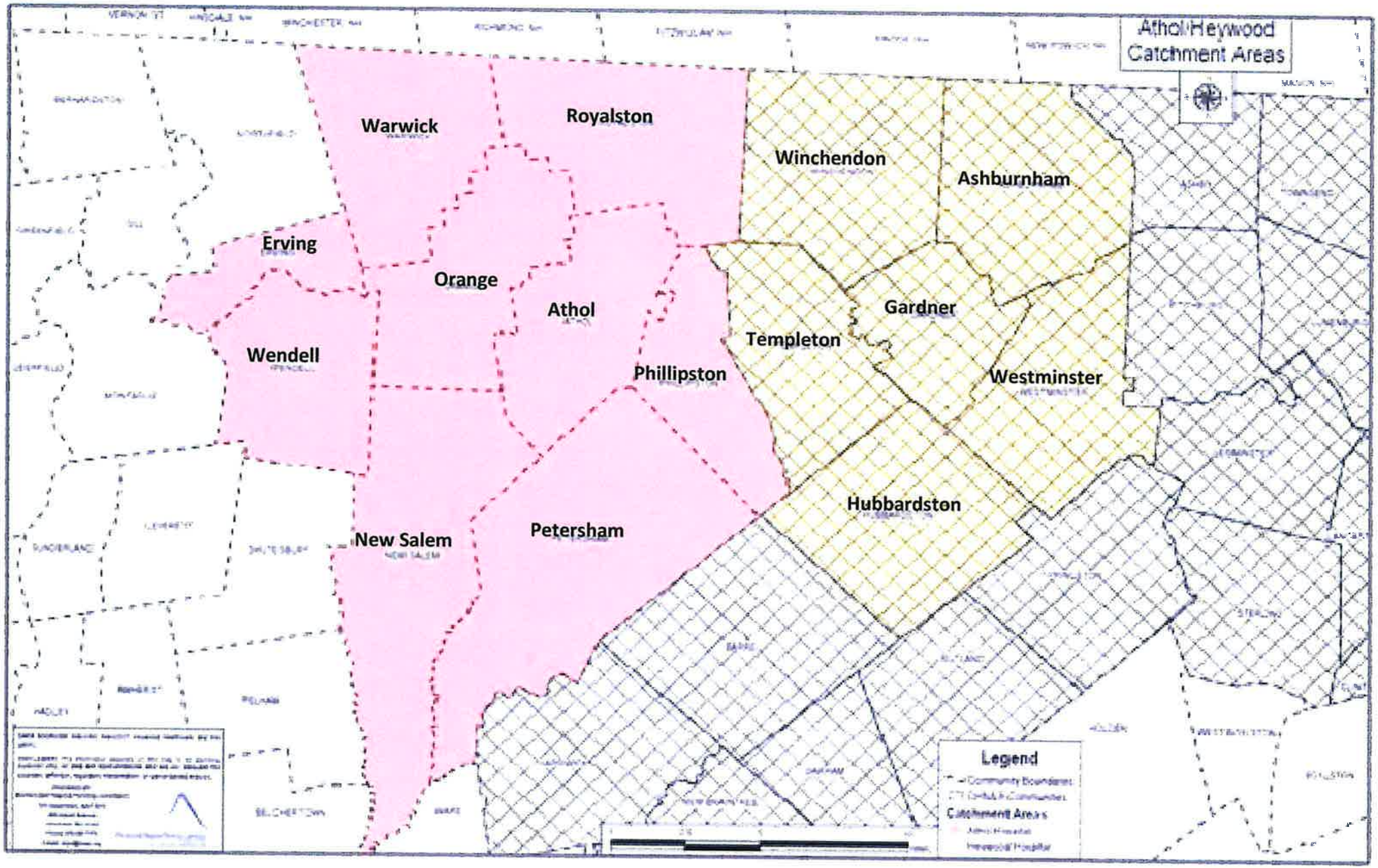
2018 Athol Hospital and Heywood Hospital Community Health Improvement Plan

Community Health Improvement Plan

Community Benefits Mission

Athol Hospital and Heywood Hospital are committed to improving the health of our community, with special consideration of disadvantaged populations, by working collaboratively with community partners to increase prevention efforts, address social determinants of health, and improve access to care.

