Dartmouth-Hitchcock Population Health Report on the FY16 Community Health Needs Assessment

The following pages provide an overview and assessment of Dartmouth-Hitchcock programs and interventions directed toward the needs of the community as identified in the FY16 Community Health Needs Assessment. The Board is required to evaluate our activities meeting these needs.

The following pages include:

- Summary of the findings from the FY16 Community Health Needs Assessment;
- Infographics summarizing FY17-FY19 results on the three highest prioritized needs;
- Narrative report providing details on work conducted between FY17-FY19.

The narrative presents information using the RE-AIM framework. The RE-AIM framework has been used in public health to efficiently communicate results of studies and to accelerate dissemination of effective practices. Results are reported in the following format:

- **R**each—number of people reached by the intervention;
- **E**ffectiveness—the impact of the intervention on outcomes;
- **A**doption—the number of people/organizations willing to adopt the intervention;
- **I**mplementation—the fidelity to core elements of the intervention;
- **M**aintenance—the extent to which the program/intervention becomes institutionalized.

In addition to this narrative, D-H Population Health, in partnership with Dartmouth Synergy's Community Engaged Research Core, has developed a web-based resource for health data and sharing results of community engaged research projects. The Community Health Hub is available to the public, providing data on the health of our populations, the impact of D-H Population Health interventions, and results on research conducted with community partners.

https://communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/

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

Community Health Improvement Plan, FY 2017-2019

Identified Needs

Dartmouth-Hitchcock's Community Health Improvement Plan addresses needs directly identified in the 2016 Upper Valley Community Needs Assessment, as well as needs identified by other Community Health Needs Assessments from communities served by Dartmouth-Hitchcock Primary Care Clinics.

	Priority Ranking
Access to Mental Health Care	1
Access to Enough and Affordable Health Insurance Cost of Rx Drugs	2
Alcohol and Drug Use Including Heroin Use and Pain Medications	3
Access to Dental Health Care	4
Lack of Physical Activity Need for Recreational Opportunities	5
Poor Nutrition/Access to Affordable Healthy Foods	6
Income; Poverty; Employment; Family Stress	7
Affordable Housing	8
Access to Primary Health Care	9
Health Care for Seniors	10
From State of NH/State of VT Health Improvement Plans*	N/A
Alignment with State of NH/State of VT Public Health Initiatives**	N/A

*These needs appear in the NH State Health Improvement Plan and the Healthy Vermonters 2020 plan. These needs often are not highlighted in Community Health Needs Assessments because they exist as chronic background concerns rather than the current crisis needs often identified in assessments.

**NH has very limited town/county public health infrastructure; both NH and VT strongly encourage development of local public health coalitions to address public health needs. Dartmouth-Hitchcock currently co-leads emerging public health coalitions in the Upper Valley region where this important community health infrastructure is otherwise severely limited

