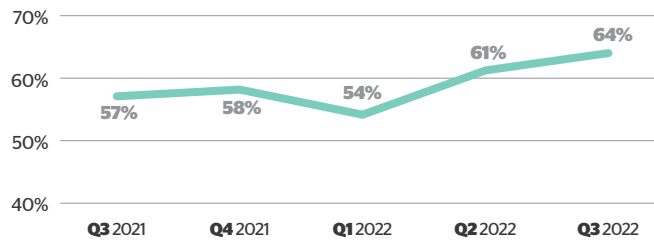
Part of access to primary care is ensuring that the services provided are hitting quality measurement goals. In Primary Care at MAHHC, our providers and staff, data analysts and quality improvement staff form teams with outside partners to tackle areas that will help improve care for a high percentage of our patients.

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.



HIGH BLOOD PRESSURE CARE / HYPERTENSION

- Community care nurses reported success in helping most patients to meet their high blood pressure goal within one to two visits.
- Quarterly data from FY21 to FY22 showed a 7% increase in the percent of patients whose last BP measurement was considered “in control”.
- The blood pressure self-management workshops continued; the program coordinator met quarterly with providers to sustain systematic referral processes.
- MAHHC clinic worked with OneCare VT to meet population health targets related to hypertension.

DIABETES CARE

- Ivan Levin, MD continued to lead this quality improvement process and worked with clinic providers to implement it. And, Community Care Nurses implement best practice order sets for labs, patient education and follow-up.
- Providers began receiving monthly reminders about the status of diabetic patients from Community Health Team care managers.

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**

Click to see Youth tobacco
and vaping trends.

DATA DASHBOARD

embed.clearimpact.com/container/embed/9992263



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



- We continued to work with Regional Planning partner organizations to advance tobacco policies one town at a time. In the past year, we have been working with the town of Bethel, VT to implement town plan health chapter recommendations on smoke-free parks. We are also assisting the town of Hartford, VT in updating and strengthening its parks ordinance to better address smoking and vaping.
- Engaged multiple youth in area schools to get feedback on what types of vaping cessation promotional items are most popular.
- Engaged area Recovery Centers to conduct focus groups, asking what cessation supports and quit kit items would be most supportive.
- Worked with MAHHC Clinic Data Analyst to better understand demographics of tobacco using patient populations to drive better cessation referral processes and targeted interventions.
- Engaged area employers by way of survey to assess prevalence of young adult smokers and how to support them via workforce initiatives.
- Continued to highlight area retailers who pass compliance checks as community champions protecting youth. Retail champions publicly tagged and thanked on social media.
- Supported Ascutney Outdoors in developing a smoke-free/vape-free policy and provided free signage via the Vermont Department of Health.



- Offered 1 group cessation class.
- Vermonters continued to receive FREE nicotine replacement products (patches, gum, lozenges) through the 802 Quits Program.



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 and continuously implemented best-practice approaches to prevent and reduce alcohol and substance use. There is still work to be done, as we are seeing some increasing trends related to the long-term impact from the COVID-19 pandemic.

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



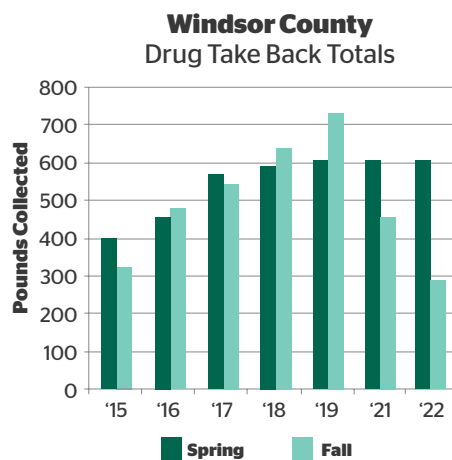
Youth substance use rate trends:

DATA DASHBOARD



embed.clearimpact.com/scorecard/embed/77781

MAPP supported April and October 2022 Drug Take Back Day events. Graph shows number of pounds of medications collected:



PROGRESS



- Subawarded ~ **\$101,463** to 8 community organizations to implement prevention strategies at the local level. Maintained grantee resource page mappvt.org/PNGgrant.
- 100% of towns considering hosting cannabis retail stores “opted in” with majority “yes” votes in 2022. MAPP worked with these towns to consider preventing youth access and use by bringing best practice policy approaches and ongoing dialogue.
- Continued support for a local school district in setting up Restorative Practices policies/procedures.
- Worked with Windsor Police Department and the Supportive Outreach Project to outline and launch a Youth PSA contest, soliciting short, youth-made videos on the benefits of a substance-free life. Winners will be selected in 2023.
- Updated disparities statement for 2022 (shorturl.at/aCDH5). Data drives improvement and planning around overcoming health disparities.
- Continued prevention policy outreach regarding health promotion in 3 towns.
- Continued partnership with TRORC to maintain Health Policy Clearinghouse (trorc.org/healthpolyclearinghouse)—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.
- Maintained supply of medication return envelopes in over 30 kiosks across region. More than 443 envelopes have been returned from the White River Junction Health District office area (7%)*.

* indicates % change from prior calendar year

MEDICAL 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:
 - As of September 2022, the VPMS report shows Windsor County providers remain in the lowest 3 rankings for prescriptions per 100 residents in all drug classes.
- 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 substance use is at a risky level. Recommendations given to patients match the level of personal use patterns reported.
 - Our goal is to screen 100% of new and annual exam patients.
 - FY22 screenings fluctuated from 63% - 100% at MAHHC and 45% - 100% at OHC.
- **3,520** individuals were screened and referred to treatment as indicated. (58%)*.

