Addison County

Community Health Improvement Plan (CHIP)

2022-2025

THE University of Vermont HEALTH NETWORK

Porter Medical Center

United Way of Addison County

ADDISON COUNTY HOME HEALTH & HOSPICE

Your nonprofit VNA since 1968

Mountain Health Center

Board Approved – February 10, 2022

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Executive Summary

The Community Health Improvement Plan (CHIP) is designed to strategically support the priorities identified from the Community Health Needs Assessment (CHNA). The CHNA was designed to view the overall health status across the populace of Addison County in order to increase accountability of health care providers to their service populations, ensuring that the health care organizations' range of services addresses local needs and promotes community health. The expectation is that health care organizations will use results from the CHNA to guide their CHIP for strategic planning and resource allocation during the next 3 years.

Brief Overview/description of Addison County:
Addison County is located in the lower Champlain Valley of Vermont with Lake Champlain and the Adirondacks to the west and the Green Mountains to the east. Addison County is rural and known for its dairy farming. Addison County has a density of around 45.5 people per square mile. The major employers in the county include Middlebury College, UVMHN Porter Medical Center and Collins Aerospace.

Top 3 Priorities Identified:
CHNA collaborators, UVMHN Porter Medical Center, Addison County Home Health and Hospice, and Five-Town Health Alliance, along with community partners used a set of criteria to identify priorities. The criteria included: scope of work, severity of issue, ability to impact, community readiness, and health equity. Based on the findings from the CHNA and criteria, the selected priorities include:

- Access to Healthcare Services
- Access to Mental Health Services
- Housing

CHNA Overview

Across several issues, respondents were concerned about the affordability of services, from healthy foods to substance use treatment to general health care services.

Employment and Demographics:
92.6% of Addison County residents are white non-Hispanic. Hispanic or Latino residents are Addison County's more prevalent minority population at 2.3%. According to the 2019 Census, the median income in this county is $68,825, higher than both Vermont and the United States as a whole, and there is a 7.9% level of poverty in the county.

Substance Abuse:
Survey respondents were concerned about stigma surrounding substance use, including stigma surrounding treatment for substance use. Respondents were also concerned about the availability and affordability of services and treatment, such as the affordability of residential substance use disorder treatment.

Healthy Eating:
Respondents were most concerned about the affordability of healthy foods; availability of healthy foods was not a concern for most respondents.

Mental Health:
The majority of survey respondents rated their mental health at a 4 or 5 on of a scale of 5, signifying overall satisfaction with their mental health. When ranking concerns about mental health, respondents were most concerned with the affordability of mental health services. However, during focus groups and stakeholder interviews, participants expressed a need for more mental health clinicians to address the demand for services, especially in schools, the healthcare system, and in the general community.

Health Care:
Regarding healthcare, survey respondents highlighted that their top concern was affordability. For example, survey respondents were concerned about the affordability of dental and health care for adults. During focus groups and stakeholder interviews, the need for more Primary Care Providers and wellness-centered care was expressed at a high frequency, as well as transportation and health insurance being a barrier to accessing care.

Environmental Issues:
The top environmental and social challenges that survey respondents were concerned with were climate change and street safety.

Housing:
Affordable Housing was identified by 55.2% of the respondents as the top social and environmental challenge in the community. During the focus groups and stakeholder interviews, the concern about housing was made apparent by more than half of the participants. The concern included all forms of housing, affordable units, space to rent, houses to buy, sober housing, and housing for elders.

COVID-19 Pandemic:
Overall, the COVID-19 pandemic exacerbated pre-existing disparities in Addison County, with the most vulnerable populations experiencing the most negative impacts due to COVID-19. For example, decreases in income were most likely to be experienced by households making $10,000-$24,999, and by underemployed people.

Community Health Improvement Plan Process

Priority Selection

A community meeting was held to present the information from the CHNA survey, focus group, and stakeholder interview to cross-sector leaders and CHNA collaborators. There were 32 leaders that joined the meeting. Once the information was presented, leaders broke out into separate break out rooms to reflect and have a discussion about the information presented. Leaders were asked to identify their top three priorities based on a set of criteria used in alignment with UVMHN Medical Center criteria.