Dartmouth-Hitchcock

I. Improve Behavioral Health Outcomes/Prevent and Reduce Harm from Substance Use and Mental Illness

Strategies

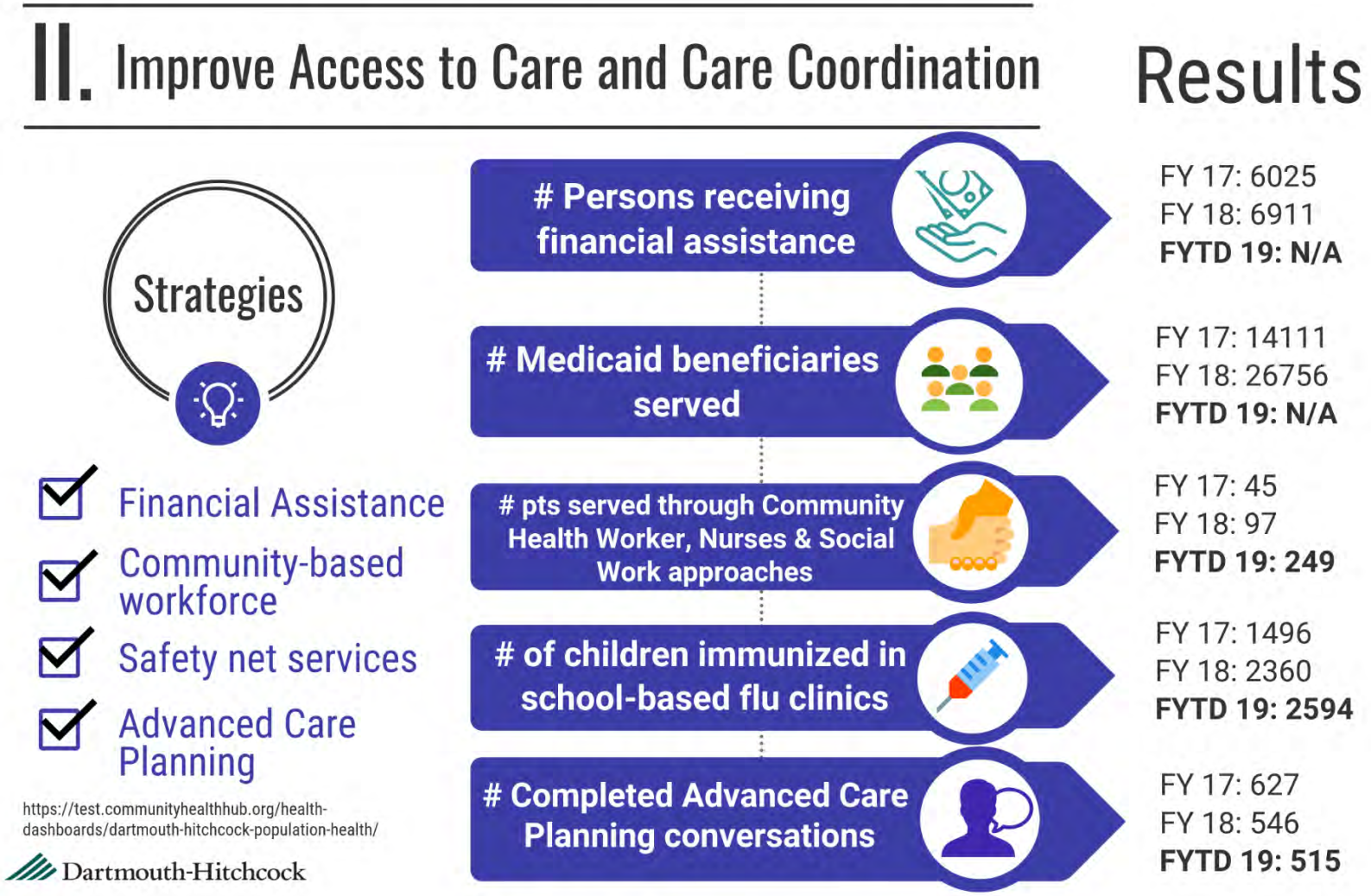
- Prevention
- Intervention
- Treatment
- Recovery

https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/

Dartmouth-Hitchcock

Results

	Results
# D-H Pediatric Patients screened at well-visits for behavioral health needs	FY 17: 10287 (56%) FY 18: 12272 (72%) **FYTD 19: N/A**
# D-H providers waivered to offer Medication Assisted Treatment as part of care for opioid use disorders	FY 18: 19 **FYTD 19: 37 (100 overall)**
# Recovery Coaches Trained	FY 17: 23 FY 18: 13 **FYTD 19: 47**
lbs medications disposed in community drop-boxes	FY 17: 902 FY 18: 2131 **FYTD 19: 905**
# community members and professionals trained in D-H sponsored evidence-based substance misuse mental health prevention/harm reduction trainings	FY 17: 315 FY 18: 772 **FYTD 19: 955**


II. Improve Access to Care and Care Coordination
Strategies
Financial Assistance
Community-based workforce
Safety net services
Advanced Care Planning
https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/
Dartmouth-Hitchcock
Results
Persons receiving financial assistance
FY 17: 6025
FY 18: 6911
FYTD 19: N/A
Medicaid beneficiaries served
FY 17: 14111
FY 18: 26756
FYTD 19: N/A
pts served through Community Health Worker, Nurses & Social Work approaches
FY 17: 45
FY 18: 97
FYTD 19: 249
# of children immunized in school-based flu clinics
FY 17: 1496
FY 18: 2360
FYTD 19: 2594
Completed Advanced Care Planning conversations
FY 17: 627
FY 18: 546
FYTD 19: 515

III. Support Healthy Aging

Strategies

- Aging Resource Center
- Geriatric Workforce Education
- Home Visiting Services
- Falls Prevention

https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/

Dartmouth-Hitchcock

Results

#pts served in LIGHT, Easter Seals and other supported home visiting programs	FY 17: 166 FY 18: 110 **FYTD 19: N/A**
# people particpating in Aging Resource Center services	FY 18: 4632 **FYTD 19: 2185**
% of patients screened for falls in Primary Care	FY 18: 86.50% **FYTD 19: N/A**
# people receiving safety net supports	FY 17: 5086 FY 18: 5163 **FYTD 19: N/A**
# balance class participants completing 75% of sessions	FY 18: 48% **FYTD 19: N/A**

