Dartmouth-Hitchcock

# FY20-22 Community Health Improvement Plan


Dartmouth Hitchcock and
Mary Hitchcock Memorial Hospital and
Dartmouth Hitchcock Clinic

# Dartmouth-Hitchcock / Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic

# FY20-22 Community Health Improvement Plan

## Executive Summary

As an academic health system, a non-profit hospital, and one of the largest employers in New Hampshire and Vermont, Dartmouth-Hitchcock has a responsibility to work with community and governmental organizations to address the health needs of the communities we serve. This *Community Health Improvement Plan* (CHIP) details actions we will take to address needs identified in our FY2019 Community Health Needs Assessment, and includes clinical strategies, clinical-community partnerships, and community investments to meet these needs.

*This plan meets Dartmouth-Hitchcock's 501(r) regulatory obligations to document how we plan to address health needs of the communities in our hospital service area.*

The CHIP describes an intentional alignment of work in the health system and community. To impact the health challenges in our communities, we must address social determinants of health in addition to screening for and responding to the health related social needs of our patients. Like the story of throngs of people in a river heading toward a waterfall, some lifesavers focus on saving the people in the water before they go over the falls, while others race upstream to prevent people from falling into the water. The CHIP describes our intent to both work downstream (in our clinics and hospital) and upstream (with community and regional partners).

Dartmouth-Hitchcock continues to learn and advance community health improvement strategies informed by national best practices. In FY18, Dartmouth-Hitchcock joined the national Healthcare Anchor Network, a coalition of 45 health systems across the US, which encourages health systems to use business practices, including hiring and purchasing, to benefit local communities and to support residents facing economic and social disparities that contribute to poor health. The FY20-22 CHIP begins to align and integrate these "Anchor Institution" practices with Dartmouth-Hitchcock's Sustainability and Community Benefit practices.

Dartmouth-Hitchcock's FY20-22 Community Health Improvement Plan addresses needs identified in the FY2019 Upper Valley Community Health Needs Assessment, as well as NH and VT State Health Improvement Plans as follows:

| FY20-FY22 CHIP Section | Needs Identified in FY2019 Upper Valley Region Community Health Needs Assessment Addressed by These Strategies | Priority Rank in CHNA* | Level of Effort |
|---|---|---|---|
| Impacts of Trauma and Violence | • Child Abuse and Neglect<br>• Domestic and Sexual Violence | 5,8 | Increase Current Investments |
| Social Determinants of Health | • Housing, Healthy Food, Nutrition, Access to Transportation, Poverty | 10,11,14 | Increase Current Investments |
| Access to Care | • Access to Affordable Health Ins., Care, and Rx Drugs<br>• Access to Primary Health Care | 1,6,7 | Increase current investment |
| Health Care for Seniors | • Senior Services, including Home-Based and Long-Term Care Services | 9,12 | Increase current investments |
| Behavioral Health Needs | • Access to Mental Health Care<br>• Alcohol and Drug Misuse | 2,3,4 | Maintain current investments |
| Strengthening and Supporting Families | • Strengthening and Supporting Families | 13 | Maintain current investments |
| Cancer Care and Treatment | • Cancer Care and Prevention** | n/a | Maintain current investments |

* From Chart 3, p. 17, FY2019 Upper Valley Community Health Needs Assessment

** Although Cancer Care and Prevention was not identified in local assessments, it is cited in state health improvement priorities in both NH and VT.

## Notable Highlights of the FY20-22 CHIP

1. Continuing Advances Made in FY17-19 to Address Mental Illness and Substance Misuse
    a. Continuing integration of Behavioral Health Care and Primary Care
    b. Investing in and leading substance misuse and suicide prevention initiatives
    c. Increasing access to substance use and mental health treatment and recovery services
    d. Developing Project ECHO to extend Dartmouth-Hitchcock's behavioral health expertise with schools, employers, and clinicians

2. Increasing our Focus on Social Determinants of Health
    a. Developing Food is Medicine initiatives to support patient needs
    b. Developing new workforce training programs to bring people living in our local communities into healthcare careers
    c. Investing in transportation and in affordable, workforce, and supported housing

3. Supporting Clinical and Community Practices to Meet the Needs of Older Adults
    a. Achieving Status as a Level 1 Geriatric Emergency Department
    b. Disseminating evidence-based falls prevention programs through NH and VT