* indicates % change from prior calendar year

RAPID TREATMENT ACCESS (RTA) AND RAPID ACCESS TO MEDICATION-ASSISTED THERAPIES (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. In 2022, the ED Director added a similar Pathway to ensure patients with alcohol use disorder received similar treatments and referrals.



- MAHHC Emergency Department continued to be a naloxone distribution and medication-assisted treatment site. These are life-saving interventions available to our communities.
- MAHHC led an effort to organize teams of Emergency Departments and treatment providers in Windsor and Springfield to create an Alcohol use Disorder Pathway, providing services for medically necessary detox.
- In addition to substance use and alcohol use medical treatments, patients received a timely referral to a treatment provider for ongoing medication and counseling.
- Consumer Guide to Substance Use Treatment (shorturl.at/qJLPR) was updated and used to support both the RAM and RTA pathways.

Narcan Education

32 Narcan kits were distributed in the ED for FY22
(33% from FY21)

Rapid Administration of Medication (RAM) through the Emergency Dept.

11 initiated for FY22
(57% from 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 follows 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 living with addiction.



- 26% of coaching was for opioid use, 46% for alcohol, 7% for methamphetamine and 2% for cannabis.
- **56 referrals** were made from the ED to Recovery Coaches.
 - 84% of patients opted in to receive follow-up.
 - 53% of patients who opted in completed 10-day check ins with recovery coaches.
- A future aspiration is to increase recovery coach visit volume in MAHHC ED.

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:

- Ottauquechee Health Center and Pediatric Parent Support Programs
- Connecticut Valley Addiction Recovery
- Bradford Psychiatric Services
- 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 Support Program program served mothers who received medication, counseling and a therapeutic playgroup for their children. Participation rates were stable since 2015, however the group ended in 2022 as participants graduated out.
- Our Blueprint for Health Self-Management programs offered a successful Chronic Pain Self-Management Program:
 - 4 Chronic Pain workshops were provided.

COMMUNITY-BASED EFFORTS TO PREVENT OVERDOSE DEATHS

Windsor County continues to be in the top 3 areas in the state for overdose deaths. We have aggressively implemented best-practice strategies to combat this devastating phenomenon. Strategies and programs implemented through generous grants support and by working with strong leadership and clinical expertise.



- MAHHC collaborated with the newly established Windsor Overdose Awareness Committee who hosted a vigil on National OD Awareness Day August 31st.
- Continued membership with Springfield Outreach Project and Hartford Overdose Collaboration Team, attended meetings and coordinated Outreach After Overdose efforts.

Number of opioid-related fatalities of Windsor County residents.



HARM REDUCTION APPROACHES

To be truly successful at overcoming devastation from substance use, approaches need to aim at meeting clients where they are, even if that means when they are not ready to stop substance use. Reducing harm associated with substance use is the first step in overcoming stigma and building relationships.

MAHHC partners with both harm reduction and recovery partners to support persons who use drugs. These approaches help link persons in need to medical care for wound infections and distribution of narcan kits and fentanyl test strips.



- Continued distribution of over **3,000** “Overdose Happens: Have a Plan” education booklets.
 - Visited 13 total pharmacies, giving out 144 OD Happens booklets and CPR masks to attach to dispensed Narcan.
 - Partner agency distribution includes: Probation & Parole, Restorative Justice, HIV/HCR Resource Center, Recovery Centers (Hartford and Springfield), Community Health & Wellness Fair, Windsor OD Awareness vigil (Windsor and Springfield).
- Ran a 3-part message about OD prevention on Gas Station TV From June - Oct 2022. We achieved 398,198 views.
 - Carry Narcan. Never Use Alone. Call 911.
- We continued to coordinate relevant drug trend information to community partners by working with New England High Intensity Drug Trafficking Agency.
- **Subawarded \$11,981** for enhanced access to medical care project through H2RC.
 - Engaged 135 Vermonters using substances, referring over 50% to medical care through newly established enhanced referral processes aimed at decreasing barriers to getting care.
 - Wound care through telehealth via 4 medical providers (Little Rivers Health Care, Dartmouth Health, Savida, and Mt. Ascutney).

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.



- MAHHC **subawarded \$6,254** for outreach after overdose activities through the Springfield and Hartford Recovery Centers. We see positive trends in the # of referrals, outreach attempts and coaching efforts.
- We saw negative trends in the # of contacts with family members, could not locate, persons refusing help/no show, and willingness to accept additional referrals.
- There was a 25% reduction in the # of harm reduction kits left behind, from 108 in FY21 to 81 in FY22, likely due to saturation at the community level.
- Quality improvement is needed for collecting proper contact information. There was a 124% increase in the # of referrals who could not be located for follow-up.

Recovery Coach Outreach After Overdose Comparison

	# of Individual Referrals	# of Outreach Attempts	# of Coaching Efforts
FY21	57	61	39
FY22	78	120	77
% Change	37%	97%	97%

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

The Alcohol and Substance Misuse CHIP workgroup transitioned to incorporate a larger array of partners working across the Substance Use Disorder (SUD) continuum, forming the Windsor County Substance Use Disorder Collaborative (WCSUDC). This group met 12 times from October 2021 - September 2022.