CHNA Priority Criteria

- ***Scope of Work –****How many people are impacted by the issue, and is it widespread or impacting a few individuals?*
- ***Severity of Issue*** *– Is this a critical issue that is impacting cost or burden on the community?*
- ***Community Readiness*** *– Is the community supportive and prepared to take action towards this issue? Is there buy-in from leaders and positive attitude from the community?*
- ***Ability to Impact –*** *What resources are available to improve this issue or are their evidence based practices in place that can be implemented to intervene.*
- ***Health Equity –*** *Is this addressing inequities or disparities in the community?*

Based on the above criteria, community members were asked to select their top three priorities in real time on a live poll which was completely anonymous. The top three priorities selected by 28 participants:

Access to Mental Health Services – 72%
Access to Healthcare Services – 60%
Housing – 44%

CHIP Steering Committees:

Based on the priorities identified, selected stakeholders with common interest and ability to impact priorities came together to discuss goals, objectives and targeted strategies. The CHIP is a living document that will be reviewed on an annual basis to determine if the selected strategies continue to achieve the goals stated or if they are able to continue to be implemented. Stakeholders are indicated in table 1.

CHIP Steering Committees

Access to Mental Health	Access to Healthcare Services	Housing
UVMHN PMC	UVMHN PMC	UVMHN PMC
FTHA	FTHA	FTHA
ACHHH	ACHHH	ACHHH
CSAC	PCMHs in area	UWAC
Schools	TVT	ACCT
ACCT		WomenSafe
UWAC		Homeless Shelters
Turning Point Center		CVOEO
Private Practices		HOPE

Table 1. Stakeholder groups identified for each priority group.

Stakeholder groups convened to discuss focus areas and resources available to address issues. The first meetings were to gather on-going or future plans from the various organizations, as well as understanding current assets in Addison County. These groups also reviewed recommendations from the community members and stakeholders from the CHNA process.

Assets in Addison County:

ORGANIZATION	SERVICE
Open Door Clinic	A free health clinic for uninsured and under-insured adults in Addison County.
Charter House	Non-profit, volunteer-based organization dedicated to providing basic food and housing in and around Middlebury, Vermont.
Addison County Parent Child Center	Programs for parents and children including Pregnancy Prevention Program, Learning Together Program, Programs for adolescents and at-risk teens, Early childhood education, Home visits, therapies, outreaches, playgroups, as well as support for professionals.
John Graham Shelter	Provides emergency and long-term shelter options as well as case management support.
Turning Point Center	Non-profit recovery center that provides a safe, friendly, and substance use free environment where all people in recovery, and their families and friends, can meet for peer-to-peer recovery support, social activities, recovery coaching, education, and advocacy.
Addison County Home Health and Hospice	Provides home care services to families and individuals of all ages

ORGANIZATION	SERVICE
SaVida	Provides FDA approved addiction treatment for substance use disorders
Helping Overcome Poverty Effects (HOPE)	Non-profit organization that works to improve the lives of low income people in Addison County by working with individuals to identify and secure the resources needed to meet their own basic needs.
Tri-Valley Transit (TVT)	Provides public transit buses for everyone and door to door Dial-A-Ride service for vulnerable populations who cannot access the buses.
Vermont Department of Health (VDH)	Providers wrap around services to families including the Women Infants and Children (WIC) program.
Elderly Services	Offers elders and their families an adult day care center to help delay or prevent nursing home placement; it also provides creative, high-quality programs to help elders live safe and satisfying lives in their own homes and communities.
Counseling Services of Addison County (CSAC)	The county's designated community mental health agency that provides a multi-disciplinary approach for developmental services, substance abuse treatment, psychiatry, psychology, mental health counseling, social work, family therapy, and child therapy.
Addison County Relocalization Network	Provides support to farmers and food producers, engages in food education, and ensures access to healthy food for all members of the community.
Champlain Valley Office of Economic Opportunity (CVOEO)	Addresses fundamental issues of economic, social, environmental, and racial justice and works with people to achieve economic independence.
Age Well	Provide access to healthy meals, in-home care, and community resource.
Support and Services at Home (SASH)	Serves older adults and those with special needs with housing and resources to live independently.
Addison County Community Trust (ACCT)	Manage over 600 units serving moderate- and low-income households, and continue to develop more attractive, energy efficient properties for families and seniors in Addison County.