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Prevent and Reduce Harm from Substance Use and Mental Illness	We have greatly enhanced programming with measurable results in this area: • # D-H Pediatric patients screened at well-visits for behavioral health needs (all clinics): FY17 10,287 (56%); FY18 12,272 (72%) • % D-H Primary Care patients in screened for behavioral health needs in two (2) early adopter clinics: FY18 93% • # D-H providers waivered to offer Medication Assisted Treatment for opioid use disorders: FY18 30; FY19 (through March) 52 • Lbs of medication disposed in drop boxes: CY17 902; CY18 2,131 Four scorecards including linked population level health outcomes and additional program measures associated with D-H's strategies to improve these outcomes are viewable at: https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/ D-H has engaged in multiple strategies to address substance use and mental health. These include an integrated model for primary and behavioral health care in primary care; co-leadership for the Lebanon-Keene NH Integrated Delivery Network; a Recovery Coach model for Emergency Dept. patients with substance use needs; Hub and Spoke services as part of NH's emerging system of opioid use disorder care; and training and clinical support for Medication Assisted Treatment in our primary care and hospital care teams. D-H continued to operate an Inpatient Psychiatric Treatment Unit, outpatient psychiatry services, psychiatric services for NH Hospital, and Intensive Substance Use Disorder services including care for pregnant women. D-H leads substance misuse prevention efforts in the Upper Valley and Greater Sullivan County regions of NH, including unused medication and syringe disposal; training for school-based prevention services; technical assistance to grow regional syringe services programs; funding for campaigns to promote protective parental behaviors; training for community members and professionals in suicide prevention; and leadership of a statewide campaign to reduce stigma associated with mental illness. In FY19, D-H began work with Upper Valley region community clinics, home visitors, and early care providers to improve care and care coordination for children ages 0-5 and their parents/caregivers who experience significant family disruption due to social and behavioral health needs.	Substance use and mental illness programs have been adopted broadly across the D-H system as well as in other regional sites. An integrated model for behavioral health and Medication Assisted Treatment has been adopted across our primary care clinics. D-H engages with the Lebanon-Keene NH Integrated Delivery Network, supporting the adoption of these approaches in other regional clinics. Our substance misuse prevention coalition work facilitates regional prevention partnerships and supports schools, police, recreation, and other community leaders working to prevent teen and adult substance misuse.	D-H has chartered an institutional Substance Use Mental Health Initiative work team to lead this work. Where evidence exists, D-H clinical and prevention services draw from research-supported approaches, with adaptations relevant to local conditions/ cultures. Quality Improvement and Micro-Systems approaches are regularly used to inform implementation efforts. In some work, D-H engages in work to extend evidence-based models or explore new ideas suggested by evidence. We use, coach, and encourage evidence-based and best-practice approaches in community settings, but do not have decision-making authority over community partners' strategies and choices. In these settings we help support, train, and provide technical assistance to help organizations and multi-stakeholder teams advance their capabilities to use data, evidence, and quality improvement in their choice and implementation of strategies.	In 2018, D-H's Value Committee resolved to provide quality care for patients with opioid use disorders, furthering formal commitments to this work. D-H has built integrated care, behavioral health coordinators, and medication assisted treatment into operational budgets and standard care models, suggesting strong sustainability. D-H has and will continue to leverage state, federal, and foundation grants with D-H community benefit funds to support these services. Medication Assisted Treatment and recovery coaching are still emerging, and require ongoing training and support. Routine suicide prevention and trauma-informed early care trainings are currently supported through Community Benefit funds and external funders. We recognize these initiatives will require ongoing fund development and resource commitments.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Improve Access to Care and Care Coordination	We continued to support access to care and care coordination, including creating new workforces to strengthen care coordination: • Financial assistance: FY18 6,911 patients; Loss at-cost $10,495,752 • Medicaid Visits: FY18 26,756; Loss at-cost $116,710,371 • # pts. served by CHW staff: FY17 45; FY18 97; FY19YTD 249 (Apr. 30) • $ sponsorship, free clinic/FQHC: FY17 $65K; FY18 $115K; FY19 $115K Four scorecards related to access to care and care coordination including linked population level health outcomes and program measures associated with D-H's strategies to improve these outcomes are viewable at: https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/	Patients are routinely offered Financial Assistance and help applying for Medicaid when indicated. The Community Health Worker services are offered at all D-H Primary Care sites with varied levels of staffing. D-H has trained and placed AmeriCorps Members at 8+ D-H and community sites. This effort has faced significant recruiting and placement barriers. Recovery Coach positions are being piloted in the D-H ED and Addiction Treatment Program. This is still considered a pilot Capacities to help patients and employees complete and document Advance Directives are widespread across D-H clinics and hospital teams.	D-H has compliant policies for financial assistance to patients; routinely notifies patients of these options, and provides assistance to qualify for these supports. D-H Population Health researched existing CHW services to inform our work. Our CHWs were trained by established external trainers to a standard level. NH does not have criteria for CHW certification. We established a Redcap database to track CHW metrics and operating efficiency. This data provides operational feedback as we develop CHW services. We also measure changes in health care utilization of patients served by CHWs. D-H's Advance Directives work is guided by the Honoring Care Decisions approach. Trained D-H staff train D-H clinical teams to have advance care discussions with patients, and Shared Decision Making staff are available to provide personal support to patients.	D-H will maintain commitments to serving uninsured patients and those who are Medicaid Beneficiaries in keeping with our charitable mission. Community Health Workers, Recovery Coaches, and other peer-self management supports have progressed from initial pilots into operational budgets. We will continue to review these approaches for cost and value. Six CHW positions were included in D-H's FY19 operational budget; other CHW roles have been funded through NH Integrated Delivery Network funding. Of these, IDN funded roles have moderate levels of risk to continuation. Operationally funded roles are currently planned to continue in the FY20 budget. Positive feedback from providers and recommendations to grow CHW work in the Huron report suggest this work will be maintained or expanded in future years. D-H will discontinue participation in AmeriCorps in Spring 2020 due to major recruitment and placement barriers, allowing us to commit administrative resources leading this work to higher outcome work.
	In FY17-19, D-H maintained its support for providing safety net access to care through Financial Assistance, health care for Medicaid Beneficiaries, contributions to FQHCs and Free Clinics, and helping patients access free or low cost prescription medication programs. In FY17, D-H implemented a Community Health Worker (CHW) program. CHWs help patients access housing, food, transportation, federal assistance programs, and help with tangible problem solving that allows patients to achieve better health and wellbeing. In FY18, some D-H primary care clinics piloted routine screening of patients for social and behavioral health needs, enabling care teams to activate CHWs and address these needs as part of clinical care. In FY17, D-H began training Peer Recovery Coaches, and hired Recovery Coaches to work in the D-H Emergency Dept. and Addiction Treatment Programs. In FY18, D-H initiated an AmeriCorps Program, recruiting and training Members to help persons with substance use and mental health disorders find housing, food, and other recovery supports. During this period, D-H has provided support staff and trained clinical providers to help patients complete and Advance Directives and other medical direction documents to help clinical providers and family members fully understand a patient's preference for care in the event they cannot communicate for themselves.			