"I saw a Worthwhile pen in the Working Fields office. I wondered who thought I was worth something. It stuck with me and I sought help (with my addiction)."

- Client

CHIP NETWORK HIGHLIGHTS: WCSUDC

2022 Accomplishments



VIEW DATA DASHBOARD

app.resultsscorecard.com/Scorecard/Embed/77775

- Collaborated across partner agencies within the workgroup.
- Decreasing self-stigma through weareworthwhile.org stories campaign. Added new vignette to the campaign, highlighting family component.

Vision for the Future

- Effective prevention, treatment, and recovery services for SUD.
- No one waits more than 24 hours for detox and/or treatment services.
- Windsor county ranks among the lowest in the state for overdose fatalities.



- Continued ongoing promotion of the We Are Worthwhile communication campaign. In FY22, we added a new story of "Taysa" which includes the story of the impact of SUD on the family unit. Visit: weareworthwhile.org
- Recovery Inclusive Community Events (RICE) totaled 9 in 2022, ranging from family venues like Wellwood Orchard, to Springfield Co-op, MAHHC Community Health & Wellness Fair, and VeggieVanGo
- Both Recovery Center partners hosted tables at 3 Overdose Awareness Vigils in Hartford, Windsor, and Springfield. Harm reduction bags were given out, containing Narcan and Fentanyl test strips.
 - Dr. Lord from CT Valley Addiction Recovery was a guest speaker also at this event, giving concrete reasons for calling 911 during or after an overdose.



Taysa with her daughters Ryleigh and Alyssa



ISSUE

Improving the mental health status of our community is a critical component of our plan. MAHHC made significant investments in calendar year 2021 to design and implement trauma-informed care through the development of a Resiliency Leadership Team. Much of that work continued in 2022.

PROGRAMS

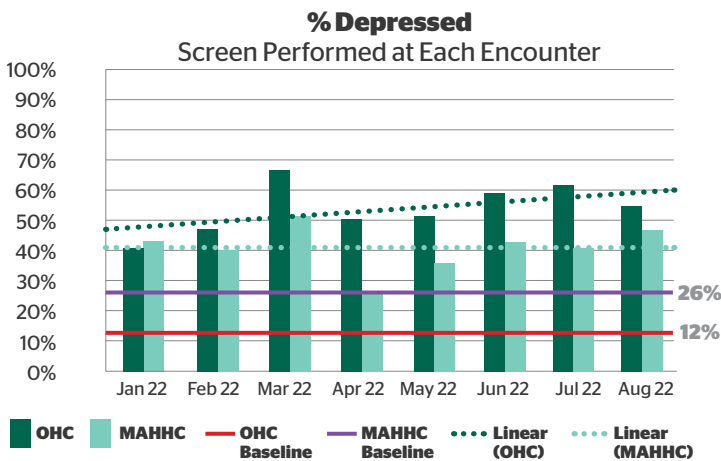
MAHHC RESILIENCE LEADERSHIP TEAM

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.

A four-part series for staff education was developed and recorded. It is an ongoing resource, available for all staff.

MAHHC CLINICAL SETTING



PROGRESS



- Trauma informed care education was embedded for all current and new staff. **440 staff** were trained.
- Worked with MAHHC Leadership Council to identify priorities and as a result began work on a resiliency toolkit and dissemination of a “tip of the month” for skill building.
- Established resilience-related goal as part of MAHHC’s annual operations plan, demonstrating commitment to engage with and build resilience in our staffing.
- Worked with “Project Launch” at Dartmouth Health as well as Health Care and Rehabilitation Services (HCRS).



- Increased capacity to provide mental health services within primary care through partnership with HCRS and area counselors.
- Established weekly care management process to address needs of youth with prolonged stays in the Emergency department. (Includes MAHHC, DCF, HCRS)
- Depression screening added to visit preplanning sheet to ensure screening compliance at every visit.
- Added embedded Mental Health clinician 1 day a week in Pediatric Clinic.
- From Jan 2022 - August 2022, both OHC and MAHHC clinics performed screenings significantly above baseline figures:
 - OHC: 230% ↑
 - MAHHC: 112% ↑

WINDSOR CONNECTION RESOURCE CENTER



- Hosted mental health counselors who provided **352 sessions**.

CHAPLAINCY SERVICES



- Continued support for staff and patients.

