North Country Hospital

Community Health Needs Assessment

2021 Implementation Strategy

Abbreviations

ACA – Affordable Care Act
CCV – Community College of Vermont
CHNA – Community Health Needs Assessment
CME – Continuing Medical Education
EAP – Employee Assistance Program
FGD – Focus Group Discussions
JTRC - Journey to Recovery Community Center
LDC - Licensed Drug & Alcohol Counselor
MCD/MCR – Medicaid/Medicare
NC Primary Care Newport – North Country Primary Care Newport
NCH- North Country Hospital
NCH Dieticians – North Country Hospital Dieticians
NCH social workers – North Country Hospital Social Workers
NCH Wellness Center – North Country Hospital Wellness Center
NEKCA-Northeast Kingdom Community Action
NEKCOA-Northeast Kingdom Council on Aging
NEK Collaborative – Northeast Kingdom Collaborative
NEKLS - Northeast Kingdom Learning Services
NKHS- Northeast Kingdom Human Services
RSVP Program – The Retired and Senior Volunteer Program
RuralEdge- Agency providing affordable Housing in Orleans, Essex and Caledonia Counties
RWJF - Robert Wood Johnson Foundation

North Country Hospital 2021 Community Health Needs Assessment
Implementation Strategy

Social and Community Needs

Priority Health Concerns	Goals	Action Steps	Measures	Timeline (Year 1-2-3)
Priority Area 1: Affordable Housing	Increase affordable housing options in the hospital's service area	• Partner with Continuum Care Group, Rural Edge and Memphremagog Rentals • Explore philanthropic support from Joshua House • Partner with Vibrant Communities	• Define numbers and types of housing needs in your area • Collect data on homeless population and number of community members living in hotel rooms	1 - Quantify unmet housing needs in the community 2 - Define current capacity with partners to address unmet needs 3 - Implement collaborative pilot strategy to address unmet needs
Priority Area 2: Employment	Connect community identified employment needs to support stable healthcare workforce at NCH (consistent with Strategic Plan for employees)	• Integrate implementation plan activities with actions to advance hospital's Strategic Plan	• Measure trends in unemployment rates • Gather information on available workforce positions	1 - Define specific areas to support healthcare workforce 2 - Implement programs in alignment with Strategic Plan for Employees 3 - Assess outcomes to guide next steps
	Increase educational training for employment	• Partner with: North Country Career Center, CCV, Workforce Solutions, NEK Collaborative, Economic Services and NEKLS	• Gather information on available workforce positions	1 - Define gaps and propose solutions in training needs 2 - Develop collaborative pilot programs based on unmet needs 3 - Assess outcomes to guide next steps
	Improve access to affordable child care	• Explore expansion options for child care workforce • Partner with NEKLS	• Gather data on childcare needs and availability of openings	1 - Quantify unmet child care needs in the community 2 - Define current capacity with partners to address unmet needs 3 - Implement collaborative pilot strategy to address unmet needs

Health Care Needs

Priority Health Concerns	Goals	Action Steps	Measures	Timeline (Year 1-2-3)
Priority Area 1: Regular Medical Care	Identify unmet needs, gaps and barriers in accessing regular medical care	• Identify any additional gaps and barriers in health care access in the community • Explore telehealth as an option for primary care visits	• Gather no show rates, same day access and appointment availability • Gather data on number of providers and panel size	1 - Quantify unmet needs and gaps in access to regular medical care 2 - Define capacity and role of telehealth in meeting needs and gaps 3 - Implement pilot strategy to address unmet needs
	Address specific needs of 65+ population, who identified primary care as a priority	• Conduct a Focus Group or structured interview of a sample of community seniors to identify specific challenges • Take action on priority items as identified during the Focus Group	• Measure focus group participation	1 - Quantify unmet primary care needs in the senior population using a focus group or structured interviews 2 - Define current capacity to address unmet needs 3 - Implement pilot strategy to address unmet needs
	Expand Community Vaccination	• Host Community Flu Clinics • Host COVID-19 Clinics as needed	• Track vaccination rates in primary care community clinics • Track pediatric and adult immunization rates	1 - Schedule seasonal flu vaccine clinics and COVID-19 clinics as needed 2 - Assess year 1 outcomes; adjust plan for year 2 clinics 3 - Assess year 2 outcomes; adjust plan for year 3 clinics
	Connect community identified healthcare needs with lessons learned from COVID-19 (Outcome 4.4 from Strategic Plan)	• Conduct a Focus Group or structured interview of internal stakeholders to identify lessons learned and gaps	• Create a list of lessons learned and gaps from focus groups	1 - Quantify unmet needs and gaps in patient care as a result of COVID-19 2 - Define current capacity to address gaps 3 - Implement pilot strategy to address gaps