CHNA Recommendations

	COMMUNITY MEMBERS	STAKEHOLDERS
Community Connection	More free events (healthy lifestyle education, farm to table, guided hike, group bike rides, community dinners, gardening education clothing swap, yoga in the park) Baby swings in parks	Better inter-organizational communication Elevating volunteer groups (faith based organizations)
Mental Health	Emergency Service for Mental Health Needs (in addition to Crisis line) More Services	More services so there is no waitlist More candidates and more funding
Workforce	Living Wage, Family Oriented Employers, Programs to Assist with transitions (new jobs) Childcare options	More staff, support for staff, trauma-informed care
Food Access	Drop off of healthy foods in rural areas, expanding food options/access More education/training for healthy food prep/cooking, self-care and life skills	Nutrition education classes for parents and youth Reduce stigma to services
Healthcare	Expand preventative and wellness-centered options and incentives Continue telemedicine options Reach out to families directly about care Longer appointments with providers for wellness centered care	Health Advocates to help navigate resources, new diagnoses, having conversations with your doctor, universal finance department for the hospital More support groups (after hours) Reach out to teens about healthcare, especially if not in sports More communication, outreach, marketing and education of services available
Housing	More affordable housing for all and programs to assist people in transition and with employment Provide services to people at home (laundry, shoveling snow, cleaning, etc.) Sober housing or housing with wrap around supports	More affordable housing with access to transportation Migrant farm working population who are unsheltered or at risk of being unsheltered Focus of homes that are not safe and where health conditions can arise Volunteer network to support people at home and people with hoarding issues.
Racism		Feeling valued and heard by their PCP or person they are receiving care from
LGBTQ		Trauma Informed Care for queer population
Schools	Supports are needed for teachers (paraprofessionals and financial resources) Speech Pathologist More counselors in schools	More counselors in schools Basic life skills education in school

Table 2. Recommendations indicated during community conversations with residents and with stakeholders

Continuous Projects:

Although not all of the priorities were selected to target and allocate resources to, there are many on-going collaborative projects between community partners that will continue and expand. Some of these projects include the:

- Farmacy – Food is Medicine program between UVMHN Porter Medical Center and ACORN as well as FTHA's individual program with local farmers to address food insecurity and diet-related illnesses.
- Rides to Recovery and Rides to Wellness in partnership between TVT and multiple healthcare and recovery partners to support patients to appointments and employment.
- Addison County Housing Solutions Group – coordinating care and housing supports for individuals in the community
- P.E.E.Ps – group supporting substance use prevention efforts for youth in the county
- Rapid Access to MAT in the Emergency Department – a collaboration between UVMHN Porter Medical Center and SaVida
- Care Coordination efforts between the various organizations
- CSAC supporting schools by embedding counselors and focusing on social, emotional health

Other priorities were not specifically included as the three top priorities integrate many of the other components, especially around the social determinants of health and referral to community resources.

Priorities Overview:

ACCESS TO HEALTHCARE SERVICES:

Goal 1: Enhance use of technology and Electronic Health Record (EHR) systems to improve access, effectiveness, outreach, and overall quality of care.

