Introduction:

The FY22 CHNA developed collaboratively by NMC and partners was an inclusive process that focused on gathering information about the health needs of our community by employing different methodologies, including focus groups, key informant interviews, and a broad community survey. The data was collected and analyzed using the Health People's 2030 Social Determinants of Health Domains. The top 4 Community Health Needs are:

- Access to Care
- Affordability
- Community Gathering and Connectedness
- Safety and Belonging

Background:

In selecting the priorities for this year's CHNA, we organized the data in underlying broad themes that emerged in the various data collection methods we employed. The committee then presented the themes, definitions, and data points to the public at over 10 community events throughout Grand Isle and Franklin Counties, as well as gathering feedback in an online survey tool to gather input on and prioritize the themes.

Implementation Plan Process:

The implementation plan was developed by conducting interviews with various department leaders at NMC to better understand the work that is currently happening at the hospital to address the needs of our community members, as well as identify what opportunities for action they are exploring or considering. In addition, because the impact the findings have on our community members and in recognition that NMC is not alone in being able to address the needs of our community, we organized a broad stakeholder event to gather information from individual organizations about their work in the four priority areas, as well as understand opportunities for action or existing initiatives that broad coalitions of stakeholders could address together. The implementation plan is organized in 3 sections:

1. Section 1: Northwestern Medical Center's individual initiatives that are currently underway and identified opportunities for action.
2. Section 2: Community partners' individual initiatives that are currently underway in their organizations.
3. Section 3: Joint initiatives that could be addressed by a broad coalition of community organizations and members.

Centering Health Equity in this work:

It is important for us to understand that certain populations of people do not experience the systems of care in our community the same way as others do. It is imperative that we address the health inequities that are the result of structural barriers including: racism, economic opportunity, and the social determinants of health (Fig. 1).