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Improve Health and Wellbeing of Older Adults	We have continued and expanded existing programs to improve the health and wellbeing of older adults: • # patients served in Community Nursing and Easter Seals home visiting programs: FY17 166; FY18 110; • # Aging Resource Center activity attendees: FY18 4,632 • % D-H Primary Care patients screened for falls risk: 2018 86.5% Three scorecards related to health and wellbeing of older adults including linked population level health outcomes and program measures associated with D-H's strategies to improve these outcomes are viewable at: https://test.communityhealthhub.org/health-dashboards/dartmouth-hitchcock-population-health/ In FY17-19, D-H's Aging Resource Center (ARC) increased the number of programs is offers as well as the number of people it serves. It opened a new location at Upper valley Senior Center in Lebanon, NH. The ARC offers education; evidence-based programs like the Stanford Chronic Disease Self-Management Program; support groups; and specialized programs such as dementia support groups and caregivers classes. D-H has also expanded support the work of community care coordination resources such as community nursing and the Easter Seals services in Manchester, NH. These services provide non-clinical, home-based care coordination and support for seniors with significant health needs who also face significant isolation or social challenges. We continue to provide funding for Grafton Co. Senior Citizen's Council's home- and congregate meals, and senior transportation services. D-H leads many strategies to reduce falls injuries, including offering evidence-based falls prevention programs at the ARC and training external partners in these approaches. Since FY17, we implemented routine clinical screening for falls and referral to prevention programs. D-H leads a Geriatric Workforce Education Initiative that trains providers nationally to improve care for older adults and to help clinical teams link with non-clinical services to improve care for older adults.	The ARC) provides education, programs, and support groups at its center at D-H and at Upper Valley Senior Ctr. in Lebanon, NH UV Community Nurses can now connect to D-H doctors via DH Connect and use standard data systems. D-H's Falls Prevention staff train organizations across NH and VT to deploy evidence-based falls prevention programs Falls risk screening is routing in D-H primary are and ED settings D-H's Geriatric Workforce Education Program trains and provide consultations re: evidence-based practices to primary care providers at D-H and nationally.	Supporting aging populations is one of three focal areas prioritized in FY16 by the Population Health Council for increased investment. Community benefit funding of the ARC and community-based care coordination and basic services have been consistent and growing over the last 10 years The ARC and GWEP offer, promote, and train evidence-based programs and practices and use subject matter experts to ensure their work promotes highest quality standards. D-H staff serve in leadership roles in the NH Falls Prevention Task Force, and we commit 1.0 FTE toward work to reduce falls injuries among older adults.	The ARC has strong institutional support, qualified leadership, and adequate operational support to maintain programs. Desired expansion to new sites will require new resources. D-H's community benefit funding for community based partners providing care coordination and basic needs is evaluated annually and has some risk. We plan to maintain current funding, though choices regarding supported organizations may vary. D-H's Falls Prevention work and Geriatric Workforce Education Program are strongly supported by grants and contracts likely to be renewed

