Alice Peck Day Memorial Hospital
FY '2017 Community Health Implementation Plan

Executive Summary

During the period March through July, 2015, Alice Peck Day Memorial Hospital (hereafter referred to as APD) collaborated with Dartmouth-Hitchcock in conducting a Community Health Needs Assessment. The report, published in December 2015, identified community health concerns, priorities and opportunities for community health and health care delivery systems improvement.

Ten high priority community health needs were identified through primary and secondary data analysis, as well as qualitative research that was inclusive of a wide spectrum of health and human services professionals and community residents. The prioritized list includes:

1. Access to mental health care
2. Access to affordable health insurance including prescription drugs
3. Substance misuse (alcohol and drug use, including heroin)
4. Access to dental health care
5. Lack of physical activity
6. Poor nutrition/access to affordable healthy foods
7. Income; poverty; family stress
8. Affordable housing
9. Access to primary health care
10. Health care for seniors

Attachment I lists APD's current strategies, impact and evaluation plan for each of the high priority health needs identified above, with the exception of #s 7 and 8. Historically, these social determinants of health have not fallen with the primary purview of our health care delivery system. While we acknowledge the growing interplay between economic and educational status and health, APD as a small, community-based rural hospital is not currently positioned to directly address these significant areas of concern. We recognize the critical role that health care providers and institutions can play in mitigating these factors, and are considering investments in these areas, alone or in collaboration with our community partners, in the near future. For the purposes of this report, however, income, poverty, family stress and affordable housing concerns are not addressed.

Attachment I
Alice Peck Day Memorial Hospital Community Health Implementation Plan, FY '17

Population Health Concern 1: Access to Mental/Behavioral Health Care

Strategy/ Impact	Resources/Collaborators	Evaluation Plan
Provide cash support to the West Central Behavioral Health "Same Day Access" project, Phase II, Access Redesign. *Impact:* client wait times will be reduced by more than 50%, client engagement and retention rates will increase by at least 10%, and cost efficiencies of approximately 24% will be achieved.	**R**: $10,000 grant to WCBH	WCBH will partner with MTM Services in establishing a rigorous data tracking and measurement system.
Provide site and in-kind technical assistance to the "Rx for School Success" pilot project. *Impact:* improved health and wellbeing of children experiencing learning difficulties who do not qualify for IEP and related academic support services	**R**: Primary care clinic space; APD pediatricians; APD Director of Quality; DH Population Health Council Grant **C**: Center for School Success	Evaluation grant, written in collaboration with the Center for Program Design and Evaluation at Dartmouth College (and the Center for School Success) was submitted to the Endowment for Health.
Expand screening for depression to include all primary care patients ages12 through adult during annual wellness visit. *Impact:* 3000+patients screened and offered appropriate follow-up treatment	**R**: Primary Care Clinical Staff Time	Number of patients screened and referred
Support development of the Region I NH Section 1115 Medicaid waiver. *Impact:* Transform the State's behavioral health delivery system to help improve care and slow long-term growth in health care costs.	**R:** Staff time: Primary Care Practice Director, Director of Quality,Executive Director of the Multispecialty Practice	Region I Project Plan Outcome Measures

Population Health Concern 2: Access to Affordable Health Insurance and Prescription Drugs

Strategy/ Impact	Resources/Collaborators	Evaluation Plan
Provide Marketplace health insurance counseling during Open Enrollment (and for individuals eligible for SEP). *Impact*: Patients with health insurance more likely to seek "the right care at the right time in the right place"	**R**: Patient Access Manager time	Number of counseling sessions held; number of individuals enrolled into new or different health insurance plan during Open Enrollment and/or Special Enrollment Periods
Provide hands-on Medicaid enrollment assistance to uninsured community members. *Impact*: Low-income patients enrolled in Medicaid are more likely to seek "the right care at the right time in the right place."	**R:** APD Community Health Director time **C**:Local schools, social service agencies, community organizations as referral sources	Number of applications submitted as "complete" and subsequently opened (approved)
Continue offering Prescription Assistance Program to uninsured and/or underinsured patients needing help paying for medications. *Impact:* low-income patients with chronic conditions who are approved for free or low-cost medications are more compliant with treatment plans.	**R**: APD Community Health Director and primary care provider time **C**: Grafton County ServiceLink as referral source	Number of PAP applications submitted; number of patients approved for assistance
Pharmacy voucher program for low-income uninsured patients with acute medication needs. *Impact*: patients receive needed medication within 24 hours	**R:** Community Health Department annual budget allocation, and CH Director's time in determining patient eligibility for this as well as other public insurance options	Number of requests for assistance; number of vouchers awarded; number of patients enrolled in Medicaid, Medicare Part D, other insurance programs
Screen uninsured and underinsured patients for in-house and NH Health Access Network financial assistance (help with insurance deductibles and co-insurance). *Impact*: approximately 300 patients assisted.	**R**: Patient Access Manager time	Number of applications processed; value of "write-offs" on annual basis