Geographic Focus Areas



Community Health Assessment and Community Health Improvement Process

Quantitative Data Sources

US Census Data	***Mass Dpt of Public Health***	***Mass Dpt of Mental Health***	***Heywood and Athol Hospital Data***
American Community Survey Data (American FactFinder)	***Mass Dpt of Labor and Workforce Development Data***	***Youth Risk Behavior Surveillance System Data***	***Behavioral Risk Factor Surveillance System Data***

Qualitative Resources: Community

17 Focus Groups:

- North Quabbin Recovery Planning Group
- Jail to Community Task Force
- Children's Health and Wellness
- North Quabbin Community Coalition
- Gardner Area Interagency Team
- Substance Abuse Task Force
- Greater Gardner Religious Council
- Community Health Connections
- Greater Gardner Chamber of Commerce
- Montachusett Public Health Network
- CHNA-9 CHIP Breakfast
- Heywood Healthcare Senior Team
- Regional Behavioral Health Collaborative
- Gardner MENders Support Group
- Montachusett Suicide Prevention Task Force
- Schwartz Center Rounds
- Multicultural Task Force

12 Health Professional Interviews:

Rebecca Bialecki, Denise Foresman, Barbara Nealon, Nora Salvarados, Brian Gordon, Elaine Fluet, Heather, Bialecki-Canning, Mady Caron, Jeannette Robichaud, Alison Smith, Chuncie Willis, and Renee Eldredge.

Target Populations

Population and Social and Economic Characteristics

Population Growth (since 2000): Service Area 6%; State 3.1%; US 9.7%

Racial and Ethnic Minorities

Hispanic/Latino -> rate than total population (Gardner & Athol)

-Hispanic Student Service Area +45% White Students -3.9%

Older Adults

-Median Age 7 years higher

-7% increase 65+ since 2010

-Rural Nature > social isolation Difficulty accessing services

Veterans

% population Service Area 10.9% State 3.9%

Veteran Status
> unemployment
> disability
< income
(Athol, Orange, Wendell)

Low Socio-economic/ Low Social Determinants

-Wide variation communities

Income

Unemployment

Educational Attainment

Rent Burdened

Transportation

Youth/ Adolescents

High Needs Students
-7 school districts > State

Teen Birth Rates (2015/ 2016)
Service Area 11.25/ 16.6
State 9.4/ 8.47
(Orange 24.6)

Priority Health Areas and Indicators

- Injuries and Poisonings
- Children Maltreatment
- Interpersonal Violence

- Suicide Prevention
- Mental Well-being
- Educational Programs

- Self-inflicted Injuries/ Overdose
- Tobacco
- Opioid Crisis

- Income
- Unemployment
- Poverty
- Education
- Housing and Homelessness
- Transportation

- Overall Physical Wellness
- Food insecurities and access
- Diabetes
- Asthma
- Heart Disease
- Cancer
- Mortality

Priority Area: Social Determinants

Goal: To collaborate with other community organizations to help minimize the effects of social determinants on health.

Target populations: Low Income, Veterans, Racial/Ethnic Groups, Under-insured and Burdened with Medical Debt

Objectives	Strategies	Metrics
Improve patients and families to overcome barriers and addressing needs by providing psychosocial supports. Direct support includes health coverage enrollments; transportation; legal services; and information and referral.	- Assist vulnerable individuals with information and referrals to community programs that could address their needs. - Assist low-income families with free legal services. Type of legal services: guardianship, healthcare proxy, power of attorney, advanced directives and civil commitments. - Arrange for transportation for individuals who do not have transportation and it would be a financial burden to go to their medical appts. - Provide uninsured or underinsured patients with information and enrollment assistance with health care .	- # individuals provided information - # referrals made - # legal services provided - # individuals assisted with transportation - # individuals counseled on health insurance coverage and financial assistance - # health insurance applications completed
Increase high school and college students knowledge of current health issues and provide opportunities to gain experiences in various departments across the hospital. The mentorship, career training, and internship s further supports the hospital efforts to improve local socio-economic factors and to increase the availability of trained healthcare workforce.	- **Rehabilitation Services serves as a clinical education site** for college students to gain experience in an array of acute inpatient and outpatient physical and occupational therapy. - **Radiology department** serves as a clinical site to train first and second-year graduate students. - **Nursing Department serves as a clinical site for nursing students** to rotate through Inpatient, Emergency Room, Geri-psych , and MHU. - **Nutrition Department provides internships for Dietetic students.** The dietetic internship provides a 17-week rotation for students to observe counseling skills and nutrition care planning.	- # students precepted - # staff hours dedicated to mentorship - # students advance - # students hired