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Impact Social Determinants of Health/Support for Safety Net Needs	D-H grew efforts to address social determinants (SDoH) in FY17-FY19 and built capacity to increase this work in FY20 and beyond. •# screened for SDoH in pilot primary care sites: FY18 320 (45%) •# persons hired at D-H through SDoH workforce training: FY18 64 •$$ invested in SDoH housing, food, & transport: FY19 $310,000 In FY17-FY19, D-H continued providing funding to regional transportation services serving Lebanon, NH as well as supporting senior transportation provided by Grafton Co. Senior Citizen's Council. Additionally, in FY17-19 we provided three years of start-up funds to help re-build public transportation in Sullivan County. During FY17-FY19 D-H increased workforce training programs to prepare people for health care careers. These programs are designed to help persons with limited work experience enter career pathways, and offer paid training leading to living wage jobs, and college credit. D-H also hosts Project Search, providing internships in health care for adolescents with developmental disabilities. In FY19 D-H funded case management services for chronically homeless persons housed in 17 renovated apartments developed by Twin Pines Housing Trust in Lebanon, NH. We provided support for housing and food-related capital projects including the renovations of New Horizon's shelter in Manchester; Crafts Hill in Lebanon; and Listen Community Services in Lebanon, and helped fund UV-Lake Sunapee Regional Planning Commission's regional assessment of housing needs. During FY18, D-H began screening Medicaid Beneficiaries for social determinants of health (SDoH). In that time we have also deployed Community Health Workers in these practices to help patients with SDoH needs connect to local human services. A project to provide emergency food for patients is planned to start in June 2019. In May 2019, D-H began partnering with Willing Hands Enterprises to use hospital land as a growing garden that will provide produce for regional shelters, and food shelves.	D-H continues to fund public transportation organization and regularly participates in planning initiatives to improve public transportation. D-H's Workforce Readiness Institute partners with established health care training entities and regional education and workforce development programs to support workforce training. D-H's Population Health team routinely interacts with community partners providing housing, food, and other social supports, and manages staff and financial support to advance important initiatives in these areas. D-H routinely screens Medicaid Beneficiaries for social needs at most of our primary care clinics, and provides Community Health Worker services to address these needs when patients request assistance.	D-HH's Community Health Committee identified SDoH needs as one of four shared focus areas for community health work for the next three years. D-H Population Health and primary care clinics have reorganized staff roles to train, place, and integrate Community Health Workers and to develop food and housing strategies. D-H employs 6 Community Health Workers through operations budgets, and 3 through grant-funds. In FY19, we developed a D-H Healthcare Anchor Leadership Team to focus attention on hiring, purchasing, and investment strategies to support improved SDoH regionally. D-H is a member of the national Healthcare Anchor Network.	These strategies are highly likely to be continued and grown over the next several years. With prioritization by the D-HH Community Health Committee and the creation of the D-H Health Care Anchor Leadership Team, infrastructure and prioritization exists to deepen this work. D-H Population Health will continue re-positioning staff and budgeting resources to support this work. These efforts are significantly dependent on community benefit funding, philanthropy, and readiness to re-align existing operational priorities. Additionally, continuing these investments requires an institutional readiness to embrace outcomes that could take 5-20 years to realize, making these efforts vulnerable to changes in leadership or organizational focus.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Improve Oral Health	D-H supports existing oral health programs in our community: • # patients treated at Red Logan Dental Center: FY17 631; FY18 824 • # pts served by Public Health Dental Hygienist Program: ~150/yr FY17-18 During FY17-FY19, D-H has primarily been a funder of oral health services provided by others, continuing past efforts to address this need. D-H provides significant annual contributions to support Red Logan Dental Center, a free dental clinic in White River Junction, VT. In spring 2019, D-H and Red Logan also created an agreement for Red Logan to offer public health dental hygienist services and silver diamine fluoride treatment at the D-H Mom's in Recovery Program, serving a high-needs population. In FY17, D-H provided annual support for school-based oral health clinics operated by Alice Peck Day Memorial Hospital (APD). In 2018, APD began billing for these services and no longer need D-H funding support. In FY18, D-H provided a one-time capital contribution to the Claremont Dental Center to help them expand operations. In FY17, D-H facilitated development of, and provided cash support for, adult oral health clinics staffed by a public health dental hygienist and offered in remote, community-based sites such as senior centers and food shelves. This service continued through fall 2018, but is currently paused as the community organization providing the service is re-organizing. The opening of the Mascoma Community Health Center in Canaan, NH, has had a significant positive impact on access to oral health care. This clinic provides a significant volume of dental services to both insured and uninsured adults. Though not targeted to support dental services, D-H provided a cash contribution to the clinic in spring 2019.	Numerous existing community organizations provide free or low-cost dental services. This capacity has grown in FY17-FY19. Place-based adult oral health clinics had been successfully piloted, but have been paused while searching for a new community lead partner. D-H regularly uses ongoing and one-time community benefit funding to support maintenance and growth of these services.	