Population Health Concern 3: Substance Misuse

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Continue to offer free meeting space for local AA and Al-Anon groups. *Impact*: Over 300 hours of weekend meeting time offered each year, with 20-25 participants attending one or more support group meetings per week.	**R**: Hospital conference room space	Unable to evaluate due to confidentiality restrictions
Provide Suboxone treatment for addicted patients in primary care clinic. *Impact:* 22 patients appointments per month	**R:** Primary care physician time (8 hours/month)	Number of current and new patient appointments
Provide meeting space for tobacco cessation support groups.	**R**: In-kind donation of hospital meeting space and public relations assistance **C**: Hartford Community Coalition	Number of participants completing the four-week sessions

Population Health Concern 4: Access to Dental Health Care

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Strategies • Expand the "Upper Valley Smiles" school-based oral health program (education, screenings, preventive treatments, interim therapeutic restorations and referrals to dentist for follow-up care.) During the 2016-17 school year, add Cornish Elementary School and include preschoolers in all participating schools	**R:** APD "Upper Valley Smiles" budgeted program expenses include: • the salaries of the dental hygienist and assistant, supplies, and mileage, • offset in FY '17 by a cash donation from the Dartmouth Hitchcock Office of Community Health Improvement and grant support from Granite United Way. (Note: Drs. Robert Keene and Arnie Burdick provide pro bono program supervison.) **C**: Ten participating local elementary schools in the Lebanon, Cornish, Mascoma, Hartford, and Hartland school districts; NH DHHS; VT Dept of Health	Annual report, shared with ReThink Health Community Health Hub project staff: 1)number of children treated, 2)number of sealants/varnish applications/ITRS placed, 3)% of children with untreated decay 4)Track "urgent" and "non urgent" referrals with end-of-year report summarizing outcomes
• Provide care coordination/referrals to dentists for children needing restorative treatment.	**R**: UV Smiles dental assistant time **C**: School nurses, private practice dentists, Ronald McDonald Care Mobile	
• Offer technical assistance to the pilot "Upper Valley Smiles for Life" oral health screening/prevention project for uninsured NH adults in Grafton County	**R**: CH Director time and donated start-up supplies	Number of public health dental clinics offered in NH sites; number of participants per clinic; number of screenings, preventive treatments and referrals made
Impacts: Improve the overall oral health of at-risk (low-income, uninsured) children and adults		

Population Health Concern 5: Lack of Physical Activity

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Pilot a 30 to 45- minute "before school" physical activity program for children enrolled in the Canaan Elementary School. *Impact*: 200-250 students will participate in the twice-weekly program, Feb-June 2017, starting the school day better prepared to learn.	**R**: APD grant of $750 to Canaan Elementary School to pay the supplemental salary of the PE teacher running the program	Number of children participating at each session; participant/parent and/or school staff survey to determine ongoing interest and benefit
Pilot a 4-week recreation/fitness scholarship program for low-income children and adults referred by primary care physicians and school partners. *Impact*: Increase fitness levels and overall wellbeing of participants	**R**: Community Health Department budget; APD volunteer coaches **C**: Carter Community Building Association; Upper Valley Aquatic Center; UV Trails Alliance	Number of scholarships awarded; number of participants completing the 4-week program; pre and post activity level questionnaires
Continue financial sponsorship of, and employee participation in the *Ledyard Live Well Walking Challenge.* Impact: 81 APD employees participated in the fall 2016 4-week wellness program. Regionally, 644 participants from 8 organizations walked a total of $148,376,063 steps.	**R:** $1300 cash donation; APD Health and Safety Safety Specialist time	Number of participants' cumulative steps walked and calories burned