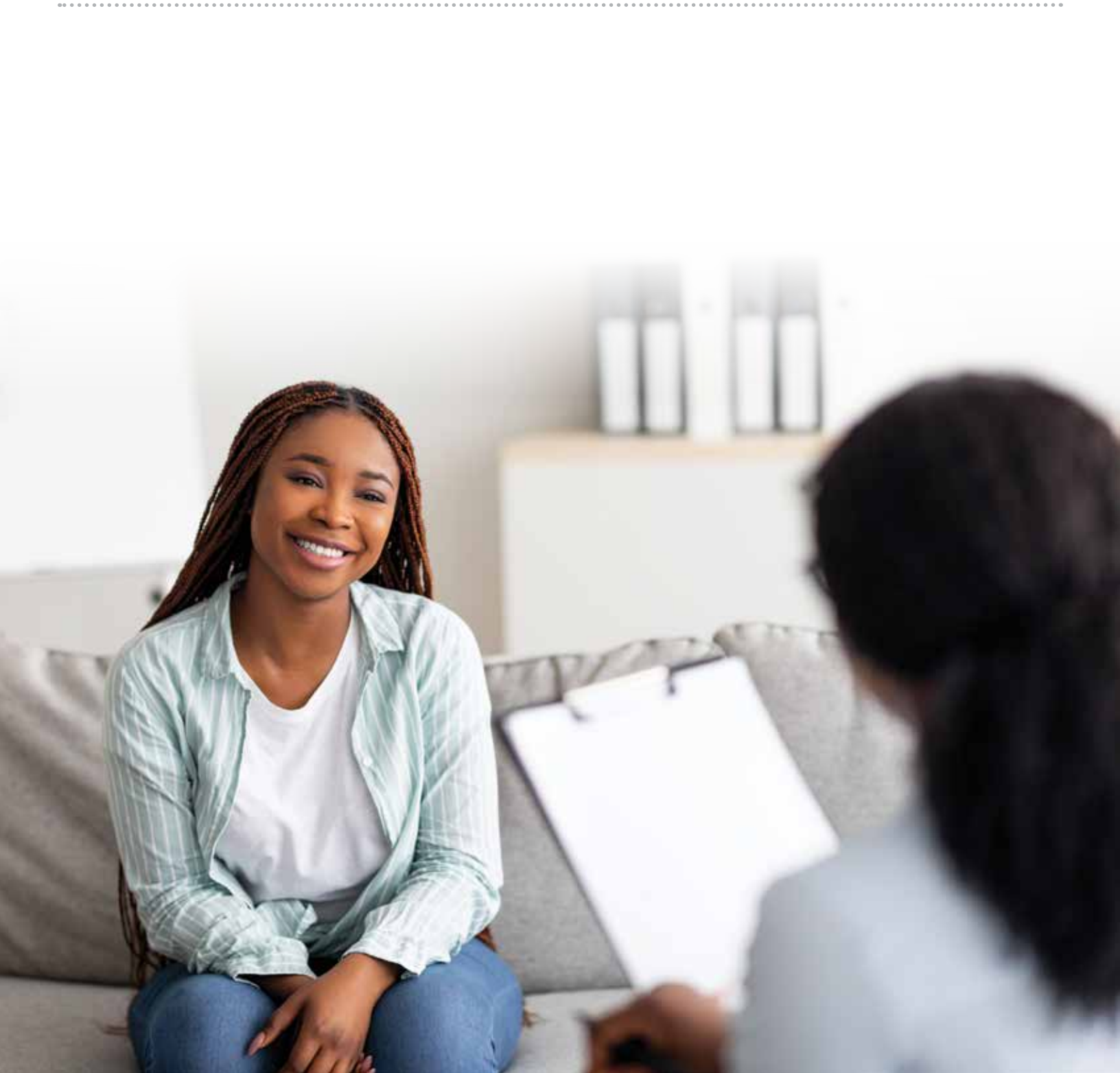
MENTAL WELLNESS CLINIC

(PART OF FAMILY WELLNESS PROGRAM, SEE PAGE 25)

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 short-term, complementary resource for patients who are waiting for care, or unwilling or unable to access usual treatment.



- Continued anxiety/depression screening protocol.
- Disseminated best practice, patient education resources on symptom management.
- 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 impact 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

MT. ASCUTNEY PREVENTION PARTNERSHIP (MAPP)

In addition to directly addressing the risk of substance use, MAPP also works with community partners to build protective factors. Protective factors, also called Developmental Assets, refer to internal and external assets that youth need in order to thrive and be resilient. Data shows that the more protective factors or developmental assets that a child has, the less risk they engage in.



Mt. Ascutney
**PREVENTION
PARTNERSHIP**

PROGRESS



- The Annual Windsor Southeast Supervisory Union (WSESU) School Supply Fundraising Drive continued, in partnership with the Windsor Rotary Club and Building Bright Futures.
 - Raised more than \$3,300 to purchase all needed school supplies for 289 students who qualify for free or reduced lunches.
 - Mascoma Bank provided administrative support and Windsor Rotary volunteers helped with moving and sorting supplies.
- In partnership with VT 2-1-1, MAPP provided Week of the Young Child bags for **93 families** at 5 early childhood centers.
 - Bag contents included a flyer on safely securing cannabis, vaping products, and other harmful substances in the home; a Time Together packet of activities to do with young children; *150 Ways to Show Kids You Care* handouts; asset development message cards on the themes of Quality Time, Family Openness, and Expressing Love; and items contributed by 2-1-1.
 - At the request of 2-1-1, the Safely Securing flyer was provided to 2-1-1 for further dissemination.
- MAPP collaborated with 4 area schools on Screen-Free Week, an annual event where children, families, schools and communities are encouraged to turn off screens and “turn on life.” Instead of relying on television, or device entertainment, participants read, daydream, explore, enjoy nature, and spend time with family and friends.
 - Worked with Hartland Elementary School, Albert Bridge School, Woodstock Elementary School and Prosper Valley School.
 - Provided communication, language, organizing/media kits as well as materials that included pledge cards and activity ideas that foster opportunities to come together and connect with one another without the screens.
- Working with partners at the Green Peak Alliance, MAPP launched an Asset Development Toolkit which highlights 10 important developmental assets. To read about this project and download the media assets, visit: <https://www.greenpeakalliance.org/toolkits/>

PATCH

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

The center is open Monday through Friday connecting citizens with services. WCRC Service Coordinator salaries are required to be raised through grant funding and donations each year. We are grateful for Windsor town support, The Byrne Foundation and the United Way for supporting the WCRC!