All services supported by D-H meet professional standards of care. Contributed support from D-H allows these services to maintain operations, replace capital equipment, and to operate in new locations. D-H has been an early funder of public health dental hygienist (PHDH) services. PHDHs are a new dental workforce and can help reduce barriers to care by bringing PHDH services to locations where people without access to care are likely to be, such as senior centers, homeless shelters, and substance use disorder programs.	There are many challenges to sustaining gains achieved in FY17-FY19 Third-party payment systems for oral health services are severely limited in NH and VT. D-H will continue its financial support for Red Logan Dental Center and continue to partner with Red Logan for services at the D-H Mom's in Recovery program. Red Logan has varying capacity based upon the number of volunteer dentists and dental externs it can attract. Dental services at the Mascoma Community Health Center and community-based oral health clinics face financial and operational uncertainties that could change, limit, or end these services.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Reduce Harm Caused by Poor Nutrition and Lack of Physical Activity	D-H supports summer feeding programs in Lebanon and Hartford • # served in summer feeding program: FY17 17,271 FY18 18,096 As defined in our FY17-FY19 CHIP plan, D-H reduced its engagement in efforts to improve nutrition and physical activity. During this time, D-H has modified this focus to increase attention to issues of hunger. From FY13-FY16, D-H organized & staffed the Upper Valley Healthy Eating Active Living Partnership. In our FY17-FY19 CHIP, we eliminated staff, but planned increased funding for community partners to continue this work. The community coalition continued, but made no use of D-H's funding support and disbanded in June 2017. Since that time, D-H has shifted this funding to support food insecurity initiatives. D-H contributions and staff supported new summer feeding programs for school age youth in Lebanon and Hartford, and we convened multiple community partners in February 2019 to prepare for possible disruption of SNAP benefits during the govt. shutdown, resulting in a substantial community fundraising campaign for food supports that provided food for more than 600 families across the Upper Valley in winter 2019. D-H contributions have helped to start and maintain FreshRx programs at New London Hospital and FitRx initiatives at Alice Peck Day Hospital, as well as to support the launch of RISE VT, a community-based approach to reducing obesity-related disease in Bennington, VT. During FY19, D-H planned an 'emergency food' partnership with the Upper Valley Haven at its Lebanon clinics to meet immediate food needs of patients, which should begin in June 2019. In FY19 we also contributed unused land on our hospital campus to be used by Willing Hands, Inc., to grow produce for distribution to regional food shelves. A FY19 contribution to Listen Community Services will help purchase capital equipment for Listen's new food shelf expansion. D-H's Weight and Wellness Center continues to provide care for persons with significant weight-related health conditions; and the CHaD Pediatric Lipids Clinic continues to care for children with weight-related conditions. CHaD clinics continue to provide educational materials for parents and communities related to healthy diet and physical activity.	Pilots of 'prescription' produce and physical activity have been implemented by D-HH system members. D-H supported summer feeding programs operate in Lebanon, NH & Hartford, VT. Clinic-based 'emergency' food strategies are in start-up stages at Heater Road and Pediatrics in Lebanon. D-H has not institutionalized its efforts in these areas, resulting in some fluctuation of support, staff engagement, and continuity of effort. The D-H Weight and Wellness Center and the CHaD Pediatrics Lipid Clinic provide well-established services to address weight, nutrition, and physical activity as a means to reduce health conditions affected by overweight and obesity. The work of the Upper Valley Healthy Eating Active Living Partnership ended following the termination of D-H staffing to lead that partnership.	Summer food programs have been well-utilized in Lebanon and Hartford and meet a clear need defined by school and community leaders. Use of hospital land to grow produce for food pantries is a novel practice. D-H funded projects at New London Hospital and APD have been well-utilized and demonstrate positive short-term results. More research is needed to evaluate long-term impacts of these programs. D-H's Weight and Wellness Center and CHaD Pediatric Lipids Clinic use evidence-based approaches to reduce weight and treat weight-related conditions, and offer opportunities to advance knowledge in this field.	D-H uses community benefits support community & clinic-based food initiatives. Current efforts are sustainable, but growing them to our whole D-H system will need philanthropy or new payment models Clinical operations to address weight and weight-related conditions have payer mechanisms that will ensure continued services.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Decrease Preventable Cancers and Improve Support and Wellbeing of Patients and Family Members Affected by Cancer	D-H has a strong and continuing program to provide support to people affected by cancer: • # people participating in cancer-related educational classes: FY17 1,535; FY18 1,615 • # people with financial barriers who receive support for colorectal cancer screening: approx. 