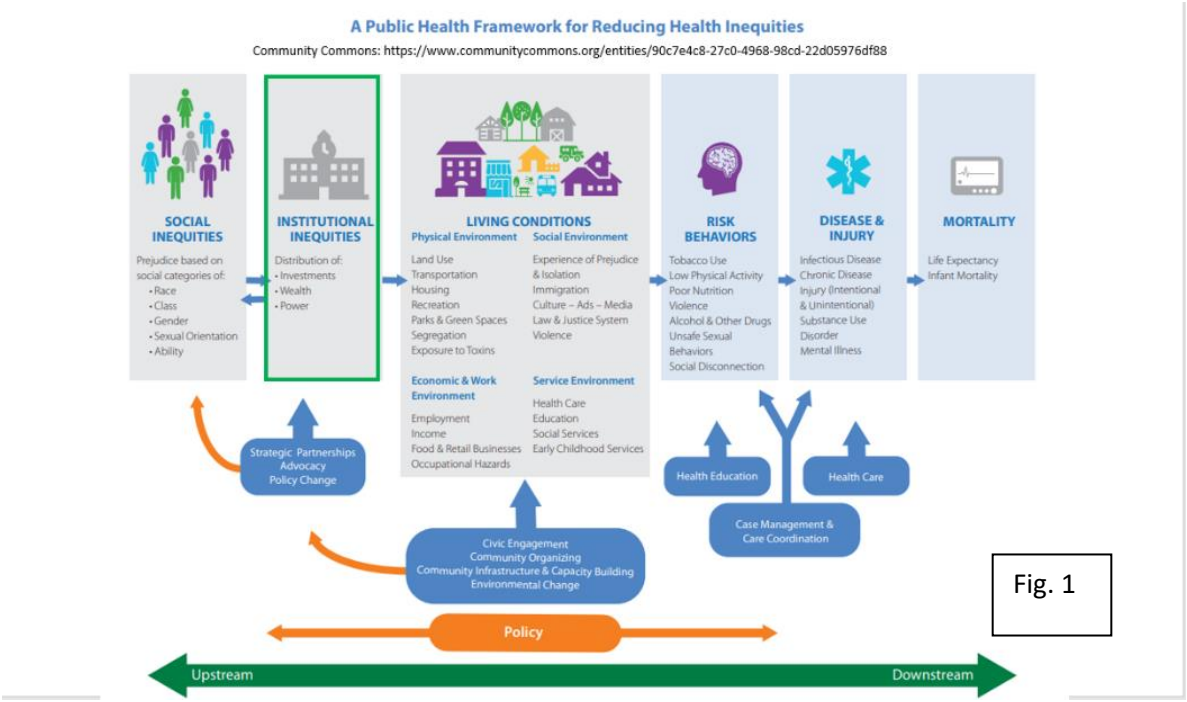
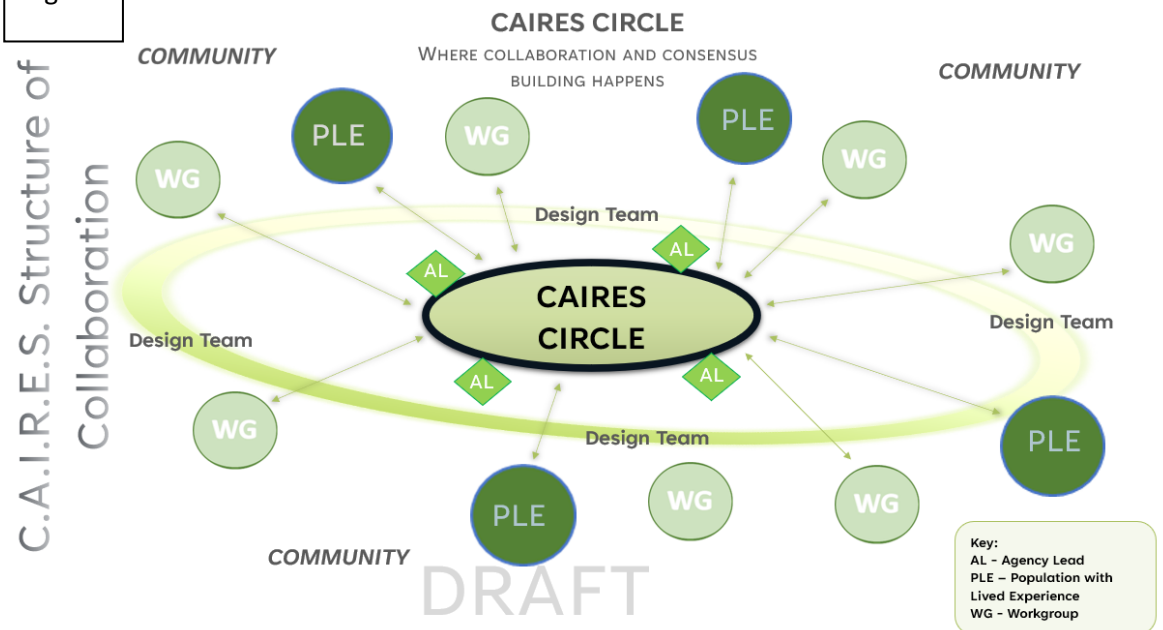


Fig. 1

To do this, we must dismantle the hierarchical systems, beliefs, and norms that created these conditions. The design of the Grand Isle and Franklin County CAIRES Accountable Community for Health has created a community collaborative that is founded in the principles of equity with tenants of decentralized decision-making, centering community participation and voice, and providing equitable access to collaboration (Fig. 2).

Fig. 2



Section 1: Northwestern Medical Center's individual initiatives that are currently underway and identified opportunities for action:

Access to Care: Equitable access to care by being able to access the right care, including social services, at the right time in a culturally appropriate and person-centered way, *no matter who you are.*

What NMC is Doing:	➢ Investing in our workforce to attract and retain employees that deliver care in our community. ie. LNA to RN Program, retention bonuses, education incentives. ➢ Supporting individuals in finding a Primary Care Provider through information for inquiring community members and inpatients who present without one. ➢ Translating Consent Form into French and Spanish, so people who have a different preferred language can read and understand it. ➢ Improving access to care in our community by providing tele stroke and pursuing stroke accreditation. ➢ Addressing Throughput to take care of patients in the right place/time, leading to greater access to hospital beds. ➢ Improving access to mammograms by expanding service.
What NMC is Pursuing and Exploring:	➢ Continuing to increase access to local specialty care services in our community, including cardiology, midwifery, physical medicine & rehab services, inpatient pediatrics, tele-neurology, urology, etc. ➢ Providing access to care that is culturally appropriate and person-centered to meets the needs of all people. ➢ Improving the process to access interpreter support within NMC's practices and services.