4. Building Clinic-Community Partnerships to Support Healthy Development of Families and Young Children
    a. Expanding Strong Families Strong Starts and on-site family support partnerships in all Dartmouth-Hitchcock Pediatric Clinics
    b. Implementing Project LAUNCH, Upstream Upper Valley, and other partnerships that create evidence-based supports for families and young children

5. Expanding Training in Trauma-Informed Care
    a. Engaging in regional solutions to address human trafficking
    b. Expanding training in trauma-informed care

6. Coordinating Community-Based Workforce to Meet Patient Needs
    a. Strengthening the role of Community Health Workers in our health system
    b. Partnering with community-based health services (VNH, community nurses, Lebanon EMS) to match the right services with the right patients in the right place

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# FY20-22 Community Health Improvement Plan

## Increase focus

## Maintain focus

| | Impacts of trauma and violence | Social determinants of health | Access to care | Health care for seniors | Behavioral health needs | | Strengthening and supporting families | Cancer care and treatment |
|---|---|---|---|---|---|---|---|---|
| **FY19 Community Health Needs Assessment priority area rankings** | 5, 8 | 10, 11, 14 | 1, 6, 7 | 9, 12 | 2, 3, 4 | | 13 | NH state priority area |
| **D-H focused measure** | # clinical staff trained in trauma informed pediatric care | % eligible primary care patients screened for behavioral health and social determinant of health needs | % new primary care patients seen within 10 days | % primary care patients aged 65+ screened for falls risk | % eligible primary care patients screened for substance use disorders | # inpatient & emergency department patients initiated on buprenorphine | # referrals made to family resource centers in the community by D-H pediatric providers | % breast cancer screening |
| **FY19 Performance** | 37 | 4% | 62.5% (Jul 2019) | 81.2% | 15.1% | 80 | 150 | 72.5% |
| **Goals** | FY22: 75 | FY20: 47% | FY20: 65% | FY20: 73% | FY20: 47% | FY20: 160 | FY22: 400 | FY20: 80% |
| **Example of related NH state population measure** | # people served by NH crisis centers for domestic violence, sexual assault, and stalking [1] | % eligible women, infants and children enrolled in WIC [2] | % adults who went without care because of cost in the past year [3] | falls-related emergency department visits per 10,000 adults 65+ [4] | opioid-related death rate per 100,000 [5] | suicide mortality rate per 100,000 [6] | # prenatal women and children under 48 months served by comprehensive family support services [7] | colorectal cancer mortality rate per 100,000 [8] |
| | 14,805 (2016) | 46.9% (2016) | 10.6% (2018) | 478.9 (2015) | 34 (2017) | 18.9 (2017) | 393 (2017) | 13.0 (2016) |

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# FY20-22 Community Health Improvement Plan

## Increase focus

### Impacts of trauma and violence

- Protect children from abuse and neglect
- Support for children and families impacted by substance use disorders
- Prevention of adverse childhood experiences
- Trauma-informed early care screening
- Use clinical systems to support persons affected by domestic violence

### Social determinants of health

- Strategies to improve housing
- Food security and nutrition: access to healthy foods and nutrition services
- Access to transportation
- Financial stability programs

### Access to care

- Affordable health care
- Assistance with cost of prescription medications
- Availability of primary care services
- Community-based health workforce development
- Mobile outreach for preventive services

### Health care for seniors

- Community- based care coordination for older adults
- Health education and support for older adults and caregivers
- Falls prevention strategies
- Safety net services
- Improved emergency department services for older adults

## Maintain focus

### Behavioral health needs

- Access to mental health care services
- Access to substance misuse and addiction prevention services
- Access to substance use disorders treatment and recovery services

### Strengthening and supporting families

- Support needs of families with hospitalized children
- Advocacy and case management for children with special needs
- Community education for pediatric residents
- Maternal and child health services
- Injury prevention

### Cancer care and treatment

- Patient and family support services: education classes, support groups, special events, wellness services
- Screening for colorectal cancer
- Reducing financial barriers to screening

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## FY2019 CHNA Priority Need: Impacts of Trauma and Violence