- Objective 1: By 2025, improve utilizations and functions of VITL and the EHR systems to better communicate between/among healthcare delivery organizations and thereby enhance both integration and access opportunities.
    - Strategy 1: Expansion of EHR on-demand services and functions
    - Strategy 2: Increase *Care Everywhere* access for community partners.
    - Strategy 3: Conduct risk-assessment screenings online prior to visits to increase physical time spent during visits with providers.
    - Strategy 4: Develop Health Service Area plan around One Care Vermont efforts and communication

Possible Evaluative Metrics:

- Utilization of MyChart/Patient Portal
- Number of community partners who are accessing *Care Everywhere*
- % of community partners utilizing *Care Everywhere* functionality
- Number of risk-assessment screenings completed prior to PCP visits

Target Population: Addison County Residents

Goal 2: Expand workforce recruitment and retention efforts to increase capacity

- Objective 1: By 2024, reduce number of vacant positions and turnover rate through recruitment efforts and improved employee experience
    - Strategy 1: Partner with academic institutions (e.g. Hannaford Career Center and Higher Education) to engage future workforce development,
    - Strategy 2: Invest in DEI efforts to create a culturally supportive, environment/community to attract and retain diverse staff across the healthcare delivery sector

Possible Evaluative Metrics:

- % of employees hired from a local academic institution
- # of days from job posting to hire
- Annual employee turn-over rate
- Employee satisfaction surveys
- DEI metrics to be determined

Target Population: Healthcare employees

Goal 3: Reimagine health care to increase access to services

- Objective 1: By 2025, redesign the health care delivery system to be patient-centered using a team based approach with wrap-around services.
    - Strategy 1: Embed services to increase access to other clinical and non-clinical supports needed to improve patients health outcome
    - Strategy 2: Expand hours of service within the primary care setting
- Objective 2: By 2025, increase number of patients receiving care coordination and wrap around services
    - Strategy 1: Create the structure for wrap around services that include Case Management.

Possible Evaluative Metrics:

- # of services provided to Primary Care and Pediatric Populations
- Patient Satisfaction with level of service and coordination health outcomes improved Employee satisfaction surveys
- % of patients who screen positive for behavioral health who are referred

Target Population: Addison County Residents

Goal 4: Improve equity in the health care system by developing a collective approach and coordinated impact within the community

- Objective 1: By 2025, the steering committee will develop key indicators to measure health equity
    - Strategy 1: Develop a cross-sector collaboration around health equity with like-minded organizations
    - Strategy 2: Screen for transportation needs to health care services and connect to case manager
    - Strategy 3: Train providers on trauma-centered, LGBTQIA +, and culturally competent care to support diverse populations

Collaborative Partners Include: UVMHN, UVMHN Porter Medical Center, Five Town Health Alliance, Open Door Clinic, Counseling Services of Addison County, Addison County Home Health and Hospice, CVOEO, United Way, HOPE, Health Department, Agewell, Hannaford Career Center, Tri-Valley Transit, Private Primary Care Offices, Turning Point Center, Parent Child Center and Building Bright Futures.

Resources Allocated: UVMHN funding, UVMHN Porter Medical Center, FTHA

ACCESS TO MENTAL HEALTH SERVICES:

Goal 1: Advance mental wellness through equitable access to timely, responsive, and integrated system

- Objective 1: By 2025, increase provider training, patient mental health screen and referral to community resources by 5%
    - Strategy 1: Establish common approach by training PCPs on the Child and Adolescent Needs and Strength (CANS) and Adult Needs and Strength Assessment (ANSA) to ensure cross-sector understanding and reduce duplication
    - Strategy 2: Assure proper cross-agency collaboration for individuals served by multiple sites including appropriate use of release of information forms
    - Strategy 3: Assess Substance Use Disorder and Alcohol Use Disorder needs and refer to treatment options
    - Strategy 4: Train clinicians to identify symptoms of perinatal mood and anxiety disorders
    - Strategy 5: Increase counseling services in the community
- Objective 2: By 2024, develop mental health work plan to address access to care and care coordination
    - Strategy 1: Conduct environmental scan and cross sector forum to develop work flow which prioritizes individual's need using a risk stratification method

Possible Evaluative Metrics:

- Number of providers cross trained in CANS and ANSA
- % of patients screened positive for AUD/SUD and referred to treatment
- Number of clinicians trained through PSI for perinatal mood disorder
- % of patients receiving care from multiple providers with 1 lead care coordinator
- Flow sheet developed and utilized for mental health referrals
- CSAC's 5 day and 14 day measure for community mental health access
- # of individuals on counseling waitlist compared to workforce vacancy
- # of individuals screened (SU, Trauma, PHQ, CANS, ANSA)

Target population: Addison County Residents

Goal 2: Strong cross-organization commitment and engagement to increase access to mental health care

- Objective 1: By 2025, increase number of non-traditional settings in which individuals can access behavioral health services and resources
    - Strategy 1: Embed mental health integration staff in PCP/Pediatric offices, law enforcement, and other human services organization
    - Strategy 2: Develop and pilot group classes around prevalent mental health needs for all residents in Addison County (i.e. Anxiety and Depression)
    - Strategy 3: Support and promote peer support groups hosted by various organizations

***Goal 2:* Strong cross-organization commitment and engagement to increase access to mental health care (Continued)**

- Objective 2: By 2025, increase number of patients receiving treatment for Substance Use Disorder/Alcohol Use Disorder by 2%
    - Strategy 1: Sustain and expand number of providers offering substance use treatment in the HSA
    - Strategy 2: Expand FQHC's mobile unit to support patients in high risk areas
    - Strategy 3: Establish a Rapid Access to Alcohol Use Treatment in the ED
- Objective 3: By 2024, engage 10% of health and human services in advocacy work to support the community mental health agency
    - Strategy 1: Bring forth concerns to local representatives and increase presence at state level.

Possible Evaluative Metrics:

- # of organizations with embedded mental health services
- Utilization of mental health providers
- # of classes offered and participation
- # of referrals to peer support groups
- # of providers accepting new SUD patients
- # of patients treated for AUD in the ED and referred to treatment
- # of services provided by the FTHA Mobile unit and # of locations unit is deployed

Target Population: Addison County Residents

Goal 3: Cultivate resilient communities to support mental and social wellbeing

- Objective 1: By 2025, identify resources and supports to promote resiliency and protective factors for individuals
    - Strategy 1: Train first responders in Team Two to support individuals with mental health challenges
    - Strategy 2: Collaborate with CSAC to identify and implement initiatives to become a trauma healing community
    - Strategy 3: Advance knowledge and disseminate information to reduce stigma around mental health, at risk-youth, and LGBTQIA+ youth
- Objective 2: By 2025, reduce death by suicide by 2% based on VT statistics
    - Strategy 1: Promote the national crisis line, CSAC crisis line, and 2-1-1 resources
    - Strategy 2: Collaborate with the substance use prevention and substance use treatment and recovery committees to support harm-reduction efforts and messaging in the community
    - Strategy 3: Provide U-matter training to professional staff, families, youth, and older Vermonters in Addison County

Possible Evaluative Metrics:

- # of individuals trained in Team Two in Addison County
- Evaluation metrics to be determined for trauma health community efforts
- # of individuals trained in U-Matter through zero suicide initiatives

Target Population: Addison County Residents

Collaborative Partners Include: UVMHN, UVMHN Porter Medical Center, Five Town Health Alliance, Counseling Services of Addison County, Addison County Home Health and Hospice, CVOEO, United Way, HOPE, Health Department, Agewell, Hannaford Career Center, Tri-Valley Transit, Private Primary Care Offices, First Responders, Law Enforcement, Addison County Schools, Local Representatives, SaVida, Valley Vista, Turning Point Center, 2-1-1, Charter House, Building Bright Futures, Parent Child Center, and John Graham Shelter.