Priority Health Concerns	Goals	Action Steps	Measures	Timeline (Year 1-2-3)
Priority Area 2: Mental Health Services	Quantify and address unmet mental health needs in people 18-44 with higher income and education	• Seek information about mental health needs in people 18-44 and available services from community partners: NKHS & JTRC • Explore expansion of EAP • Explore feasibility of telemedicine implementation for mental health	• Track utilization of services • Request and review yearly feedback from Advisory Boards regarding availability and utilization	1 - Quantify unmet mental health needs in the 18-44 population using a focus group or structured interviews 2 - Define current capacity to address unmet needs including EAP, telehealth and other support services 3 - Implement pilot strategy to address unmet needs
	Increase visibility of state-wide suicide prevention efforts	• Increase hospital led promotion of state-wide suicide prevention life line	• Review state-wide suicide prevention data and utilization rate	1 - Define specific areas for promotion 2 - Implement promotion strategy 3 - Assess progress and enhance promotion strategy
	Expand mental health-oriented facilities, providers, and support staff	• Identify barriers for access to care entry • Identify barriers to continuity of care	• Number of providers and panel size	1 - Quantify unmet needs and gaps in mental health facilities, providers and staffing 2 - Identify opportunities for expansion, recruitment and retention 3 - Implement pilot strategy to address gaps
	Connect community identified priorities with strategic priorities for partner agencies (Strategic Plan 5.2)	• Develop a process to engage with partner agencies to support existing community identified priorities	• Determine priorities and data metrics in partnership with Vibrant Communities	1 - Connect with partners to align strategic priorities 2 - Identify opportunities for collaboration 3 - Implement community-wide support programs

Health Behavior Needs

Priority Health Concerns	Goals	Action Steps	Measures	Timeline (Year 1-2-3)
Priority Area 1: Use of illegal drugs	Expand access to medication assisted treatment	• Raise awareness of local medication assisted treatment options	• Measure assisted treatment options in the community • Measure time to treatment	1 - Define specific areas for promotion 2 - Implement promotion strategy 3 - Assess progress and enhance promotion strategy
	Increase community and provider education around substance abuse	• Consider in-person or remote presentations and/or CME opportunities for health professionals	• Identify current offerings with community partners • Track participation rates in educational offerings	1 - Quantify gaps in substance abuse education 2 - Develop plan for creation and delivery of educational materials for providers and community members 3 - Launch priority programs and assess outcomes
Priority Area 2: Stress, Anxiety or Depression	Engage community in wellness activities	• Gather community partner mental health and wellness events and opportunities • Define gaps and barriers to participation	• Number of annual events and wellness opportunities • List gaps and barriers to participation	1 - Define barriers for engagement in community partner mental health and wellness activities through focus groups or structured interviews 2 - Implement pilot strategy to mitigate identified barriers 3 - Assess progress of pilot strategy
	Expand partnerships with clinicians in schools to identify and address anxiety and depression in adolescents	• Define and meet with appropriate stakeholders to determine year 1, 2 and 3 priorities • Define gaps and barriers	• Utilization rate of current services among schools	1 - Identify prospective schools and partners 2 - Develop collaborative pilot programs based on strategic priorities 3 - Assess outcomes to guide next steps