Priority Area: Social Determinants

Objectives	Strategies	Metrics
mentorship, career training, and internship s **(continued**	- **Philanthropy and Human Resources Department hosts summer work study** for students to explore and gain knowledge of hospital administration and population health . - **Social Services Department** provides internship for students enrolled in a Human Services.	
Improve the systems and infrastructure to advance community benefit through Community Participation/ Community Building Initiatives. Involves leading and/or actively participating in coalitions that bring together multi-sector partners in the planning and implementation of strategies aligned with CHIP priority area.	- GAIT (Gardner Area Interagency Team) administered by Heywood, consists of over 50 members representing school departments, elected officials, health and human service providers, mental health providers, home care services and businesses. This well-established coalition has been working together for over 35 years to improve access to health and social services for the communities' most compromised populations. - The Multicultural Task Force- lead by Heywood, with community participation is focused on addressing health disparities and social determinants of health focused on under - represented populations - Hospital staff actively participate on the CHNA 9 Racial Justice and Transportation working group, North Quabbin Community Coalition, Greater Gardner Religious Council, Gardner Emergency Housing Task Force, and other boards and committees focused on promoting health equity and improving socio determinants of health	- # meetings held - # active members - # events held - # trainings held - # services provided - # PSE changes made

Priority Area: Interpersonal Violence & Injuries

Goal: To identify and support individuals affected by interpersonal violence, elder abuse and neglect, and child maltreatment within the region.

Target populations: Youth, Older Adults, 'High Risk' Suicide Groups

Objectives	Strategies	Metrics
Implement Handle With Care (HWC) an Initiative to address and minimize child trauma and its negative effects. HWC will develop a process for identifying, communicating, and providing appropriate trauma informed supports for the student and family. The initiative will promote partnerships between schools, first responders, healthcare and -community partnerships aimed at ensuring that children who are exposed to trauma in their home, school or community receive appropriate interventions and support to help them achieve academically and grow personally.	- Regional Behavioral Health Collaborative convenes multisector partnership to develop the systems, processes, and materials necessary to implement Handle with Care - Provide training to build capacity of schools , early educators, medical community, and first responders to deliver trauma-informed care.	- # active partners - # trainings conducted - # PSE changes - # youth and families assisted
Reduce the high levels of firearm related injuries/ deaths by providing resources and education to the public.	- Provide Gunlock Education and Distribution to those who are in possession of weapons to increase the community's safety.	- # informational events held - # gun locks distributed
Improve the systems and infrastructure to advance community benefit through Community Participation/ Community Building Initiatives. Involves leading and/or actively participating in coalitions that bring together multi-sector partners in the planning and implementation of strategies aligned with CHIP priority area.	- Participate on committees and support community activities focused on promoting safety and security such as the CHNA 9 Healthy and Safe Relationships Working Group.	- # meetings attended - # active members - # events held - # trainings held - # services provided - # PSE changes made

Priority Area: Interpersonal Violence & Injuries

Goal: To identify and support individuals affected by interpersonal violence, elder abuse and neglect, and child maltreatment within the region.

Target populations: Youth, Older Adults, 'High Risk' Suicide Groups

Objectives	Strategies	Metrics
Improve screening and coordinated care for elders neglected and/or abused and for victims of sexual assault .	- **Emergency Department Elder Neglect and Screening and Referral Program**- Partner with Aging Service Access Points (Montachusett Home Care and LifePath) to improve identification and build a network of support and safe living arrangements for elders identified with abuse or neglect. - **Sexual Assault Nurse Examination (SANE) services-** Utilize telehealth technology to provide victims of sexual assault with timely local access to a certified (SANE) services.	- # screening completed - # referrals made - # elders assisted with obtaining safe living arrangements - # individuals receiving SANE
Improve the opportunity for residents returning to the community post incarceration by building a network of support and promoting productive engagement with their community, health, and families.	- Partner with the Regional Behavioral Health Collaborative and the NQCC Jail to Community Task Force and support strategies identified in the region's Sequential Intercept Mapping.	- # meetings attended - # programs developed - Policy, System, Environmental Changes made

Priority Area: Mental Health & Substance Use Disorder

Goal: Continue to develop and strengthen behavioral health strategies and programs to address the region's Substance Use Disorder issues.

Target Populations: Working-aged Men, Older Adults, Veterans, Youth/Adolescents, Low Income, Pregnant Women, LGBTQ.