Resource Allocation: UVMHN, UVMHN Porter Medical Center, CSAC, FTHA, ACHHH, STAMPP Grant Funding

HOUSING:

Goal 1: Strong cross-organization commitment and engagement to expand opportunities for affordable and quality housing in Addison County

- Objective 1: By 2025, develop cross-sector collaboration and expand conversations to identify solutions around affordable housing in Addison County
    - Strategy 1: Gather housing and non-housing partners to inform partners of need and supports needed
    - Strategy 2: Support partners in advocating for housing, land use, and development of policies that prioritize affordable and supportive housing
    - Strategy 3: Explore affordable housing options for workforce and recruitment efforts
- Objective 1: By 2024, increase number of affordable housing units by 5%
    - Strategy 1: ACCT to acquire funds and build 20 unit affordable housing complex in Bristol, VT
    - Strategy 2: Seek and collaborate on funding opportunities to procure additional housing

Possible Evaluation Metrics:

- Agenda and Minutes (Collaboration metrics to be determined)
- # of units built and filled

Target Population: Addison County Residents

Goal 2: Reduce displacement and homelessness in Addison County

- Objective 1: By 2025, identify needs for housing and other environmental factors
    - Strategy 1: Medical Homes complete risks assessment to identify social determinants of health and refer to appropriate internal or external resource
    - Strategy 2: Provide onsite health and wellness support through mobile unit and community initiatives
    - Strategy 2: Based on needs identified, establish a workgroup with field experts to help advance knowledge and disseminate information in a community base setting

Possible Evaluation Metrics:

- # of referrals to community partners
- # of mobile unit visits to housing unit
- # of community outreach efforts

Target Population: High risk patients in Addison County

Goal 3: Promote a safe environment for youth, families, and older Vermonters in the home setting

- Objective 1: By 2025, increase collaboration with service organizations to understand services and need for individuals at various age levels
    - Strategy 1: Develop community forum to elevate needs identified, discuss solutions, and review planned interventions
    - Strategy 2: Base on needs identified, establish a workgroup with field experts to help advance knowledge and disseminate information in a community base setting
- Objective 2: By 2025, increase number of safety assessments conducted in the community by 10% and provide appropriate supports
    - Strategy 1: Increase awareness and training of ACHHH services around safety assessments and referrals
    - Strategy 2: Expand existing volunteers program to support elders at home – shoveling snow, laundry, cleaning, and other basic needs

Possible Evaluation Metrics:

- Workgroup developed to address housing needs
- # of referrals to ACHHH for safety assessments
- Volunteer metrics to be determined

Target Population: Addison County Residents

Collaborative Partners Include: UVMHN, UVMHN Porter Medical Center, Five Town Health Alliance, Counseling Services of Addison County, Addison County Home Health and Hospice, CVOEO, United Way, HOPE, Health Department, Agewell, Tri-Valley Transit, Private Primary Care Offices, First Responders, Law Enforcement, Addison County Schools, Local Representatives, SaVida, Valley Vista, Turning Point Center, 2-1-1, Charter House, Building Bright Futures, Parent Child Center, and John Graham Shelter.

Resource Allocation: ACCT, UVMHN, UVMHN Porter Medical Center, CSAC, FTHA, ACHHH

Implementation and Evaluation

The CHIP will be reviewed on an annual basis by the lead steering committee and community leaders to evaluate the listed goals, objectives, strategies, and evaluation metrics. Based on progress and impact, the community partners will collaboratively evaluate the on-going work and decide if adjustments need to be made based on various factors. These factors may include: metrics, data, resource allocation, capacity, and other competing priorities.

Timeline for Annual Review:

- August 15, 2022
- August 15, 2023
- August 15, 2024
- February 15, 2025

Evaluation Tool:
An evaluation tool is scheduled to be created to track evaluation metrics identified to measure progress and communicated anticipated successes of strategies to achieve overall goals.

Definitions:

Care Everywhere: *function used within Epic as a communication tool between partners for care transitions*
DEI: *Diversity, Equity and Inclusion*
Epic*: Electronic Health Record used by UVMHN Porter Medical Center*
Team Two: *Mental Health training for crisis providers to help develop proper responses to situations*
U-Matter: *Suicide prevention program developed to ask for help and train individuals from all levels to identify signs and symptoms of suicide*