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 well-child visits the family specialist uses a newborn 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 4th year within the MAHHC Pediatric Clinic.

- MAPP maintains a curated Developmental Assets trifold, which is available for loan to area school and community partners. The trifold was featured at the MAPP table for a Hartland Elementary School Community Dinner and the Autumn Moon Festival in Windsor.



There were **566 providers** on site at the Windsor Connection Resource Center, serving **2,153 clients**, providing the following key services:

- 632 Senior Solutions, help for 50+ age group
- 352 mental health services
- 287 Department of Children & Families (DCF) support
- 236 family investigators through Easter Seals
- 162 alcohol and drug recovery services
- 150 educational support services
- 119 economic services supports
- 72 employment supports
- 47 housing supports

In addition to the above, the WCRC hosts weekly young child and parent playgroups (hosted by the Family Wellness Program and Springfield Area Parent Child Center), provides a free “clothing” exchange room, allows public access to a computer for online program applications, hosts access to a shower and laundry services, and free Panera bread donations on Wednesdays!



DULCE

- **30** Families engaged in the DULCE element of Pediatrics at the OHC.
- **69** families engaged in the DULCE element of Pediatrics at MAHHC.
- **221** total well-child health visits attended by DULCE Specialist.
- Families receive screening for mental health/caregiver depression, intimate partner violence, food security, employment security, utility needs, transportation, housing stability, housing health and safety and substance use disorder.
 - 30 families completed screening

“The DULCE approach ensures that families are connected to resources effectively when a need for support is identified. This is something we have seen at our OHC site and also reflected in nationwide data from all DULCE sites. DULCE Family Specialists’ role within the early childhood system (in our community, through Parent Child Centers) helps support an effective and warm referral to helpful resources and opportunities for families.”

- Sue Olmstead, DULCE Family Specialist

FAMILY WELLNESS PROGRAM

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 approach, anchored in health promotion and prevention with the family unit as the focus, and is offered universally to all families.

FAMILY WELLNESS

- Family Wellness Coach - works to keep the well, well; and to protect families who are at risk for developing emotional and/or behavioral health issues as well as group-parenting workshops.
- Family Wellness Therapist - treats families whose emotional and/or behavioral health has been impacted in a way that prevents positive family functioning. Participating families receive individual education and counseling.

Funding for our Family Wellness Program continues, with gratitude, from the Couch Family Foundation supporting the Wellness Coach and from the Green Mountain Foundation supporting the Family Therapist.



- The Family Wellness Program served **201** patients in **571** sessions.

FAMILY WELLNESS COACH

- The Family Wellness Coach visited with **128** children / caregivers (9% ↓) in a total of **164** sessions (36% ↓).*
- The Family Wellness Coach consulted and advocated for universal and family-based practice at multiple regional meetings of:
 - Early Childhood Service Delivery Integration Team.
 - Whole School, Whole Community, Whole Child Committee of the Windsor Southeast Supervisory Union.
 - Building Bright Futures of Springfield & Northern Windsor/Orange County Councils.
- Provided leadership for Strengthening Families Network Action Teams.
- Provided leadership for monthly Pediatric Mental Health provider meeting and weekly Psychiatric Case Review.
- Continued as a member of the Resiliency Team at MAHHC, trauma transformed organization work.

FAMILY WELLNESS THERAPIST

- The Family Wellness Therapist met with **73** individual patients (69% ↓) in 407 sessions (53% ↓).*
- Developed group-based Therapeutic Art Program to address increased anxiety in elementary school-aged children, called "Doodling as a Superpower!"
- Provided guidance to Pediatric Mental Health Team regarding supervision for potential new candidates for additional therapy positions.

* ↓ indicates % change from prior calendar year



COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP: STRENGTHENING FAMILIES NETWORK


Over the past year, two action teams 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.



CIRCLE OF SECURITY (CoS)


- **12** CoS groups were held in 2022, (140% - In collaboration with Dartmouth Trauma Intervention Research Center, additional CoS facilitators were trained. As part of trainings, Memorandums of Understanding were signed in order to solidify agreement to be involved in the regional approach.
- Strengthening Families Network and Project Launch at Dartmouth Hitchcock Medical Center have collaborated on data collection methods to track outcomes on social connectedness:
 - 93% of participants were likely or very likely to reach out to the facilitators if help or advice was needed.
 - 45% of participants would reach out to another parent from the group if help or advice was needed.

*  indicates % change from prior calendar year

PLAYGROUP CONNECTIONS

- In person, outdoor Woodstock Playgroups continued with walks, visits to playgrounds, and at Moonrise Therapeutics through a collaborative arrangement.
- Windsor playgroups returned after COVID-19 shutdowns and continued weekly throughout the year.
- 89% of parents/caregivers reported feeling socially connected and valued.

CHIP NETWORK HIGHLIGHTS: STRENGTHENING FAMILIES

2022 Accomplishments  VIEW DATA DASHBOARD	Vision for the Future
<p>embed.clearimpact.com/Scorecard/Embed/77870</p> <ul style="list-style-type: none"> • Circle of Security Action Team met regularly for strategic planning. • Agencies involved are using shared evaluation methods. • 24 new facilitators trained, across 8 agencies, which resulted in the doubling of Parenting series offered to families from 36 towns across VT & NH. • Added 2 new playgroups, engaging families from 18 towns across VT and NH. 	<ul style="list-style-type: none"> • Continued and expanded cross-agency collaboration, systematic data collection process, and a sustainable communication plan. • More families served, thriving, parents feeling connected. • Broad spectrum of partners contributing to Strengthening Families Network.