Treatment and Health Care Services

Priority Health Concerns	Goals	Action Steps	Measures	Timeline (Year 1-2-3)
Priority Area 1: Urgent Care/Walk in Clinic	Develop and implement an Urgent Care/Walk in Clinic	• Align with One Care and North Country Hospital Strategic Plan to determine feasibility	• Depending on results of feasibility study, determine next steps	1 - Define priority needs using focus groups or structured interviews 2 - Identify resources and barriers 3 - Develop plan for implementation
Priority Area 2: Emergency Mental Health Services	Improve access to emergency mental health services	• Align with NEKHS and North Country Hospital Strategic Plan to determine next steps	• Availability of safe space • Providers and panel size • Utilization of primary care psychiatry services	1 - Identify unmet needs and barriers in accessing emergency mental health services 2 - Define current capacity with partners to address unmet needs 3 - Implement collaborative pilot strategy to address unmet needs

Appendix
North Country Hospital 2021 Community Health Needs Assessment: Implementation Strategy
Priority Areas: Current Strategies, What Works, Partners

Social and Community Needs

Priority Area 1: Affordable Housing

Current Strategies

- Chronic Care Coordination Team
- Connecting patients to RuralEdge/NEKCA due to housing issues

What Works

- Housing First: Provide rapid access to permanent housing and support (e.g., crisis intervention, needs assessment, case management), usually for chronically homeless individuals with persistent mental illness or substance abuse issues

- Healthy Home Environment Assessment: Train volunteers, professionals, or paraprofessionals to help residents assess and remediate environmental home health risks and recommend low cost changes (e.g., improved ventilation, integrated pest management, etc.)

- Housing Rehabilitation Loan Grant: Provide funding, primarily to families with low or median incomes, to repair, improve, or modernize dwellings and remove health or safety hazards

- Housing First: Evidence shows Housing First programs decrease homelessness, increase housing stability, and improve quality of life for homeless persons living with disabling conditions, including those with HIV infection.

Partners

- Continuum Care Group
- Joshua House (foundation/financial support)
- Northeast Kingdom Community Action
- Northeast Kingdom Council on Aging: 60+
- Northeast Kingdom Human Services
- Support and Services at Home/Rural Edge
- Umbrella

Social and Community Needs

Priority Area 2: Employment

Current Strategies

What Works

- Adult vocational training: Support acquisition of job-specific skills through education, certification programs, or on-the-job training, often with personal development resources and other supports
- Flexible scheduling: Offer employees control over an aspect of their schedule through arrangements such as flex time, flex hours, compressed work weeks, or self-scheduled shift work
- Paid family leave: Provide employees with paid time off for circumstances such as a recent birth or adoption, a parent or spouse with a serious medical condition, or a sick child
- Transitional jobs: Establish time-limited, subsidized, paid job opportunities to provide a bridge to unsubsidized employment

Partners

- CCV
- Clergy
- NEK Collaborative
- North Country Career Center
- Northeast Kingdom Learning Services
- Rural Community Transportation
- The Community Health Team/NCH social workers
- Workforce Solutions

Health Care Needs

Priority Area 1: Regular Medical Care

Current Strategies

- Available new patient appointments
- Chronic Care Coordination Team
- Diabetes Prevention Program
- NCH Dieticians
- Wellness Center

What Works

- Medical homes: Provide continuous, comprehensive, whole person primary care that uses a coordinated team of medical providers across the health care system
- Telemedicine: Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth
- Text message-based health interventions: Provide reminders, education, or self-management assistance for health conditions, especially chronic diseases, via text message
- Community health workers: Engage professional or lay health workers to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes; also called *promotores de salud*
- Health literacy interventions: Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase overall literacy

Partners

- National Committee for Quality Assurance (re: Primary Care access)
- NC Primary Care Newport, NC Primary Care Barton Orleans, Northern Counties Health Care, etc.
- Representative from the state MCD/MCR
- RSVP Program
- Rural Community Transportation
- Social Workers

Health Care Needs

Priority Area 2: Mental Health Services

Current Strategies

- Available new patient appointments
- Chronic Care Coordination Team
- Outreach and follow-up on PCP and patient self-referrals