Affordability: Rising prices including gas, groceries, day care, housing, health care insurance premiums, and the cost of healthcare are forcing people to make choices between basic needs and accessing healthcare.

What NMC is Doing:	➢ Providing the public with proper pricing transparency and a cost estimator for services on our website in alignment with the Price Transparency Act and the Good Faith Estimate Act passed in 2021. ➢ Working to contain rate increases year over year to keep costs affordable while remaining sustainable for access. ➢ Providing fair, equitable wages for the market to recruit/retain staff and reduce costly reliance on travelers. ➢ Providing guidance to patients who are eligible to enroll in Dr. Dinosaur and Medicaid by our certified assisters through VT Health Connect. ➢ Identifying if patient's preferred language is non-English so we can we translate their bill into their preferred language.

	➢ Supporting individual patient needs through the NMC Community Fund and in partnership with the Jim Bashaw Fund to help patients access resources for medically necessary items to support their health.
What NMC is Pursuing and Exploring:	➢ Updating our Free Care / Charity Care policy in light of proposed legislation within Vermont to ensure we continue to meet the provisions of the law once enacted. ➢ Continuing to improve the proactive offering of financial counseling/supports to patients pre-service. ➢ Continuing to work with our community in implementing the State's value-based care model to reduce health care costs, improving patient experience, increasing equity, and improving population health.

Community Gathering and Connectedness: Feeling connected to place and community through the arts, cultural events, accessible transportation, community input and gathering, and public recreation spaces.

What NMC is doing:	➢ Implementing a Patient Family Advisory Council (PFAC) to provide more and direct opportunity for reflection on our care delivery system and improvement at NMC. ➢ Providing ongoing community health and wellness education and outreach, including offerings through Vermont Blueprint for Health and NMC provider/staff hosted "lunch and learns", etc. ➢ Participating in the collaborative work of the Accountable Community for Health CAIRES Circle and the ongoing work of NMC's Population Health department.
What NMC is Pursuing and Exploring:	➢ Engaging in opportunities to promote community activities and resources that bring people together, foster belonging, and improve the overall quality of life. ➢ Determining the post-pandemic use of NMC conference rooms by community groups when not in use for hospital trainings, meetings, and events. ➢ Exploring opportunities for continued alignment and partnership with local public transportation providers.

Safety and Belonging: Physical and emotional safety in the community, including neighborhoods, schools, institutions, and family structures. Accepting and celebrating differences and embracing belonging.

What NMC is doing:	➢ Formally advancing Diversity, Equity, and Inclusion throughout our organization – leveraging measurable improvement as both a provider of care and an employer, as per this component of NMC's '22-24 Strategic Plan. This work may well inform and prompt new initiatives and

	areas of emphasis for NMC in all aspects of the response to the CHNA. ➢ Modernizing the Emergency Department to improve safety, privacy, and care, including the provision of private rooms for emergent patients; the enhancement of negative air capabilities for infection prevention; and the enhancement of the care environment for patients at risk of harming themselves or others. ➢ Conducting Health Related Social Needs (HRSN) screenings in the PCU to better be able to assess, refer, and stratify our patient's needs and have a better referral process and wrap around services. ➢ Making NMC safer for staff – and patients and visitors - by proactively avoiding incidents of workplace violence and decreasing incidents of verbal assaults through use of an evidence-based approach and tool kit. ➢ Continuing NMC's High Reliability journey with emphasis on eliminating preventable harm to patients through evidence-based strategies.
What NMC is Pursuing and Exploring:	➢ Improving collection of gender/identity at Registration and standardize within Electronic Health Record to properly identify patients with their preferred pronouns, sex assigned at birth, legal sex, and their preferred name identification. ➢ Gathering and appropriately sharing data about physical and sexual assaults to help inform the work of and with community partners. ➢ Creating safe spaces by having opportunities for modeling our differences as staff, medical staff, and administration, drawing guidance from our DEI work, which could include encouraging pronoun usage in our communications, showing support through intentional actions, posting "welcome" in different languages, etc.