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Operate D-H Child Advocacy and Protection Program | • Provide trained staff, interview space, and multi-disciplinary team approach to serve children interviewed re: possible sexual abuse/child abuse in Lebanon and Manchester<br>• Provide care management to caregivers of children affected by abuse<br>• Provide forensic clinical examinations, consult with Child Protection Services, and provide forensic and clinical testimony in court proceedings as needed | # children medically evaluated/year | 400 evaluations/yr |
| | | # children receiving Team Care via CAPP | Incr. to 100% |
| | | # testimonies/depositions via CAPP staff | Varies as needed |
| Continue Increasing trauma-informed practices in pediatric clinics | • Disseminate Strong Families/Strong Starts initiative to D-H Manchester, Nashua, Concord, and Keene pediatric practices, and to APD, NLH, and Valley Regional Hospital practices<br>• Improve referral of families w/ children 0-5 years from D-H clinics to community-based family resource and other social services<br>• Build improved partnerships between Family Resource Centers/Parent Child Centers and D-H pediatric clinics | # practices/sites actively engaged in SFSS consults/yr | 5 D-H practices by FY22; 3 More practices by FY22 |
| | | # referrals from D-H Pediatrics to Family Resource Centers | 400 pts by Jun 2022 |
| Train early care providers | • Provide trauma-informed early care training to child care providers via Upstream Upper Valley | # early care providers trained | 175 total trained by end of FY21 |
| Provide family-based therapies and consultations (Project LAUNCH) | • Provide evidence-based therapies for families with children 0-5 years affected by trauma at sites in the Upper Valley/Sullivan County region<br>• Provide expert consultation to other providers via Project LAUNCH<br>• Train pediatric teams in principles of Trauma-Informed Care, Substance Use Disorders, and Stigma | # families served/year | 75 families/yr by June 2022 |
| | | # pediatric consults | 400 consults by Jun 2022. |
| | | # providers trained | 150 providers by Jun 2022 |
| Participate in early child community partnerships | • Participate in and/or foster development of community partnerships working to improve systems of services for families with young children in Upper Valley/Sullivan County communities. | # meetings/year | 4 meetings/year |
| Exchange knowledge to improve perinatal care | • Host Northern New England Perinatal Quality Improvement Network; and peer sharing of evidence-based and evidence-informed practices via conferences, case reviews, and other learning strategies | # participating organizations<br># conference participants/yr<br># case reviews | 50 orgs/year<br>450 participants/year<br>Ad Hoc |
| Support domestic violence, sexual assault, and human trafficking efforts | • Contribute to support NH State Coordinator role to address human trafficking<br>• Continue the D-H Domestic Violence and Sexual Assault Task Force<br>• Continue the Dartmouth-Hitchcock Sexual Assault Nurse Examiner Program<br>• Participation in Statewide and Local Domestic Violence and Sexual Assault Task Forces | TBD -Emerging Opportunity | TBD |
| | | Documented mtgs/plans | TBD |
| | | # patients served | Varies |

## FY2019 CHNA Priority Need: Social Determinants of Health

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Support strategies to improve housing | • Contribute to supported, workforce, and low-income housing projects in D-H communities | # and $$ of Housing Grants | # and $$ will vary |
| | • Examine opportunities for ROI lending for projects such as workforce housing, groceries in food deserts, and other projects to address Social Determinants of Health needs | Varies by Project | TBD |
| Increase access to healthy foods and nutrition | • Establish a Food is Medicine Prescription Pantry on-site at DHMC or off-site | # pts served | TBD |
| | • Provide nutrition education | # pts. participating | ?? |
| | • Support Food Provision | # pts receiving food | 1000-2000 pts |
| | • Provide take-home food bags for patients with urgent food needs in Lebanon clinics; expand to at least one additional D-H clinic | | |
| | • Offer farm shares/food support for pregnant pts w. social needs | # pts served | 20 pts/yr by June 2022 |
| | • Maintain/grow the Willing Hands-D-H Farmacy Garden | # servings of produce grown | Ann Incr. from 2019 |
| | • Contribute to community-based summer feeding programs | $ invested | $5K-10K/year |
| | • Participate in regional food and nutrition coalitions | # mtgs | TBD |
| | • Connect pts with food assistance programs | # pts meet WIC reps on-site | TBD |
| | | # pts enroll in WIC on-site | TBD |
| | • Pilot and evaluate medically tailored meals to inform future options | # pts supported by meals | 30 |
| Address access to transportation | • Subsidize public transportation and senior transportation systems | # total rides provided by transportation providers | Increase from FY19 |
| | • Identify and support new multi-commuter transportation options for employees and patients travelling to DHMC | # rides provided to D-H | |
| Recruit and hire to advance social well-being | • Offer training programs to help under-employed residents enter career pathway jobs | # persons hired via tailored recruitment/training programs | TBD based on specific training program choices and characteristics |
| | • Partner with Community Colleges, HS Career Centers, and community NPOs to engage persons with employment barriers to enter front-line health care careers | | |
| Seek opportunities to purchase local and sustainable foods/products | • Establish 'preferred vendor' criteria for catered food | % catered food meets criteria | 50% by FY22 |
| | • Purchase sustainable products through GreenHealth Exchange | $ purchased via GreenHealth | $1.2M/year |
| | • Seek additional opportunities to purchase from local/sustainable vendors | # new local vendors | TBD |
| | • Purchase food from sources within 250 mi. for D-H Food and Nutrition Services | % food sourced w/in 250 mi. | 20% by FY22 |
| Support financial stability programs | • Provide support through the Tipping Points program | # tipping point recipients | 15+ persons/year |
| | • Explore opportunities to support financial education/training classes | TBD – Emerging Strategy | TBD |