What Works

- Mental health benefits legislation: Regulate mental health insurance to increase access to mental health services, including treatment for substance use disorders
- Telemedicine: Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth
- Text message-based health interventions: Provide reminders, education, or self-management assistance for health conditions, especially chronic diseases, via text message
- Mental Health Targeted School-Based Cognitive Behavioral Therapy: targeted school-based cognitive behavioral therapy programs to reduce depression and anxiety symptoms among school-aged children and adolescents who are assessed to be at increased risk for these conditions
- Mental Health Interventions to Reduce Depression Among Older Adults, Clinic Based: depression care management in primary care clinics for older adults with major depression or chronic low levels of depression (dysthymia) on the basis of sufficient evidence of effectiveness in improving short-term depression outcomes.
- Mental Health Interventions to Reduce Depression Among Older Adults, Home Based: depression care management at home for older adults with depression on the basis of strong evidence of effectiveness in improving short-term depression outcomes
- Telemental health services: Provide mental health care services (e.g., psychotherapy or counseling) via telephone or videoconference
- Mobile health for mental health: Deliver health care services and support to individuals with mental health concerns via mobile devices using text messaging or mobile applications (apps)

Partners

- Journey to Recovery
- NCH social workers
- NCH Wellness Center
- Northeast Kingdom Human Services-on call with NCH ED
- Northern Counties Health Care
- Private Practitioners, School Counselors and Clergy

Health Behavior Needs

Priority Area 1: Use of illegal drugs

Current Strategies

- Connecting patients with a Licensed Drug & Alcohol Counselor (LADC):21
- Connecting patients with Community based drug & alcohol treatment: 9
- Connecting patients with Inpatient Substance Abuse Treatment: 4
- Connecting patients with Mental Health/counseling: 162
- Outreach/connecting with Kelly Hensley, DNP/Dr. Edelstein: 227
- Referrals to Medication Assistance Program: 15
- The Chronic Care Coordination Team:
- The Wellness Center

What Works

- Family treatment drug courts: Use specialized courts to work with parents involved in the child welfare system who may lose custody of their children due to substance abuse
- Syringe services programs: Provide sterile injection equipment and often other treatment and referral services to people who inject drugs; also called needle or syringe exchange programs and needle syringe programs
- Drug Use Screening: Screen by asking questions about unhealthy drug use in adults 18 years or older. Screen when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

Partners

- Better Life Partners
- Clergy
- Drop Boxes in the ED & Newport Police Department
- Local Pharmacists
- Medication Assisted Treatment -Blueprint (Partner with Northeastern Vermont Regional Hospital working with Bay Area Addiction Research and Treatment & Savida)
- Savida
- Sheriff's Dept & Newport Police Department
- Substance Abuse/prevention at schools-Counselors
- Umbrella-Prevention Intervention Treatment Recovery

Health Behavior Needs

Priority Area 2: Stress, Anxiety or Depression

Current Strategies

- Chronic Coordination Team
- I Love Me Online Health Coaching: Free to wellness participants, runs 10 weeks
- The Wellness Center

What Works

- Mental Health Targeted School-Based Cognitive Behavioral Therapy: targeted school-based cognitive behavioral therapy programs to reduce depression and anxiety symptoms among school-aged children and adolescents who are assessed to be at increased risk for these conditions

- Mental Health Interventions to Reduce Depression Among Older Adults, Home Based: depression care management at home for older adults with depression on the basis of strong evidence of effectiveness in improving short-term depression outcomes

- See mental health-related services under health care needs

Partners

- Blueprint Self-Management classes
- Local therapists (full panels currently)
- NCH Wellness Center
- RCP

Treatment and Health Care Services

Priority Area 1: Urgent Care/Walk in Clinic

Current Strategies

What Works

Partners

- One Care
- Vermont Hospital Association

Priority Area 2: Emergency Mental Health Services

Current Strategies

What Works

Partners

- Northeast Kingdom Human Services partnering with NCH Emergency Dept
- One Care