ACCESS TO CARE

Equitable access to care by being able to access the right care, including social services, at the right time in a culturally appropriate and person-centered way, *no matter who you are.*

AFFORDABILITY

Rising prices including gas, groceries, day care, housing, health care insurance premiums, and the cost of healthcare are forcing people to make choices between basic needs and accessing healthcare.

COMMUNITY GATHERING & CONNECTEDNESS

Feeling connected to place and community through the arts, cultural events, accessible transportation, and public recreation spaces.

SAFETY & BELONGING

Physical and emotional safety in the community, including neighborhoods, schools, institutions, and family structures. Accepting and celebrating differences and embracing belonging.

Section 2: Community partners' individual initiatives that are currently underway in their organizations.

Below is an inventory of some of the work being done by our community partners to address the identified community health needs. This is not an exhaustive list of all of the initiatives occurring in our community. This is a working document and is subject to change more initiatives and groups are identified.

Create a community mapping project to identify resources, gaps, and greatest leverage points.

List of Community Partners – Please note this is a working document and not all partners have been listed or identified.

Northwestern Counseling and Support Services	Voices Against Violence | Laurie's House
Northwestern Medical Center	The Sheldon Food Shelf
AgeWell	Franklin Grand Isle Community Action
The Samaritan House	United Way of Northwest Vermont
St. Albans Primary Care	My Healthy VT
SASH	Franklin County Industrial Development Corporation
Franklin West Supervisory Union	Abenaki Nation of Missisquoi
Howard Center	Franklin County Home Health
Franklin-Grand Isle Tobacco Coalition	Caring Communities
Vermont Department of Health | District Office and Self-Management Programs	Northwest Regional Planning Commission
Franklin County Home Health Association	Suncrest
Monarch Maple Pediatrics	Cold Hollow Family Practice
Outpatient Medicine Service Committee	OneCare
Bi-State	Franklin Grand Isle Prevention Coalition
Rotary International	Savida
University of Vermont Extension Services | Migrant Farm Workers	

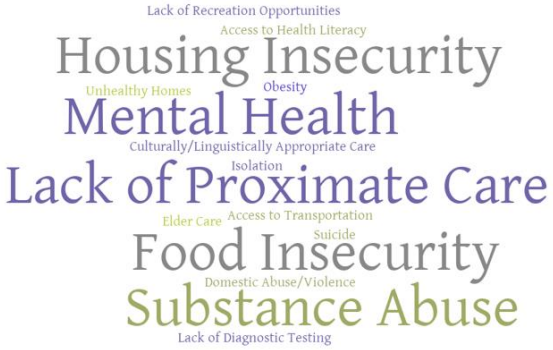
Access	➢ The United Way of Northwest Vermont is investing resources in supporting a mental health initiative that will expand capacity to services in our region. ➢ The Howard Center has open office hours in the morning for anyone who would like to explore substance use treatment options that is judgement free, as well as a mobile unit to support people in the community.

