

Community Health Improvement Plan 2023-2025

Introduction

In response to a growing awareness about unjust differences in health outcomes between and within the communities we serve, Dartmouth Health has an increasing emphasis on health equity. In 2022, we launched the [Center for Advancing Rural Health Equity](#) to help identify causes of health disparities and develop solutions together with community partners. As part of these efforts, we will strive to incorporate principles of justice, equity inclusion, and belonging in all our Community Health Improvement Plan strategies.

We recognize that various population groups—whether defined by geography, race, ethnicity, age, income level, insurance status, or other factors—have different levels of access to health care and social services, have different experiences when it comes to utilizing health care, and have unique perspectives on health needs. We also know that there are nuances in how people and communities prioritize health needs that may not come through in our Community Health Needs Assessment. We will continuously work in our communities to understand barriers to optimal health across the diverse populations we serve.

Therefore, we will aim to bring a health equity lens to each of the strategies and programs detailed in the following pages. This will include efforts to collect demographic data, such as Race, Ethnicity, and Language (REaL) data, and to stratify outcomes across subpopulations in order to improve our understanding of where health disparities exist and the needs of underrepresented populations. We will also engage community members who may traditionally have faced barriers to having their voices heard in the design, implementation, and evaluation of Community Health programs.

Working in partnership with the community is a critical part of our Community Health Improvement Plan. Ultimately we aim to align the power of the academic health center with the wisdom of the community and collaboratively tackle community health challenges, ensuring our work positively impacts people in greatest need.

Sally Kraft, MD, MPH
Vice President, Population Health



Regulatory requirement

This plan meets Dartmouth Hitchcock Medical Center's 501(r) regulatory obligations to document how we plan to address the health needs of the communities in our hospital service area. It details the action we will take to address the needs identified in our [2022 Community Health Needs Assessment](#).

Improve access to care

Responding to the following community-identified concerns:

Accessibility of

- Mental health services
- Substance misuse prevention, treatment and recovery services
- Dental care

Cost of

- Health care services
- Prescription drugs
- Health insurance

Baseline

Poor mental health days (average number of mentally unhealthy days reported in past 30 days, age-adjusted)

Windsor County 4.4
Grafton County 4.6

Dentist ratio

Windsor County 1617:1
Grafton County 1193:1

Number of drug overdose deaths

Windsor County 70
Grafton County 47

Percent of adults who report having a personal doctor or health care provider

Vermont 86%
New Hampshire 88%

Improvement strategies

Focus on population oriented prevention

- Reduce access to lethal means
- Support regional capacity for dental hygienist in community setting
- Maintain overdose harm reduction efforts including naloxone and fentanyl test strip community distribution

Support community capacity

- Provide financial contributions to safety net oral health, healthcare, mental health and community in-home care/mobile programs
- Provide financial and technical support to SUD tx system providers, with special support to treatment services for pregnant and parenting persons
- Continue funding to safety net senior services to support senior transportation, home delivered meals and case management

Remove barriers to care for underserved populations

- Provide financial assistance to qualifying patients
- Continue to develop telehealth capacity
- Provide Medication Assistance Program services to qualifying patients
- Maintain and grow capacity to provide behavioral health and MAT care as part of DHMC primary care (Collaborative Care)

Positively impact social drivers of health

Social drivers of health include:

Food, housing, transportation, employment, financial stability

Baseline

% of population who lack adequate access to food (food insecurity)

Windsor County 10%
Grafton County 10%

Spend 50% or more of household income on housing

Windsor County 15%
Grafton County 11%

Improvement strategies

Focus on population oriented prevention

- Provide Community Health Worker (CHW) services at DHMC Primary Care Clinics and support CHW-like services in other community organizations
- Support stable housing and strengthen community capacity
- Pilot supportive hiring pathways for special populations

Support community capacity

- Contribute to supported, workforce and low-income housing projects in DHMC communities
- Subsidize public transportation and senior transportation systems
- Develop the [Center for Advancing Rural Health Equity](#)

Remove barriers to care for underserved populations

- Provide shelf-stable food bags for patients experiencing food insecurity
- Contribute to community-based summer meal programs in the Upper Valley
- Continue Boyle Pediatric Resident rotation to community-based locations and BPR advocacy initiatives

Support cancer care and treatment

Areas of focus include:

Patient and family support services

Preventing youth tobacco use and vaping

Baseline

% of women who have received a mammogram in the past two years, ages 50-74

Vermont 74.74%
New Hampshire 78.48%

% of adult smokers

Windsor County 16%
Grafton County 16%

% of high school students who currently use electronic vapor products

Windsor County 15%
Grafton County 11%

Improvement strategies

Focus on population oriented prevention

- Continue to offer school and community trainings on vaping and tobacco use prevention
- Reduce access to underage vape products through coordination of tobacco and vaping compliance checks at retail outlets
- Utilize social media and web-based health targeted outreach and education about colorectal screening, prioritizing rural areas

Support community capacity

- Collaborate with local partners to develop and implement multi-pronged health promotions campaign about lung cancer and screening
- Optimize clinical practices of care and collaborations with communities for lung cancer screening