Population Health Concern 6: Poor Nutrition/ Access to Affordable Foods

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Provide (co) leadership of the "Healthy Eating, Active Living" workgroup of the Public Health Council of the Upper Valley. *Impact*: Revitalized HEAL coalition prioritizing strategies and creating action plans to support communities where all residents are able to make healthy lifestyle choices.	**R**: Community Health Director time **C**: Public Health Council of the Upper Valley	Annual review of HEAL workplan
Provide HEAL workgroup representation to the Mascoma School District Wellness Committee. *Impact:* Evaluate current strategies, identify new wellness opportunities for the district and share best practices with other school districts.	**R**: Community Health Director time (quarterly meetings held) **C**: Public Health Council of the Upper Valley	Annual review of Mascoma Wellness Policy
Create pilot summer feeding program for the Lebanon School District. *Impact*: Reduce food insecurity experienced by low-income school age children in the summer.	**R**: Community Health Director time; cash donation for initial start-up costs; APD volunteer time **C**: Lebanon School District, Healthy Eating Active Living workgroup	TBD
Convene a working group of summer feeding program managers from the Mascoma, Hartford and Claremont school districts. *Impact:* Identify best practices, create more streamlined operations, reduce costs, and serve greater numbers of vulnerable children and adults.	**R**: Community Health Director time; cash donations for supplies; in-kind donations of time from APD volunteers. **C**: Mascoma,Hartford and Claremont School Districts; Hartford Community Coalition; Healthy Eating, Active Living Workgroup; Public Health Council of the Upper Valley	"Best Practices" document to be created and disseminated
Future: Consider implementing "Healthy Foods" policy for APD meetings and activities. Impact: APD employees access healthier food and beverage offerings during worktime hours	**R:** Senior leadership, employee wellness and dietician staff time	TBD

Population Health Concern 9: Access to Primary Care

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Continue annual cash donation to the Good Neighbor Health Clinic/Red Logan Dental Clinic, with funds supporting operational costs	**R**: $7500 cash donation	Annual GNHC report of operations
Purchase seasonal flu vaccine earmarked for uninsured patients at the Good Neighbor Health Clinic and Claremont Soup Kitchen	**R**: 250 doses of flu vaccine ($2625) **C**: Good Neighbor Health Clinic clinical staff; Geisel School of Medicine student volunteers	Number of flu vaccine doses administered at the two sites
Increase the APD in-kind donation of space for Good Neighbor Health Clinic's Lebanon satellite clinics, from one per month to two-three per month depending on volunteer capacity. *Impact*: greater numbers of uninsured patients gain access to free primary and specialty care provided by GNHC volunteer providers	**R**: in-kind donation of clinic space **C**: Good Neighbor Health Clinic, Geisel School of Medicine	Monthly reports summarizing patient appointment totals by clinician, and no-show rates

Population Health Concern 10: Health Care for Seniors (Frail/Vulnerable Elderly)

Strategy/Impact	Resources/Collaborators	Evaluation Plan
Continue Senior Care Team's home-based primary care program for frail elderly in the local community. *Impact*: 250 home-bound frail elderly patients are served annually. 250 home-bound patients have current advance directives in place, to assure their wishes for end of life care are met.	**R**: 2 geriatricians, 1 social worker, 1 nurse care coordinator and 2 flow staff members	TBD
Host "Elder Forum," a networking/educational forum for health and human services organizations focused on the elderly, is hosted monthly at APD. *Impact:* 25-30 professionals meet 10 times/year	**R**: APD Director of Community Health provides staff support to the Forum **C**: Upper Valley Community Nursing Project, Alice Peck Day Lifecare	Number of meetings held per year; number of participants per meeting; annual member feedback survey
Continue annual support for the Grafton County Senior Citizens Council, earmarking transportation. *Impact:* Elderly and disabled residents are able to use the subsidized bus to get to medical appointments in the southern Grafton region.	**R**: $17,000 cash donation to GCSCC	Ridership data is collected annually
Expand the Elder Friend program (matching frail elders referred by Senior Care team staff to volunteers who make home visits.) *Impact:* vulnerable elders' lives are enriched by interaction with a volunteer, and vice versa	**R:** APD Volunteer Coordinator time; Senior Care Team time; volunteers	Length of time (number of weeks/months) matched pairs participate; feedback from Senior Care Team
Future: Train staff or volunteer as Medicare SHIP (State Health Insurance Assistance Program) Counselor for local community members *Impact:* Increase access to Medicare benefits counseling for community members	**R**: Staff time to complete SHIP training and/or recruit volunteer(s) **C**: NH and VT Area Agencies on Aging (ServiceLink of Grafton County; Senior Solutions VT)	Number of APD staff and/or volunteers who complete SHIP training