	➢ Primary Care with the support from Blueprint and NCSS has embedded RN Care Coordinators, Behavioral Health Workers, and Community Health Workers in Primary Care Practices across the region. ➢ NOTCH has offices in multiple communities throughout the region and is partnering with the Turning Point to offer recovery coaching in Alburg by providing a co-locating staff in their clinic. ➢ The ACO is working to provide improved data on diversity to help facilitate quality improvement processes around healthcare outcomes. ➢ VDH provided community-based immunization clinics to migrant farm workers and at the Abenaki Tribal Council in Swanton. ➢ Department of Substance Use has rolled our rapid access to treatment for both opioid use and alcohol use disorder, as well as funding to support the Recovery Coaches at the ED. ➢ St. Albans Primary Care is doing same day appointments and providing evening appointments 3 nights/week. ➢ NCSS is exploring Community Health Workers program as an essential part of their care delivery team and have implemented "Open Hours" to allow for same day access.
Affordability	➢ United Way's Working Bridges Program that works directly with employers to support employees experiencing financial, medical, or social needs. ➢ WIC provides formula and food to families in need. They are working on increasing access to culturally relevant nutritional foods in our region. ➢ University of Vermont Extension Program provides support to migrant families applying for health insurance and financial aid. ➢ OneCare is exploring payment reform for primary care model to support value-based care and make it more affordable for patients. ➢ CHEP grant was given to Health Roots Collaborative to increase storage capacity to improve distribution of gleaned products to community organizations throughout the region. ➢ The NOTCH, our largest provider of primary care in our region has a sliding scale payment system. ➢ Free access to immediate behavioral health/mental health for children through the Blueprint at Monarch Maples. ➢ CVOEO, Healthy Roots Collaborative, Franklin Grand-Isle Hunger Council, NOTCH, and others are working on addressing food insecurity in our region.

	➢ Franklin Grand Isle Community Action supports weatherization, housing navigation, financial futures, homelessness prevention, and benefits navigation.
Community Gathering and Connectedness	➢ The Community Partnership is an active and resilient community group that convenes monthly and provides insights, information, collaboration opportunities, etc… ➢ The St. Albans Rotary Interact Youth Group provides volunteerism for local youth. ➢ Caring Communities is leading efforts with Vermont Teen Institute and Junior Teen Institute. ➢ Northwest Vermont Regional Prevention Collaborative. ➢ Swanton Arts Council. ➢ New pool at Hard'Ack. ➢ Recreation Department programming. ➢ Outreach and education to kids about substance misuse. ➢ Afterglow Event at Hard'Ack focused on messages about suicide prevention. ➢ St. Albans Walk and Bike Committee. ➢ Music in the parks. ➢ Farmer's Markets in communities. ➢ VDH is piloting a project that will improve health inequities through the built environment. ➢ Local Motion is funding a part time Safe Routes to School Coordinator in our region who is supporting the work local groups looking to increase safe, walkable, and bikeable communities. ➢ NOTCH Grocery Store in Richford.
Safety and Belonging	➢ NCSS has integrated the use of pronouns into their culture to improve a sense of belonging for all individuals. ➢ Spectrum Youth Center in St. Albans provides a safe, judgement free zone for youth. ➢ Howard Center has a Public Inebriate Program that provides a safe place for someone to detox. ➢ VDH hired a Spanish speaking breast feeding counselor to support migrant mothers in our region. ➢ CHEP Grant to support the design and construction of the Abenaki Nation of Missisquoi food shelf. ➢ WIC supporting and expanding community-based nutrition education and training. ➢ St. Albans Primary Care provides a Facebook page for diabetic support group and is pursuing other health groups and supports patients with Health Bank News and Portal. ➢ The Franklin West Supervisory Union has a Racial Justice Alliance.

	➢ Franklin Grand Isle Community Action has a community closet, free store, and an accessible food shelf. ➢ Voices Against Violence has a drop-in center and provides a safe shelter from domestic and sexual violence. ➢ NOTCH Summer camps in Swanton and Richford.

Challenges to achieving health and wellbeing



Section 3: Joint initiatives that could be addressed by a broad coalition of community organizations and members.

In addition to working on initiatives as individual organizations, by working together the community has identified more complex strategies that need a broad coalition of organizations and people to solve them. Some of this work is already underway, some of it is in development, and some of it needs to be addressed. Through the development of the CAIRES ACH, the identified needs below could have a structure in which to expand and connect the work to multiple resources and stakeholders. The section below has been drafted to provide context and information on the issues identified by the community in the CHNA data collection phase, as well as provide some draft strategies and identified partners. This is a working document and needs to be reviewed, assessed, edited, and expanded upon by the broader community of stakeholders doing this work.