Remove barriers to care for underserved populations

- Continue tobacco cessation via telehealth
- Continue support of Cancer Help Line, connecting patients to resources and support services
- Provide tailored food/nutrition support to food insecure patients participating in care for cancer
- Support screening efforts at lung cancer screening centers by addressing transportation barriers
- Continue [Cancer Center Complementary Care Program](#) virtually to include classes, support groups and events to improve wellness during cancer treatment

Strengthen and support vulnerable populations

With a focus on:

Preventing child abuse and neglect

Healthcare for the aging

Maternal and child health services

Baseline

Percent of adults ages 65 and older who reported falling in the past 12 months

Overall U.S. 27.1%
Vermont 31.1%
New Hampshire 28.5%

Percent of children in poverty

Windsor County 9%
Grafton County 11%

Percent of low birthweight deliveries

New Hampshire 6.5%

Improvement strategies

Focus on population oriented prevention

- Continue to offer hybrid health education and support for older adults and caregivers at [Aging Resource Center](#)
- Host evidence-based practice, [Circle of Security](#) parent training, utilizing regional partnerships

Support community capacity

- Contribute to Family Resource Centers and NH Children's Fund
- Facilitate train-the-trainer for Circle of Security program across community partners
- Facilitate development of improved service networks for maternal care in northern New Hampshire
- Continue [Project Launch](#)/wrap-around care for families affected by parental substance use

Remove barriers to care for underserved populations

- Continue geriatric emergency department services
- Support Medical Legal Partnership to address health harming legal needs for families impacted by substance use disorder
- Connect pregnant and parenting families to home-visiting programs
- Improve community referral network to facilitate earlier entry to care for pregnant persons with substance use disorder

Supporting strategies

**Improve
access
to care**

Focusing on population oriented prevention	Supporting community capacity	Removing barriers to care for underserved Populations
<ul style="list-style-type: none"> • Organize and support Mental Health First Aid and Connect Suicide Prevention community trainings • Facilitate school-based dental clinics in the Upper Valley and Sullivan County • HRSA grant for Behavioral Health workforce development/training/mentoring • Support COVID-19 vaccination clinics • Support public flu vaccination clinics 	<ul style="list-style-type: none"> • Contribute to and support local syringe services programs • Support safe syringe disposal in Upper Valley and Sullivan County • Support Thrive Youth Recovery Resources and mentoring program in Sullivan County • Facilitate regional SUD Continuum of Care teams in Upper Valley and Sullivan County 	<ul style="list-style-type: none"> • Expand SUD/BH screening to all pediatric, primary care and OB/GYN practices • Continue to provide gas cards for patients treated at the Cancer Center and CHaD • Continue and subsidize DHMC Addiction Treatment Program • Continue and subsidize Inpatient Behavioral Health Services • Expand Collaborative Care Model in Primary Care, including support for alcohol and opioid use disorders • Continue to improve our ability to assist patients with their non-clinical health needs through investments in the community, community partnerships, and optimizing the role of our CHWs. • Provide medication for OUD for the uninsured through the CTN 100 study • Maintain Recovery Coaches in Emergency Department, Addiction Treatment, Moms in Recovery and Psychiatry • Maintain embedded Psychiatry care for mental health concerns at Addiction Treatment Program • Support recovery-friendly, trauma-informed pediatric practices • Provide psychiatric evaluations for asylum seekers • Contribute leased land to David's House to support housing needs of families with hospitalized children

Positively impact social drivers of health

Focusing on population oriented prevention

- Grow fresh produce for the community through the Farmacy Garden in partnership with Willing Hands
- Provide culinary medicine classes

Supporting community capacity

- Continue Boyle Pediatric Community Grants supporting family-centered care projects to improve the health and well being of children and families
- Contribute to safety net food services supporting the Upper Valley

Removing barriers to care for underserved Populations

- Provide healthy food prescriptions for pediatric patients and their families
- Provide farm shares for patients in multiple clinics
- Continue Tipping Point Grants for families experiencing acute financial expenses
- Continue to distribute food vouchers for families receiving CHaD inpatient services
- Continue to support Heater Road Resource Room for primary care patients
- Maintain the embedded resource specialist position at Addiction Treatment Program

Support cancer care and treatment

- Provide tailored information to patients about local available resources to address barriers to screening
- Collaborate with a coalition to develop provider and community-level training programs about lung cancer screening

- Continue Patient and Family Resource Lending Library
- Continue distribution of Hematology/Oncology discretionary patient assistance funds for food, gas and utilities

Strengthen and support vulnerable populations

- Continue use of the Early Childhood Wellbeing screening, including maternal depression and Social Determinants of Health
- Continue use of SBIRT screening for ages 12 and up
- Provide trauma-informed care trainings for early childhood providers/ professionals
- Maintain the Injury Prevention Center's infant and young child safety programs

- Support Women's Health Resource Center classes and services
- Continue to support Molly's Place with shared strategies that align and enhance clinic and community partnerships and resources

- Maintain CHaD Family Center services, including parent support services, case management and financial supports for transportation, crisis food and other maternal supports during hospitalization
- Offer tech support for older adults through the Aging Resource Center
- Continue DHMC providers' in-home care of homebound patients
- Continue partnership for medical oversight with assisted living and long term care facilities