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.

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.

COMMUNITY HEALTH IMPLEMENTATION PLAN WORKGROUP (CHIP): 50+ HEALTH NETWORK

The 50+ Health Network, formerly the Senior Health Workgroup, continues to increase the connection of older adults to needed resources in the Mt. Scutney Health Service Area (HSA). The group is comprised of various community members and related service organizations, and we work to bring in experts to discuss and understand various topics in more depth and subsequently disseminate and distribute related flyers, resources, and more.

PROGRESS



- Advance Directive Clinics at MAHHC and Thompson Senior Center provided free individualized support across 11 visits to complete and disseminate their advance directive.
- For the 2021 tax year, we worked with Southeastern Vermont Community Action (SEVCA) to provide tax assistance to 86 area residents.
- Continued to provide leadership and support to Scotland House Adult Daycare.



- 600+ Senior Health Quick Guide resource magnets distributed throughout the service area.
- Collaborated with Substance Use and Aging Specialist to increase public awareness on the increased impact of alcohol/substance use on people as they age, which resulted in better screening tools in primary care.
- Increased utilization of 2-1-1 as a resource through education and collaboration.
- Participated in MAHHC Health & Wellness Fair, providing an opportunity to learn about myriad of services and build organizational collaborations.

CHIP NETWORK HIGHLIGHTS: 50+ HEALTH

2022 Accomplishments



VIEW DATA
DASHBOARD

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- Community Nurse Seed Funding for Aging-in-Place in West Windsor/Reading established.
- Engaged Guest Speakers and mapped outreach activities obtained.
- Successful Substance Use among Older Adults initiative, increased awareness among community and improved medical visit screening tool implemented in MAHHC clinics.

Vision for the Future

- An increased number of Aging-in-Place groups.

VOLUNTEERS IN ACTION (ViA)

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.

ViA 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.

ViA not only benefits the recipients of services, but also the individuals providing those services. Research has shown that volunteering can: decrease the risk of depression, give a sense of purpose and teach valuable skills, help people stay physically and mentally active, reduce stress levels, help individuals meet others and develop new relationships, and may even help one live longer.

"There just aren't words to say it. When you're this age and by yourself, your group (Volunteers in Action) was part of what gave me the energy and the strength and the mental desire to fight physically. To be able to get out inspired me to keep going - there are no words to say how much I appreciate that. I was used to being independent, and to have someone to help me gain it back - what you all are doing is just phenomenal. Such a gift to the community and the areas you serve. It can be hard to remember to thank people, but you have been such a help to me - the entire organization has. You are a blessing, you - honestly - saved my life. What you're doing is fantastic! I don't know what I would have done without you. I talk to my family in other parts of the country, and they don't have a service like this - it's a gift from God! I don't know how often you hear it, but when the days are long, please remember all the good you do, there are not enough words to thank you!"

-Margaret from Windsor, VT

ViA's 2022 progress updates are found in respective report sections such as Transportation and Food Access.



DEFINITION OF SPIRITUAL HEALTH

Spiritual health is the aspect of our wellbeing 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.

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

PROGRAMS

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) WORKGROUP: SPIRITUAL HEALTH

Spiritual Health is considered one of many domains of wellness is integral to the achievement of optimal health. The workgroup was formed as a way to increase spiritual awareness for better health and well-being.

PROGRESS



- Implemented a spiritual health asset mapping project. **41** Interviews were conducted and analyzed.
- The information gathered will serve as the basis of an improvement plan to increase spiritual awareness (our aim).

CHIP NETWORK HIGHLIGHTS: SPIRITUAL HEALTH

2022 Accomplishments	Vision for the Future
<ul style="list-style-type: none"> • Worked to define spiritual health in an inclusive way. • Conducted 41 interviews as part of asset mapping project. • Prayer was offered as a means of overcoming hopelessness at Windsor Overdose Awareness Vigil. 	<ul style="list-style-type: none"> • Inclusion of spirituality in the CHNA will lead to data we can track over time. • Spiritual health assets are leveraged to improve health and wellbeing of our communities by building interfaith collaborative to address local challenges, issues, and crises.





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 (WCHC) 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 but also how people are seen and feel about themselves, impacting self-confidence.

PROGRAMS

WINDSOR COMMUNITY HEALTH CLINIC

The WCHC is a member of Vermont's Free and Referral Clinics. As a member of the Community Health Team, WCHC staff provide care coordination and patient advocacy to better serve the needs of our patients.

WCHC is one point of access to help establish care at MAHHC and our office is listed as the contact for questions on new patient paperwork.

Dental services were harder to access given a lack of new patient appointment slots with dentists.

SCHOOL AND COMMUNITY-BASED DENTAL OUTREACH

MAHHC arranges services that provide access to dental care by collaborating with the Windsor Elementary School Nurse, dental hygienist, and 802 Smiles.

MAHHC Director of Community Health joined the VT Oral Health Advisory Council and participated in the VT Oral Health Plan development and review.