48k annually D-H, as part of Norris Cotton Cancer Center, continues to offer a wide array of support services to patients and family members affected by cancer. These support services include information via help lines and the lending library, a range of patient support groups, educational and wellbeing classes, comfort care programs (e.g. gas cards, hat donations, reiki, etc.), creative arts, and other special events. As per our FY17-FY19, D-H has continued these services at consistent levels of activity. D-H leads the New Hampshire Colorectal Cancer Screening Program (NHCRCSP) as part of the Centers for Disease Control and Prevention Colorectal Cancer Control Program. NHCRCSP works with partners to improve the rate and quality of colorectal cancer screening. The Geisel School of Medicine supports additional cancer prevention, education, outreach, and other services as part of services offered at Norris Cotton Cancer Center. Because these services are provided through the Geisel, Dartmouth-Hitchcock considers these needs to be met through the activities of Geisel.	A well-established set of cancer support services is available at our Lebanon campus, as well as through telephonic and other virtual approaches to reaching possible participants. D-H works with FQHCs and hospitals clinics in seven of 10 NH counties to implement colorectal cancer screening activities.	Support services offered by D-H are consistent with those offered at other Comprehensive Cancer Services, and are based in established methods for helping patients and family members cope with the impacts of cancer; improve comfort of care; and mitigate negative side effects associated with cancer treatments. NHCRCSP uses evidence-based approaches to help partners scale up screening and provides training and education to providers and clinic staff.	D-H has made a long-term commitment to these support services and will continue these services into the foreseeable future. D-H's colorectal cancer screening work is largely funded by a CDC grant that will be resubmitted in FY20. D-H will continue to implement effective strategies to increase screening rates and quality.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Continue Maternal Child Health Programs; Supports for Children and Families during Hospitalization; and Supports for Specialized Health Concerns of Children and Families	D-H continues to offer a wide of array of services to support healthy growth and development of children and their families and to provide focused supports for children with specialized health needs: • # of patients seen for specialized need: FY17 10,865; FY18 10,3014 • # children served by Children's Advocacy Program: FY17 343; FY18 341 As per our FY17-FY19 plan, we have maintained services that support healthy child and supports for children with specialized health needs. CHaD's Child Life Program, provides consultation and case management services for children with specialized health needs. These services allow children to receive better clinical care, and participate more fully in their home, communities, and schools, while managing serious health issues. We continue to operate Molly's Place at DHMC, providing a place for families and children to play, relax, obtain financial help with transportation & other needs, and to learn about their child's health care. The Boyle Pediatrics Program engage Pediatric Residents in community organizations as part of their medical training to broaden their understanding of how community conditions impact child health. D-H's Women's Health Resource Center continued providing programs and classes that support maternal-child connection and healthy parenting; and also provides tangible assistance, such as a diaper bank, car-seat fitting, food support, and other basic needs. Our Children's Advocacy and Protection Program provides specialized services for children & families who have experienced sexual & physical abuse. The program partners clinical experts with families, police, and child protection partners to improve care for these children & families. CHaD's Injury Prevention Center provides consultation to statewide injury prevention efforts, including educational campaigns such as the Period of Purple Crying; serves on statewide suicide prevention work teams; and supports youth bike and walking programs throughout NH. CHaD Pediatric sites are beginning to incorporate Social Determinants of Health screening, and have incorporated behavioral health screening of adolescents (DartScreen) at most CHaD locations.	The capacities described here (Child Life, Molly's Place, Boyle Pediatrics, Women's Health Resource Center, Child Advocacy and Protection Program, and Injury Resource Center) have strong operational support, including established staffing and supervision structures, funding streams, and well-developed services. Most of these services are based at CHaD's Lebanon hospital location. Many extend their services to other parts of NH through telephonic/telehealth type capacities; Child Life services may travel to a child's home community or sponsor care coordination consults with rural health providers. The Injury Prevention Center participates in statewide injury prevention work teams, including suicide prevention and falls injury prevention task forces. The Children's Advocacy & Protection Program has numerous MOUs with external partners to define its operations and role as part of a multi-stakeholder approach to caring for children affected by sexual assault and violence.	These services use well-established approaches, based in evidence, clinical expertise, and best practice. The Children's Advocacy and Protection Program services meet researched national standards for these efforts; staff are highly trained and supervised with regular review of operations to ensure the highest standards of operation are followed. Injury Prevention Center programs apply the science of injury prevention in the context of state and community data regarding common injuries to recommend and implement prevention programs and state and local policies. Financial assistance to patients and families follows well-established policies and practices.	D-H has made a long-term commitment to these support services and plans to continue these services into the foreseeable future. CHaD has a robust Philanthropy team and has demonstrated success being able to attract philanthropic funding to support many of these initiatives. Because these efforts are almost entirely supported through philanthropy and contracts, these programs face modest vulnerability to funding reductions.