## FY2019 CHNA Priority Need: Access to Care

| Strategies | Projects, Programs, Initiatives | Measures | Target/Yr |
|---|---|---|---|
| Assist w/cost of health care | • Provide Financial Assistance to qualifying patients | # pts receiving fin. Assistance | 6,000 patients |
| | • Provide care to Medicaid Beneficiaries at loss | # Medicaid Recipients served | 25,000 patients |
| | • Provide contributions to FQHCs and other safety net health care providers | # pts seen at FQHC/Free Clinics | 15,000 patients |
| | • Convene D-H Work Group to explore how to mitigate impacts of high-deductible health plans | TBD | TBD |
| Assist w/cost of prescription drugs | • Provide Medication Assistance Program services to qualifying patients | # pts assisted via Med. Assist. | 500 patient |
| Increase availability of health care services | • Continue developing telehealth capacities | # sites served via telehealth<br># sites w/ ED telepsychiatry srvcs.<br>#sites w/ telepharmacy srvcs. | Incr. from FY19<br>Incr. from 9 sites<br>Incr. from 10 sites |
| | • Continue implementation of eConsults | # eConsults/month<br># providers using eConsults | 500/mo by June 22<br>90% of providers |
| | • Implement Project ECHO to strengthen capabilities of rural workforce to care for persons with complex health needs in community settings | # Echo Courses/year<br># Locations Served/year | 12 courses/year<br>360 participants/yr |
| Address social barriers to health of D-H patients | • Continue developing/expanding Community Health Workers in D-H Clinics | #pts served by CHWs | 500 patients |
| | • Expand HOBSCOTCH self-management approach for patients w/epilepsy | # D-H clinics w/CHWs<br># pts served w/HOBSCOTCH | 5 clinics<br>30 patients |
| Support access to oral health services | • Provide contributions to support safety net oral health services | # pts. served at safety net providers | 800 pts/year |
| | • Partner to provide oral health services at D-H Mom's in Recovery program | #pts. served at Moms in Recovery | 30 pts. year |
| Employ mobile health outreach for preventive screening and services | • Implement D-H Heart and Vascular Center mobile outreach screening and healthy heart education and promotion programs | # Mobile Outreach Events<br># Persons Served via Outreach | 12-24 events/year<br>300-600 people/yr |
| | • Implement Hepatitis A vaccination clinics in community settings (FY20) | # Community Hepatitis A Clinics<br># Immunized | 16 (FY20)<br>150 (FY20) |
| | • Provide financial and operational planning support to the City of Lebanon to develop a Paramedicine program | TBD as program developed | TBD |
| | • Support free public flu vaccine clinics at DHMC | # immunized | 10,000 pts/year |
| | • Implement school-based flu clinics | # immunized | 2,500 pts/year |
| | • Provide vaccine for community-based flu clinics | # immunized | 1,500 pts/year |
| | • Promote completion of and honor advanced care directives (e.g. POLST) | TBD – Work being Reorganized in FY20 | TBD |