ACCESS

- ✓ **TRANSPORTATION was identified as the number 1 reason people are unable to access health and human services in our region. It came up in all the methodologies we used to gather information about our Community Health Needs. Prior to the pandemic there was an attempt to bring multiple stakeholders together to discuss this important issue impacting the health and wellbeing of our community.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
The lack of accessible, reliable, flexible transportation in our region causes individuals to miss medical appointments, not be able to access social services and basic needs and is resulting in lost revenues and increased costs. In addition, workforce transportation is an issue impacting employers being able to hire staff.	✓ Bring a broad coalition of stakeholders together to define the problem and identify the barriers and complete a root cause analysis. ✓ Examine how other communities in Vermont are addressing this issue. ✓ Identify current solutions that are being explored. ✓ Develop creative strategies with braided funding to support systemic change in transportation delivery services in our region.	Abenaki Nation of Missisquoi GMTA CIDER VDH FCIDC NRPC NMC Transportation insecure community members MEDICAID Transport Porter Medical Center Suncrest VTRANS GO Vermont UWNWVT

- ✓ **<u>WORKFORCE SHORTAGES</u> were quickly identified as a key barrier to care impacting the hospitals' ability to discharge patients to the next level of care required and even impacting our ability to provide care in all our organizations.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
Workforce challenges post the pandemic are causing shortages in every industry in our region, including health care and human services. This is resulting in an access issue affecting individuals in need of services.	✓ Work with FCIDC who are creating a multi-sectoral committee to address workforce challenges in our region. ✓ Identify opportunities to partner with training centers and local colleges. ✓ Continue to identify ways to support employees by offering programs like Working Bridges and EAP.	FCIDC Tech Centers CCV Vermont Technical College High Schools Vermont Adult Learning Suncrest NCSS FCHHA NRPC Other Businesses UWNWVT

Of note: the results from our CHNA and community process highlighted the lack of access in our region specifically to **youth mental health services and understanding, primary care and pediatric appointments, durable medical equipment, reproductive and gender affirming care, and long-term care.** The reasons for the lack of access vary however are tied to workforce shortages and the closure and transfer of businesses in our region. The CAIRES ACH may begin to address these and explore short and long-term solutions through various workgroups, including the United Way of Northwest Vermont's Mental Health Initiative, the Transitions of Care Committee, and The Family and Child Wellness Partnership.

Community Survey

AFFORDABILITY

- ✓ **<u>CHILDCARE AND ELDERCARE</u> came up frequently when we inquired about affordability and what was causing financial stress to family budgets.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
These services have been stressed for some time and changes in regulations and statewide delivery goals, as well as broken financial models, including Medicaid staffing reimbursements have caused unintended impacts resulting in further closures and affordability issues for families to be able to access childcare and eldercare services and housing. This is compounding the workforce shortage issue, as people who deliver care to young children and aging family members are often unable to also seek gainful employment.	✓ Continuation of quarterly meeting with the state and regional LTCF, home health, and our partners to understand barriers and constraints to eldercare. ✓ Statewide initiative to provide state funding for high quality day care that is affordable and accessible to all.	✓ Building Bright Futures ✓ AgeWell ✓ Home Health ✓ DAIL ✓ Suncrest ✓ NCSS Department of Family and Children ✓ Federal Delegation ✓ State Legislators ✓ UWNWVT ✓ FCIDC ✓ NRPC ✓ Abenaki Nation of Missisquoi

- ✓ **<u>HOUSING</u> continues to be a complex problem that needs multi-pronged solutions.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
Lack of safe, affordable, and accessible housing causes multiple downstream impacts on our population health outcomes and is impacting our workforce shortages and ability to discharge patients safely.	✓ Explore increasing transitional housing for individuals that need a safe place to discharge to when no longer in need of medical services. ✓ Support NRPC and their housing initiative that is being funded through the Boston Federal Reserve. ✓ Support and align regional homelessness initiatives. ✓ Explore supporting a transitional housing program for non-medical houseless individuals who are discharging from hospital.	✓ NRPC ✓ CVOEO ✓ VDH ✓ NCSS ✓ NMC ✓ WIC Housing Project ✓ Spectrum Youth ✓ Municipal Planning and Governance Boards ✓ League of Cities and Towns ✓ State Legislators ✓ Federal Delegation ✓ UWNvt