	Reach & Effectiveness	Adoption	Implementation	Sustainability
Support Development of Community Health Capacities in D-H System and in Communities Served by D-H	D-H continues to support, lead, and grow numerous community health coalitions/partnerships: • # early care staff trained in trauma-informed early care: FY18 112 • # vaccinated in school flu clinics: 1,496; FY18 2,360 ; FY19 2,594 • # lbs syringe waste safely collected in communities: FY18 125lbs • # PCW members serving as Community Ambassadors: FY19YTD 43 In FY17-FY19, D-H continued to hold Region Public Health Network contract for the Upper Valley and Sullivan Co. regions, developing multi-agency public health, substance use prevention and substance use disorder system of care coalitions. In FY17-FY19, these Councils initiated work to prevent falls, lead poisoning, child trauma, and suicide; initiated safe syringe & medication disposal efforts; and many other projects. D-H staff led emergency preparedness in each region, and organized school-based flu clinics, growing the # of participating schools and # of children vaccinated. In FY17-FY19, D-H and Cheshire Medical Center formed and led the NH Region 1 Integrated Delivery Network (IDN), a multi-partner effort to improve behavioral health, which has supported integration efforts in primary care practices in west-central NH. In FY19, D-H obtained NH funding to start and operate a regional 'Hub' for NH's response to opioids and state-wide after hours call center. The D-HH Population Health Council ended in FY17, and was succeeded in FY19 by the Regional Primary Care and Community Health Committees. Both teams set D-HH priorities during FY19. Partners in Community Wellness (PCW) reorganized in FY19, including training members as community Ambassadors and as advocates for public policies that support health and well-being. D-H conducted a new Community Health Needs Assessment (CHNA) in FY19, with several other D-HH system partners; we engaged 2,000+ community and 150+ key stakeholders, hosted 14 focus groups, and reviewed 50+ public health data elements to complete this assessment. In addition, D-H also completed a FY17 regional Behavioral Health Needs Assessment.	D-H operates well-established public health, substance use prevention, and public health emergency preparedness councils in the NH-Upper Valley and Greater Sullivan Co. regions, and has committed staff and supervisory capacity to support this work. The Region 1 IDN has well-established policies and practices for decision-making and employs staff to lead IDN initiatives. Implementation teams are formed in each clinical practice to lead this work. D-H Population Health provides staff support for the D-HH Regional Primary Care and Community Health Committees. These committees. PCW efforts are guided by an Executive Team and by D-H staff. Ambassadors and Advocates coordinate efforts with D-H leadership. There is a well-established and documented process for conducting robust CHNAs and follow-up assessments in our region.	D-H's Public Health region leadership activities follow state-established practices and report regularly to the state of NH on activities. D-H's staff help these coalitions increase use of data & evidence to inform decisions and activities. IDN projects include evidence-based options. D-H staff leading the IDN use quality improvement and micro-systems approaches to inform and guide IDN work. PCW is increasingly aligning its work with existing D-H processes, such as informing CHNAs, and Community Health Committee work; and working with D-H Government Affairs on advocacy opportunities. D-H uses common CHNA tools and approaches, including contracting with a consultant with expertise in community assessment, to improve the quality and usefulness of CHNAs and other assessments.	These efforts are maintained with D-H operational funds, state contracts, and philanthropy. The State of NH indicated strong support for continuation of Public Health Networks. We anticipate continuation of these efforts. IDN funding in NH ends in December 2020, threatening sustainability. We are likely to continue integrated care in D-H clinics, but non-D-H practices will face serious cost challenges. PCW has established executive team and staff support and current activities are well aligned with ongoing D-H initiatives. CHNA activities are required by law and will continue. The current structure for CHNA completion is well-documented and should be sustainable with existing staff.