Objectives	Strategies	Metrics
To increase knowledge on recognizing the signs and symptoms and how to respond to a suicide risk, mental illness, and /or substance misuse by providing community education.	- Provide **Opioid Overdose and Narcan Training** to the public in order to make an effort to reducing the rates of fatal overdoses. - Provide **QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention** designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. - Provide **Mental Health First Aid training** helps you identify, understand, and respond to signs of mental illnesses and substance use disorders.	- # trainings offered - # individuals increase knowledge
To promote healthy living and increase coping skills for managing symptoms related to mental illness by offering support groups for 'high risk' populations for mental health issues and suicide.	- **MENders**- Men's support group promoting healthy living and offering coping skills for managing symptoms associated with mental illness and substance use.	- # support groups offered - # individuals participate - # individuals increase skills

Priority Area: Mental Health & Substance Use Disorder

Objectives	Strategies	Metrics
Support groups (continued)	- **Adolescent Suicide Risk Support Group-** to connect adolescents who are at risk for suicide to a group of peers who share similar experiences and gives participants a chance to learn skills to cope with their suicidal thoughts and feelings in order to stay safe in the future. - **Suicide Risk Caregiver Support Group** runs concurrently with our adolescent suicide risk support group to offer resources and guidance for caregivers. - **Learn to Cope** is a support network for families dealing with addiction and recovery. LTC offers compassionate, experienced facilitators who have been there, support, resources, educational materials and guest speakers who are in long-term recovery or professionals in the field. - **Military Family Support Group** for family members of both active and former military members to share their experiences, struggles and hope and supports military family members to find healing, balance, and strategies for positive re-integration for military members with their family.	- # support groups offered - # individuals participate - # individuals increase skills

Priority Area: Mental Health & Substance Use Disorder

Objectives	Strategies	Metrics
Improve the systems and infrastructure to advance community benefit through Community Participation/ Community Building Initiatives. Involves leading and/or actively participating in coalitions that bring together multi-sector partners in the planning and implementation of strategies aligned with CHIP priority area.	- **The Montachusett Suicide Prevention Task Force** – Spearheaded by HH, this multi-sector Task Force serves the City of Gardner and the surrounding 22 towns. It's mission is to prevent suicide by providing education and resources to help those who struggle with depression, have lost loved ones to suicide or survivors' of suicide. - **Regional Behavioral Health Collaborative**-a multisector collaborative to identify gaps and available resources to better integrate and enhance existing services to meet the needs of the mental health health patient populations. The goal is to improve systems involved in the delivery of mental health services in North Central MA. - Participate on committees and support community activities focused on improving behavioral health and preventing substance abuse such as CHNA 9 Mental and Behavioral Health and Substance Abuse Working Group, NQCC Prevention, Addiction, Recovery, Treatment Task Force, GCAT, SAPC and MOPC.	- # meetings attended - # active members - # events held - # trainings held - # services provided - # PSE changes made

Priority Area: Mental Health & Substance Use Disorder

Objectives	Strategies	Metrics
To reduce barriers and improve access to behavioral health and social services for high-risk, school-aged youth and their families.	- **School Based Care Coordination and Behavioral health Supports-** Community Health Workers support students' and families' psycho-social-emotional needs. The CHW assist s families with accessing community-based services link youth with appropriate mental health counseling. - **School based Tele-behavioral Health** services offered in collaboration with the school district and offered to youth in the school to address behavioral health issues.	- # families assisted - # referrals made - # students connected to behavioral health counseling - Improved behavioral health outcomes - Improved academic performance
To reduce the possible injury or exposure to disease from medical sharps used at home by educating and providing resources for the community on the safe storage, handling, and disposal of sharps and needles.	-Offer the **Sharps Disposal Program** for community members at no cost to safely dispose of needles, syringes, and lancets, reducing the possible injury or exposure to disease from medical sharps used at home.	- # participants trained - # sharps boxes distributed - # sharps boxes returned and disposed

Priority Area: Mental Health & Substance Use Disorder

Objectives	Strategies	Metrics
Increase access to local mental health and substance use support and treatment.	- **Develop the next phase of services at the Quabbin Retreat.** Engage stake holders in the planning process assess the need for services and in the identification ad implementation to fill gaps in the adolescent and adult behavioral health treatment continua. - **Peer Recovery Coaches** support to Emergency Department and Primary Care. In collaboration with GAMHA, Alyssa's Place and the North Quabbin Peer Recovery enter to give assistance to people seeking help for substance use, people in recovery, and people affected by the substance use.	- Local behavioral health needs assessment completed - Recommendation and plan developed for list of needed services - Increase MH/SU treatment services offered. - # patients referred to peer coach. - # patients working with peer recovery coach and developed a supported plan and pathway to recovery.