PROGRESS



- Enhanced partnerships with Recovery Centers and Volunteers in Action to provide transportation through Rides to Recovery and Rides to Job Access programs.
- Served **331 patients**.
- With Byrne Foundation funding, we continued to help offset the high-cost of dental care and medications for eligible patients (see pg. 40).



- Provided education, toothbrushes, and toothpaste to **220 families** of elementary school students.
- Provided professional education to all regional school nurses.
- Dental hygienist provided dental assessments for **37 students** whose parents consented.
- Made follow up plans for fluoride applications for eligible students.
- Made an urgent care referral for 1 student.

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.

In the 2021 Community Health Needs Assessment, transportation was ranked 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.

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.

PROGRAMS

MAHHC LEADERSHIP AND STAFF

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.

PROGRESS



- Director of Community Health participated in the Springfield Area Working Communities Challenge (SAWCC) subcommittee for transportation. This Transportation Subcommittee continued to gather information surrounding resources and areas of need in the region and identify opportunities for funding support.
- Volunteers in Action program lead continued to represent our region at the Elderly and Disabled Transportation Meeting to advocate for our clients' needs.
- Director of Community Health and program lead for ViA continued to participate in the Vermont Micro-Transit Project with the Vermont Transportation Agency. This project is a free, Uber-like service that will increase transportation options in Windsor.



- Volunteers gave **1,000 rides**, driving over **13,000 miles** to address quality of life needs, such as trips to medical appointments, grocery store, and pharmacy.
- Emerging from the pandemic, utilization of volunteer transportation increased by **646%**).



RIDES TO WELLNESS (R2W)

We continue to utilize and distribute a roadmap or algorithm to educate the community and community partners about the various options for transportation.

WINDSOR COMMUNITY HEALTH CLINIC

New in 2022, the WCHC was able to offer "Rides to Recovery" and "Rides to Job Access" to get to recovery meetings, treatment centers, group support meetings, and new jobs.

To ensure maximum benefit, WCHC partnered with area Recovery Centers and addiction treatment providers to offer gas cards and rides directly to their clients.



Rides to Wellness trips and program gas cards made it possible for patients to access doctor, pharmacy, and therapist visits, emergency dental care, hearing aids, and more!

- o \$720 in gas card purchase and distribution
- o \$4,070 in taxi ride vouchers purchased
- o 3,355 miles between R2W and ViA rides using this program



Officially launched in late spring, these programs transported clients, driving **594 miles**.

\$365 in gas cards provided under these programs.

"This really means so much - it's everything - I'm able to get the care I need, it makes all the difference."

- Elizabeth from Windsor, VT



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 were already experiencing 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 to address this issue.

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 access to food security resources.

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



RISE VERMONT

The core of RISEVT at MAHHC is working with community partners to create environments that improve health and wellness. Over the years, we have made significant investments in local projects through our Amplify grants.

The RiseVT program ended statewide in June of 2022. Work to increase access to healthy foods will continue through MAHHC's CHIP Food Security Workgroup and Volunteers in Action. The Community Health Department will continue to promote opportunities to increase physical activity.

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 safely with no interruption in service).
- Partnering with the Vermont Foodbank to help our neighbors facing food insecurity by helping to distribute fresh produce to more than **330** households per month through the VeggieVanGo program, totaling nearly 4,000 meals.



Rise Amplify grants to the community supported efforts to increase access to healthy foods by:

- Supporting Flexible Pathways program and school garden rehabilitation at Windsor High School.
- Establishing a garden at World of Discovery early childhood center in Weathersfield.
- Distributing porch gardens to 100 families served by food shelves in Windsor, Weathersfield, and Hartland, in partnership with Cedar Mountain Farm, Crossroad Farm, and Deep Meadow Farm.

Rise Amplify grants provided funding for the following projects to promote physical activity:

- Signage to increase trail use in Hartland.



- Get Those Bodies Moving program at Childrens Place Preschool.
- Getting Kids Active staff training and equipment for Bridging the Gap after school and summer programs in Windsor.
- Winter playground toys for the Windsor Early Childhood Education School.
- A treadmill for Hartland Elementary School staff.
- Sensory play equipment and bike desks for Weathersfield Elementary School.

Activities conducted to advance the RISE mission outside of amplify grants include:

- Distributed 200 seasonal Fun Packs to promote physical activity and mindfulness for children ages 4-6 and 7-10 through libraries in Windsor, Hartland, and Springfield.
- 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 Runnemede. Partners included the Town of Windsor and the VT Department of Health.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) WORKGROUP: FOOD SECURITY

The Food Security Workgroup's aim is to increase access to nourishing food for all people in our communities. To advance this aim, the workgroup is currently implementing two strategies:

1. Increase awareness of food security resources to area residents to reduce barriers to access.
2. Identifying gaps and barriers to food access in our region through a comprehensive analysis of food security assets, and using the results to develop and implement a plan for increasing access.



- 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.
- Regular, monthly Food Security workgroup meetings, met 12 times.

CHIP NETWORK HIGHLIGHTS: FOOD SECURITY

2022 Accomplishments	VIEW DATA DASHBOARD	Vision for the Future
<p style="text-align: center;">embed.clearimpact.com/Scorecard/Embed/77754</p> <ul style="list-style-type: none"> • Created a detailed inventory of regional food access points and food security program availability. • Established ArcGIS mapping process to highlight gaps and opportunities in the food security network. • Developed and shared a website (sites.google.com/view/stretchyourgrocerybudget/home) promoting options to stretch family grocery budgets over the summer when school meals are less available. • Launched a social media campaigns to build awareness of food security programs, area food shelves, and VeggieVanGo. 		<ul style="list-style-type: none"> • Everyone is aware of the food resources available to them and is accessing them – stigma and other barriers are removed. • Systems level change that advances equitable access to food resources.