		✓ Abenaki Nation of Missisquoi

✓ **<u>FOOD</u> security has become a significant issue impacting people's health needs and behaviors, leading to unhealthy outcomes for a large percentage of our population.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
Having access to healthy and affordable food in our region continues to emerge as an issue. One member of a focus group stated, "There is plenty of food in St. Albans, but the food I can afford is not the healthy food I need." There is a correlation between food insecurity and the co-morbidities of chronic conditions related to proper diet and nutrition. We can no longer simply tell people to "Eat 5 A Day" because people do not have the resources to afford the healthy choices.	✓ Work with CVOEO on providing medically tailored meals for patients. ✓ Provide nutrition education and grocery store programs to support healthy, affordable meal prep and consummation. ✓ Work with primary care on implementing the 2 hunger vial signs screening to support identifying food insecure patients and help them register for SNAP benefits. ✓ Provide access to Community Supported Agriculture to local medical offices. ✓ Provide support to Healthy Roots gleaning program and identify opportunities of expanding food prep with gleaned food. ✓ Regional marketing campaign for WIC Nutrition Program and easy sign up and access for families. ✓ Work with AgeWell on identifying volunteers for senior meal delivery. ✓ Provide transportation to local farmers markets for elderly Vermont residents. ✓ Work with the Abenaki Nation of Missisquoi on improving food shelf and community gathering space expansion.	✓ Franklin Grand Isle Hunger Council ✓ CVOEO ✓ VDH ✓ WIC Nutrition Program ✓ State EBT Program ✓ SNAP ✓ Schools ✓ Hunger Free Vermont ✓ Health Roots Collaborative ✓ The St. Albans COOP ✓ Local Farmers ✓ AgeWell ✓ CIDER ✓ UWNWVT ✓ Abenaki Nation of Missisquoi

COMMUNITY GATHERING AND CONNECTEDNESS

- ✓ **CONNECTIVITY emerged as a newly identified community health need in FY22.**

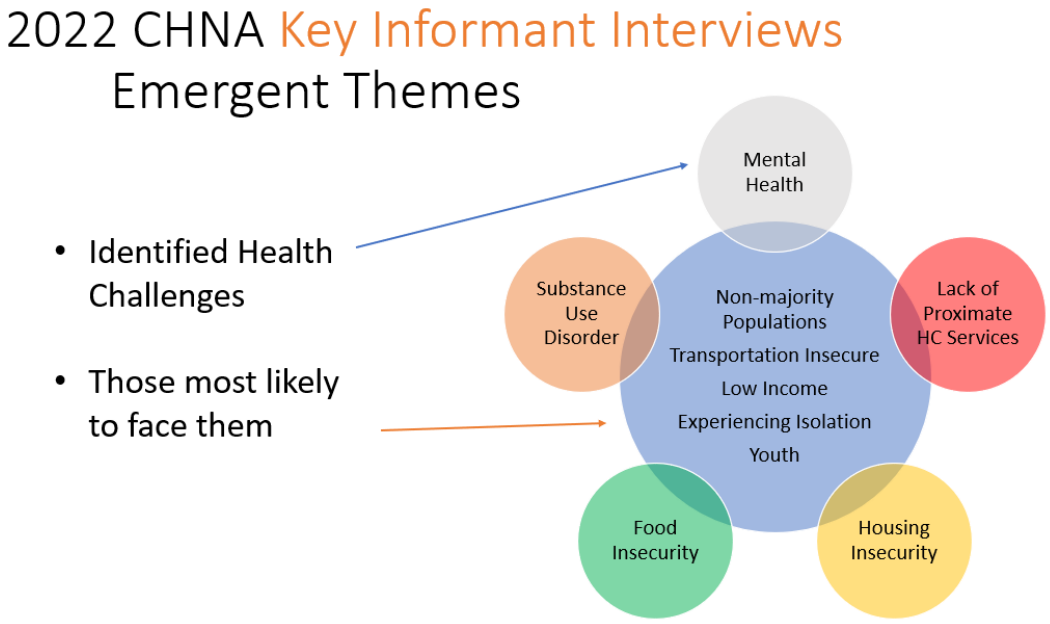
Definition of the Problem:	Identified Strategies 2023	Identified Partners
The impact of the COVID 19 pandemic disrupted many cultural, social, and community projects and events that had connected people to one another and their communities. This has led to isolation, and increased anxiety and mental health issues. As we emerge from the pandemic and return to a somewhat "normal" state of being, people are seeking meaningful, safe, and authentic connections.	✓ Better understand what our community is requesting for connectivity. ✓ Explore opportunities to create affinity groups to address differing cultural needs for connectivity. ✓ Map our existing connectivity opportunities.	✓ Local arts councils ✓ Recreation Departments ✓ Neighborhood groups ✓ AgeWell ✓ VDH ✓ Abenaki Nation of Missisquoi