## FY2019 CHNA Priority Need: Health Care for Seniors

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Support community-based care coordination for older adults | • Contribute to and support community nursing and home visiting services for older adults<br>• Universal information releases for care coordination for older adults who need multiple supports | # persons served by home visitors | 250 persons/year |
| Offer health education and supports for older adults and caregivers | • Continue offering health education classes at the Aging Resource Center and at the Upper Valley Senior Center | # persons served by Aging Resource Center | 5,000 people/year |
| | • Disseminate Aging Resource Center classes and support groups in at least two new communities served by D-H | # new sites at which ARC offers classes or other activities | 2 new sites by June 2022 |
| Support falls prevention strategies | • Implement falls screening and prevention practices in routine older adult care and Emergency Dept. care | % pts 65+ screened at PCP visit | 90% pts screened |
| | | # pts referred for falls risk | Increase over FY19 |
| | • Offer Balance Day Screening Events for patients identified as at-risk for falls | # pts engaged in Balance Day events | Increase over FY19 |
| | • Offer Matter of Balance and evidence-based Tai Chi supports | % referred pts enrolled | Increase over FY19 |
| Support safety net senior services | • Funding contributions to safety net senior services to support senior transportation, home delivered meals, and case management | $$ committed | $18K/year |
| Implement Geriatric Emergency Dept. | • Implement practices and procedures to enable DHMC ED to achieve Level 1 Geriatric ED status | # of required Level 1 criteria achieved | DHMC achieves all Level 1 criteria & certification |
| | • Develop telehealth capacities and implement practices to enable four rural New England hospitals to achieve Level 2 Geriatric ED status | # of hospitals achieving meeting Level 2 criteria | 4 hospitals achieve Level 2 status |
| Implement Geriatric Workforce Education Program | • Train and consult with northern New England health care practices to implement core evidence-based geriatric care practices such as Annual Wellness Visits, and Complex Care Management | # clinics implementing 80% of evidence-based practices | 9+ practices by June 2020 |
| | • Train providers to become Dementia Resource Specialists | # dementia resource specialists trained | 40+ trained by June 2020 |
| Support Medicare options counseling | • Fund/Host ServiceLink education/options counseling on-site at D-H primary care practices to help pts improve plan choices | # pts engaged in consults | 40 pts in FY20 |

## FY2019 CHNA Priority Need: Behavioral Health Needs

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Integrate behavioral health care | • Continue to grow Collaborative Care in D-H Primary Care Clinics | # Active Pts on BHC Registry<br># BHCs/10,000 medical home pts | 500 patients<br>1 BHC/10,000 patients |
| | • Implement screening for and medical management of opioid/substance use in Primary, Emergency, and Inpatient settings | % w/medicaid screened in PCP<br># pts initiated w/MAT in hosp. & ED | 70% PCP pts w/Medicaid<br>160 pts by FY20 |
| | • Co-Lead the Region 1 Integrated Delivery Network, supporting implementation of Integrated Behavioral Health and Primary Care | # IDN1 Orgs using CCSA screener<br># IDN1 Orgs w/multi-disciplinary team<br># IDN1 Orgs using ED Pre-Manage | 9 Orgs by Dec. 2021<br>9 Orgs by Dec. 2021<br>4 Orgs by Dec. 2021 |
| | • Expand SUD/BH Screening to all Pediatric, Primary Care, and OB/GYN practices | % teen pediatric pts screened<br>% OB pts screened at 1st visit in 2yrs | 80% by FY22<br>90+% by FY22 |
| Support and develop substance misuse prevention services | • Host/manage All Together and Greater Sullivan 360 prevention coalitions; invest in prevention practices, policies, programs and community workforce training<br>• Support Development of and participate in a D-HH 'best practices' network/consultation service and invest in community prevention coalitions in Upper Valley, Sullivan County, Windsor County, Orange County, Manchester, Concord, Nashua and Keene | # coalitions led or supported | 8 coalitions/year |
| | | # evidence-informed policies or practices implemented | Varies annually |
| | | # project grants made | 8 project grants/year |
| | | # evidence-informed policies or practices implemented by coalitions | Varies Annually |
| Support tobacco and vaping prevention and cessation | • Provide education and consultation for Upper Valley/Sullivan County communities and schools to address vaping<br>• Employ Tobacco Treatment Specialists for pts affected by tobacco use<br>• Train D-H Comm. Health Workers to engage, refer, and support pts to gain tobacco tx<br>• Provide/subsidize Tobacco Tx training for D-H and community partners | # policy/practice consults re: vaping<br># education sessions re: vaping | 2 consults/year<br>6 education events/year |
| | | # pts receiving tobacco tx services. | 300+ pts. served/year |
| | | # CH Resource Specialists Trained | 10 trained by FY22 |
| | | # providers/partners trained | 2 persons/year |
| Support development of substance misuse harm reduction strategies | • Consult and contribute to Claremont and White River Junction Syringe Services Programs and support development of 1+ new program site<br>• Organize Unused Medication Disposal in Upper Valley/Sullivan Co.<br>• Organize/support Safe Syringe Disposal in Upper Valley/Sullivan Co.<br>• Consult/train re: access to Naloxone efforts in Upper Valley/Sullivan Co. and distribute free Naloxone via D-H Doorway and D-H Emergency Department | # clients served/year | TBD |
| | | # lbs medications recovered/year<br># lbs used syringes recovered/year | 1,000 lbs medications/yr<br>125 lbs syringes/yr |
| | | # trainings/year<br># naloxone kits distributed | 3 trainings/year<br>100+ naloxone kits/year |
| Foster suicide prevention initiatives | • Train clinical and non-clinical community members in suicide prevention using NAMI-NH CONNECT Suicide Prevention and CALM (Counseling on Access to Lethal Means) in Upper Valley/Sullivan Co. regions<br>• Improve clinical skills to address patient suicidality | # persons trained in CONNECT/CALM<br><br>TBD - Emerging Project | 150+ people trained/yr<br><br>TBD |
| Lead awareness campaigns | • Present REACT anti-stigma campaign at schools/colleges/organizations | # presentations<br># people reached via presentations | 100+ presentations/year<br>30K people reached/yr |