"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 Workgroup



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 median 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 residents impacted by loss of income are continuing to have trouble making ends meet.

PROGRAMS

MT. ASCUTNEY HOSPITAL COMMUNITY HEALTH LEADERSHIP

Efforts are sustained 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: HOUSING

The Housing Workgroup's aim is to promote and create conditions for a broad cross-sector regional effort to increase housing availability. To advance this aim the workgroup is implementing the following two strategies:

1. Creation of new units within existing structures by way of safe home sharing practices, renting rooms, and creating accessory apartments.
2. Develop a broad base of public support for creating new housing that meets community needs and desires.

PROGRESS



- Organized a community team to address the rising needs of homelessness in our area:
 - Updated and disseminated the housing resource guide and homeless resource guide originally produced last year.
- Director of Community Health, as a member of the Windsor Improvement Corporation, worked to support a new housing complex in Windsor that will support residents living within low to middle income brackets and those living without homes.



- Continued to support [HomeShare program](#), completing a positive match, linking area home owner with a resident in need of housing.
- Conducted outreach to recruit potential HomeShare hosts in support of the first Thompson Senior Center HomeShare match.
- Director of Community Health and CHIP Co-Chair intentionally linked with other regional and statewide housing groups to keep abreast of opportunities to strengthen our work and address issues.
- 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.
- Combined forces with Vital Communities for Co-Chair Leadership.

“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



CHIP NETWORK HIGHLIGHTS: HOUSING

2022 Accomplishments

- Listened to many voices which helped to define a new mission.
- Launched of Thompson Senior Center HomeShare Program (Woodstock).
- Increased awareness and knowledge about home sharing. Other organizations are interested.

Vision for the Future

- Communities with a greater awareness of housing needs and options around them.
- A general acceptance of the idea of home sharing as a housing option.
- Local and state policies that make it easier to adopt new living situations like home sharing or accessory dwelling units (ADUs).

“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.”

- Keys to the Valley

WINDSOR COMMUNITY HEALTH CLINIC SERVED

331 PATIENTS

\$19,027

GIVEN OUT IN
Medication Vouchers

3,355

Miles Driven
BY RIDES TO
WELLNESS PROGRAM

28 Dental Vouchers

GIVEN OUT
TOTALING \$6,918



WINDSOR COMMUNITY
RESOURCE CENTER AND
PATCH TEAM SERVED

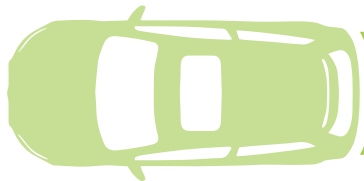
2062 Clients



VeggieVanGo SERVED

**3960 Families/
Households**

**VOLUNTEERS
IN ACTION:**



Gave 1,000 Volunteer Rides
DRIVING 13,000 MILES

Delivered 350 Meals on wheels
DRIVING 18,000 MILES



SELF-MANAGEMENT, CHRONIC DISEASE CLASSES

18

Groups Held



239

Registrants



55%

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, 2021 - September 30, 2022

Description	Total Cost	Grants, Trusts, Foundations, Private Contributions	MAHHC (Hospital Subsidized)
MAHHC - Community Health Infrastructure	\$ 58,396	\$ 11,853	\$ 46,543
Connecting to Mental Health Services	\$ 64,211	\$ 21,953	\$ 42,258
Decreasing Alcohol and Substance Use	\$ 651,828	\$ 635,977	\$ 15,852
Increasing Access to Affordable Health Insurance and Prescription Medication	\$ 121,268	\$ 110,700	\$ 10,568
Strengthening Families	\$ 72,238	\$ 58,300	\$ 13,938
Ensuring Access to Primary Care & Care Coordination	\$ 442,829	\$ 374,764	\$ 68,068
Supporting Aging in Place	\$ 60,520	\$ 55,021	\$ 5,499
Coordinating Housing Stabilization, Expanding Opportunities, and Addressing Homelessness	\$ 2,269	\$ 0	\$ 2,269
Access to Dental Care	\$ 10,075	\$ 9,018	\$ 1,057
Decreasing Tobacco and Nicotine Use	\$ 68,775	\$ 67,718	\$ 1,057
Facilitating Access to Transportation	\$ 52,026	\$ 5,225	\$ 46,801
Increasing Food Security, Access to Healthy Food, and Opportunities for Physical Activity	\$ 43,257	\$ 24,619	\$ 18,638
Fostering Spiritual Awareness	\$ 1,602	\$ 545.52	\$ 1,057
	\$1,649,293	\$1,375,690	\$273,603

Not Included in the above costs :

- Over \$30,000 of in-kind support from partners and agencies contributing resources to our Community Health Improvement Plan Networks.
- Any hospital subsidized costs related to marketing and communications of Community Health programs / initiatives.
- Chaplaincy services costs, reported in prior years as part of Fostering Spiritual Awareness, as this is a hospital-based, not community-based service.

COMMUNITY HEALTH BENEFITS REPORT

2022

Melanie P. Sheehan, MPH, Director of Community Health

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mtascutneyhospital.org/about/community-health-needs



VIEW ONLINE