- ✓ **TRAUMA INFORMED COMMUNITY is a term used to define a community that is curious about what is happening within a community that is leading to the conditions in someone's life, or a population of people where self-harm is a coping mechanism for addressing previously inflicted trauma.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
When we ask, "what is wrong with you?" instead of "what happened to you?" we are negating the trauma that may be leading to the behaviors we are witnessing, and we are re-traumatizing people with our judgement and the shame they feel. The impetus is on us, as healthcare organizations and social service providers to change our behaviors and create trauma informed community structures, practices, and systems that change how a person feels and behaves in our systems of care.	✓ Educate service providers and organizations about trauma informed practices and systems that support curiosity and reflection. ✓ Create a trauma informed learning collaborative to implement trauma informed practices throughout our region. ✓ Explore community-wide opportunities to implement trauma informed policies. ✓ Work with marginalized communities on better understanding and treating generational trauma.	✓ Abenaki Nation of Missisquoi ✓ VDH ✓ NCSS ✓ Primary Care Offices ✓ Law Enforcement ✓ Municipal leaders ✓ Schools ✓ Recreation Departments ✓ UWNWVT

SAFETY AND BELONGING

✓ <u>HISTORIC PATTERNS OF RACISM, SEXISM, AND NON-ACCEPTANCE OF DIVERSITY</u> are leading to inequitable population health outcomes for certain members of our community.



Definition of the Problem:	Identified Strategies 2023	Identified Partners
Certain members of our community, including members who identify as people of color, indigenous, migrant laborers, LGBTQIA+, youth, veterans, transportation, and housing insecure, and the elderly are more likely to experience mental health, substance use disorder, and lack of proximate and culturally appropriate health care and human services leading to higher levels of comorbidities and early death.	✓ Identify and understand the impact inequities are having on our community. ✓ Educate and inform agencies and community members about the findings. ✓ Work within our organizations and across our community and agencies to identify solutions that impact our whole region.	✓ Schools ✓ TCDG ✓ NCSS ✓ Municipalities ✓ AgeWell ✓ Veterans Groups ✓ Spectrum Youth ✓ VDH ✓ Samaritan House ✓ CVOEO ✓ Martha's Kitchen ✓ Law Enforcement ✓ Howard Center

- ✓ **<u>TRANSITIONS OF CARE</u> between health care settings with the inclusion of human services is essential to ensuring safety for vulnerable community members.**

Definition of the Problem:	Identified Strategies 2023	Identified Partners
Being able to transfer a patient from one care setting to another safely has been an issue that is exacerbated by our ability to meaningfully share data across our Health Service Area (HSA) and provide transparent care team response. This has led to gaps in care resulting in hospital readmissions, lack of trust in the health care system, and poor patient care quality.	✓ Work on developing an OHCA for our region that allows for cross collaboration of population health level data to meaningfully share results. ✓ Use the LACE tool at NMC and educate partners in the score that identifies readmission risk for patients. ✓ Transitions of Care Committee and the Document Workgroup meets monthly to discuss best practices, case reviews, and implements quality improvements at their practices. ✓ Address lack of access to DME. ✓ Work on improving PCP and timeliness of TOC visits with providers on admitted patients and ED patients.	✓ CIDER ✓ Home Health ✓ Suncrest ✓ LTCF ✓ NOTCH ✓ Primary Care ✓ VDH ✓ ACO ✓ Readmissions Workgroup at NMC

What supports overall health in the community?