## FY2019 CHNA Priority Need: Behavioral Health Needs

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Support development of professional, peer, and lay workforce | • Provide/sponsor BH training for clinicians and non-clinicians | # D-H and other clinicians trained | 200+ FY20-21. TBD FY22 |
| | • Sponsor increases in the # of D-H clinicians w/Buprenorphine Waivers | # total D-H clinicians waivered<br># D-H PCPs waivered<br>% waivered PCP w/1+ rx/year | 150 w/waivers by FY22<br>50 PCPs by FY22<br>TBD |
| | • Implement Project ECHO to strengthen capabilities of rural employers, schools, clinicians, and others to support persons with SUD/MH needs | # BH/SUD Echo Sessions<br># participants | 5 sessions/year<br>60 participants/year |
| | • Organize and support training for SUD Peer Recovery Coaches | # People completing RCA training | 30 people/year |
| Increase access to specialty behavioral health services including SUD treatment and recovery services | • Subsidize D-H Mom's in Recovery Perinatal SUD Treatment Program | # births/yr to enrolled women | 25 births/year |
| | • Provide expert consult to help NH OB practices adopt MAT practices | # OB practices assisted to offer MAT | 5 Practices Offering MAT |
| | • Continue and grow D-H 'NH Doorway' SUD treatment services | Program Measures TBD | TBD |
| | • Continue providing after-hours assessments for NH Doorway Program | # days after-hours availability | 365 (FY20); TBD after |
| | • Continue and subsidize D-H Addiction Treatment Program | # pts engaged in OP/IOP | 2,000 pts/year |
| | • Continue and subsidize D-H Inpatient Behavioral Health Services | # pts. served | 800+ patients/year |
| | • Facilitate planning and development of a non-D-H, community-based Residential SUD Treatment for women with young children | Progress to work plan milestones | New Organization Operational by June 2021 |
| | • Continue Recovery Navigator Role in DHMC Emergency Department and expand to at least one new clinic | # pts engaged in ED & related care<br># Recovery Coaches employed | 400-800 pts engaged/yr.<br>3 Coaches by FY22 |
| | • Facilitate regional SUD Continuum of Care Teams in Upper Valley/Sullivan Co. regions | # community organizations participating in CoC teams | 50 orgs engaged/year |