Priority Area: Wellness & Chronic Disease

Goals: To improve the overall wellness of youth and adults in the service area and also to reduce the rate of chronic diseases.

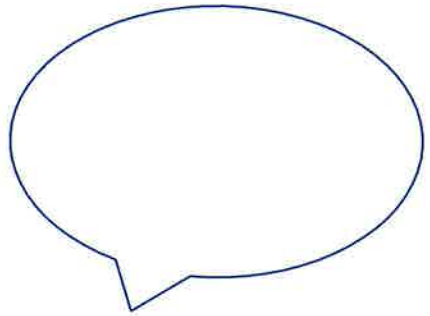
Target Populations: Older Adults, Youth/Adolescents, Low Income, Food Insecure Communities

Objectives	Strategies	Metrics
Increase access to healthy Food and food assistance programs.	- **Weekend Backpack Program:** A backpack of nutritious, easy-to-prepare food items provided over the weekend when kids are likely to be most hungry. The food is discreetly and conveniently distributed at the school. - **Food as Medicine-** Farmacy prescriptions and subsidies to support fruit and vegetable shares and purchase of healthy food items. - **Built enviroment-** Support patient teaching gardens - Partner with Winchendon Healthy Eating Access Group to assess and explore the feasibility of alternative food access points to address the transportation and food desert issues in this community.. (ie Mobile Market , Local Food Hub)	- # individuals receiving food assistance - # back packs distributed - # Farmacy prescriptions prescribed - # gardens built - Winchendon Food Access Model developed
Increase knowledge and provide services to support wellness and chronic disease prevention and management.	- Nutrition Presentation and interactive classes (such as supermarket tours/ cooking demos) focused on the role good nutrition can have on the management and slowing the progression of chronic disease.	

Objectives	Strategies	Metrics
Increase knowledge and provide services to support wellness and chronic disease prevention and management. (continued)	- Offer Blood Pressure Screening to the community to monitor risk factors of many chronic diseases. - Offer free flu influenza shots and flu prevention education in the community to help lower the occurrence of the flu. - Provided educational information on chronic diseases (diabetes , CVD) at community health fairs and events.	- # Blood pressure screenings conducted - # flu vaccinations provided - # information events attended - # receiving health information
Improve the systems and infrastructure to advance community benefit through Community Participation/ Community Building Initiatives. Involves leading and/or actively participating in coalitions that bring together multi-sector partners in the planning and implementation of strategies aligned with CHIP priority area.	Collaborate on local efforts to promote wellness in the following areas of health include nutrition, physical activity, and overall wellness. Such as the CHNA 9 Healthy Eating and Active Living Working Group and the NQCC Children's Health and Wellness Task Force. Participate on the State Malnutrition Commission to assess , evaluate, and provide education on the nutrition risk for Older Adults.	- # meetings attended - # active members - # events held - # trainings held - # services provided - # PSE changes made
Increase knowledge of and promote self-care techniques to improve chronic disease self –management through support groups.	- Cancer Support Group is designed to provide support for patients and their families through participation in group discussion with people with similar life experiences, Coping with Chronic Illness through Meditation, Rekeii, and American Cancer Society Feel Good Look Good Program	- # support groups offered - # individuals participate - # individuals increase skills

Objectives	Strategies	Metrics
Support Groups (continued)	- Diabetes Support Group provides an opportunity for people with diabetes to come together to receive continuing support and exchange of ideas, networking, and education as it pertains to diabetes. - The Better Breathers Club is designed to provide a source of ongoing education and support for individuals with breathing problems and lung disease, along with their families and friends.	- # support groups offered - # individuals participate - # individuals increase skills
Improve the built environment to support physical activity.	- Collaborate with local organizations to improve the trail system adjacent to the hospital and on the grounds of the Quabbin Retreat	- # collaborative events held - Environmental changes made
Improve care transitions and better health outcomes for patients being discharged from the hospital	Provide patients being discharged from the hospital with Medication Management and follow up wellness checks, health education, and assistance with referrals wither by phone or a Home Visit.	- # of patients that receive follow up transitional care

CHA and CHIP Input



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