## FY2019 CHNA Priority Need: Strengthening and Supporting Families

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Support needs of families w/hospitalized children | • Maintain CHaD Family Ctr. services, including parent support services; case management; and financial supports for transportation, crisis food, and other material supports during hospitalization<br>• Contribute leased land to David's House to support housing needs of families with hospitalized children | # persons served at CHaD Family Center | 15,000 persons/year |
| | | # families receiving financial/ tangible assistance | 4,000 families/year |
| Provide advocacy and case management for children's health needs | • Maintain Child Life Services, including services, consultation, and education re: needs of patients and families | # encounters in support of child patients and their families | 10,000 pts/year |
| Support community education for pediatric residents | • Maintain the Boyle Pediatrics Program, enhancing Pediatric Residencies through rotational placements of Residents in community-based service locations | # pediatric residents deployed in community settings | 21 Residents/year |
| Support maternal and child health education and support programs | • Maintain Women's Health Resource Center's (WHRC) classes, support groups, and tangible services such as car seat checks, WHRC library, and diaper bank | # persons participating in WHRC classes | 450-500 people/ year |
| | | # persons receiving tangible supports from WHRC | 700 people/year |

## FY2019 CHNA Priority Need: Cancer Care and Treatment

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Maintain and adapt patient and family support services | • Implement classes and events for patients and families affected by cancer<br>• Offer comfort care services, creative arts, and special events<br>• Offer telephonic and in-person support groups<br>• Maintain Patient and Family Library | # class participants | 1,800 people/yr |
| | | # served | 29,000 people/yr |
| | | # support group participants | 650 people/yr |
| Increase screening for colorectal cancer | • Participate in NH Colorectal Cancer Screening Program initiatives | # clinics trained/participating | 14 clinics |

Norris Cotton Cancer Center provides numerous other initiatives aimed at cancer prevention and/or support services for patients and families affected by cancer. Most of these services are provided via budgets managed by the Geisel School of Medicine and thus are not included in the Dartmouth-Hitchcock Community Health Improvement Plan.

## FY2019 CHIP Partnership Infrastructure: Develop and Maintain Infrastructure for Public Health and Health Partnerships

| Strategies | Projects, Programs, Initiatives | Measures | Target |
|---|---|---|---|
| Public Health Networks | • Coordinate NH Regional Public Health Network in Upper Valley and Greater Sullivan County regions; grow D-H participation in networks serving other NH communities | # Member organizations in UV, GSC | 40+ organizations |
| | | # regions where D-H sits on PH Councils | 5 public health regions |
| Public Health Emergency Prep. | • Coordinate NH Public Health Emergency Preparedness planning and related initiatives in Upper Valley and Greater Sullivan Counties | # Orgs participating in emergency planning | # 40 organizations |
| Partners in Community Wellness | • Recruit and engage new Partners in Community Wellness members<br>• Train PCW members to serve as 'Ambassadors' between D-H and communities<br>• Train PCW members to serve as 'Advocates' for health-related social policies<br>• Fund and implement Tipping Points grants program | # PCW Members total | 450 by June 2022 |
| | | # Ambassadors trained | 20 Ambassadors/year |
| | | # Advocates trained | 30 Advocates/year |
| | | # Tipping Points grants supported | 20 grants/year |
| Facilitate shared community strategy across D-HH System | • Chair the D-HH Community Health Committee | Documentation of shared strategies | N/A |
| Promote Anchor Strategies at D-H | • Convene cross-departmental D-H Anchor Leadership Team | Documentation of shared strategies | N/A |
| D-H Regional Primary Care Committee | • Convene cross-D-HH Primary Care leaders to decrease variation in care for patietns | Documentation of shared strategies | N/A |
| Host D-H Injury Prevention Center | • Chair, consult, and serve as members of multiple NH statewide injury prevention work teams including state Suicide Prevention Task Forces and NH SafeKids Alliance<br>• Support Bike/Pedestrian Safety events in NH communities<br>• Promote and consult re: Infant Safety and Trauma Prevention in NH<br>• Conduct and support Bike/Ped/Auto safety campaigns | Varies Annually | Varies Annually |

Endnotes


1. NH Coalition Against Domestic and Sexual Violence
2. USDA Food and Nutrition Service. 2016. National WIC eligibility and coverage rates by year and participant category [online]. Accessed Sep 09, 2019: https://www.fns.usda.gov/wic/wic-2016-eligibility-and-coverage-rates#Chart2
3. CDC Behavioral Risk Factor Surveillance System (BRFSS)
4. NH Department of Health and Human Services, NH Hospital Discharge Data Set (HDDS)
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