

**Rutland Regional Medical Center**  
**Rutland, Vermont**

**IMPLEMENTATION STRATEGY**  
**Addressing the 2018-2020 Community Health Needs Assessment**

**PROGRESS REPORT**

*To improve the health of the Rutland Region and surrounding communities by providing appropriate, superior, integrated, preventative, diagnostic and therapeutic health services in a caring environment through the strength of our people, technology and relationships.*

*Mission, Rutland Regional Medical Center*

Introduction

As the priority areas identified through the Community Health Needs Assessment (CHNA) overlap, there are shared purposes of many of the initiatives outlined here. We need the strength of the triad – the hospital’s activities, policy change, and community commitment to realize change in the health status of our community and its members.

Rutland Regional Medical Center (RRMC) leads and partners in many collaborative initiatives to address issues of access to and utilization of health care services, and to improve and promote healthy choices and behaviors; we support and rely on community organizations that work to influence social, physical and economic factors that are beyond the scope of a healthcare organization’s control or expertise. In our rural community, collaboration and coordination are both necessary and beneficial to affecting change. This Implementation Strategy highlights the actions RRMC will employ that are new or significant improvements building upon existing efforts to address the prioritized health needs.

The below listed programs/initiatives are on-going or began before the results of the most recent CHNA. The 2018 CHNA identified four distinct priority areas that overlap and support current programming and gaps within our community. Please see the attached visual that illustrates RRMC’s role in supporting and sustaining the current priority areas with existing services as well as new initiatives. This graphic was developed for the Project Vision Health Subcommittee Meeting in 2/2019.

**Community Health Priority: Support an Aging Community**

Anticipated impact:

- Increase self-management skills; ability to ask for specific help
- Improve provider knowledge on older Vermonters
- Reduce inappropriate utilization of services
- Improve access to transportation for health needs

Goals: Increase primary care visits, decrease no-shows, enhance primary care visits, decrease gaps and missed opportunities in care; increase seamless care transitions

**Activity:** **Transitions of Care Committee**  
 Lead Organization/Partner(s): Community Collaborative, HVNASR, ECF, RRMCM, Bayada, CHCRR, SVCOA  
 Performance measures: Decrease 30-day readmissions, decrease information lost between transitions  
 Progress: Rutland Community Collaborative, Education and Engagement sub-committee is focused on early detection and treatment of sepsis.

**Activity:** **Transportation Committee**  
 Lead Organization/Partner(s): RRMCM, CHCRR, Project Vision subcommittee, VNA  
 Performance Measures:  
 Progress:

**Community Health Priority: Housing as Health Care**

Anticipated impact:

- Provide noncategorical case management
- Increase knowledge base of those providing direct care/support
- Develop communal space for people to spend time

Goals: Increase number of family shelter space, decrease housing gaps, decreased precariously housed population

**Activity:** **Healthy Homes**  
 Lead Organization/Partner(s): RRMCM and Neighbor Works  
 Performance measures: Number of patients referred to program, number of qualified homes who accept renovation  
 Progress: Pilot successfully completed and program will continue on into 2019 with funding through BHT.

**Activity:** **Increase Homeless prevention efforts**  
 Lead Organization/Partner(s): Homeless Prevention Center, Project Vision, RRMCM,  
 Performance measures: Decrease Point in Time counts  
 Progress: A Sub-Committee spurred from the hospital has been created to examine community needs related to preventing homelessness and precarious housing situations.

**Community Health Priority: Mental Health**

Anticipated impact:

- Support mobile response to mental health needs
- Increase outreach to the community and promotion of available services
- Reduce suicide rate

Goals: Decrease suicidality and mortality rate due to suicide; increase amount of people trained in how to recognize suicide ideation

**Activity:** **Youth Mental Health First Aid**  
 Lead Organization/Partner(s): RPP, RRMCM

Performance measures: Number of people trained to identify and respond to suicide ideation in youth

Progress: Two 8-hour trainings were held with a total of 48 people (teachers, college staff, youth leaders, mentors, etc.)

**Activity: Zero Suicide, Rutland Suicide Safe Care**

Lead Organization/Partner(s): RRMC, CHCRR, RMH

Performance measures: Number of trained professionals in Zero Suicide

Progress: Center for Health and Learning has presented to stakeholders and is administering a self-assessment plan for all three partner programs. Additionally, they are exploring the extent of needed training for all staff associated with the three community partners.

**Activity: Participation in Accountable Care Organization**

Lead Organization/Partner(s): RRMC, OneCareVT, CHCRR, Southwestern Vermont Council on Aging

Performance measures: 30 day follow up after discharge for Mental Health, alcohol/drug dependence

Progress: The Behavioral Health subcommittee of the Rutland Community Collaborative has developed a tool that will help them follow patients that have been screened in the Emergency Department. With the use of a data collection software, care coordinators, and specific partners, clinicians will have a boarder idea of what has happened in the patient's life since their initial visit.

**Community Health Priority: Childcare and Parenting**

Anticipated impact:

- Create culture of compassion for parenting & empower people to reach out for help'
- Promote community engagement and volunteerism to provide peer support network for parents/caregivers
- Build partnerships
- Increase opportunities for parents and children to connect with peers

Goals: Increase peer support recourses and mentoring supports in the community; Increase well child visits; increase supports for pregnant women; increase supports for new parents

**Activity: Women's Health Initiative**

Lead Organization/Partner(s): RRMC, Planned Parenthood, New Story

Performance measures: Number of partners using "one key question", number of referrals to services

Progress: Currently, Planned Parenthood and Rutland Women's Health Clinic are routinely and consistently implementing the "one key question" that initiates a conversation about pregnancy and family planning.

Additionally, each practice has an imbedded social worker through the Community Health Team. They have seen an increase in referrals for

other services as patients are able to meet with them while at the clinic for well checks or as new patients. The Social Workers have been training support staff who have become empowered to ask patients questions about needs outside of reproductive health.

**Activity:**

Lead Organization/Partner(s):

Performance measures:

Progress:

**Family Mentoring Program**

Mentor Connector, Westridge, RRMCC

Number of families enrolled/graduated from program, # of mentors

In 2018 they hired a Mentor Coordinator and developed a strong rapport with West Ridge Center. They were able to work with three families and three additional mentors have been trained for 2019. They have served four adults and seven children.

**Activity:**

Lead Organization/Partner(s):

Performance measures:

Progress:

**Centering Pregnancy**

RRMC Women's Health

Number of attendees

Program runs when groups of interested pregnant women with similar due dates are identified. Each group runs for 10 weeks and completed groups have shown positive outcomes for Mom and baby. A one-time follow up post-partum peer support is offered.

**Activity:**

Lead Organization/Partner(s):

Performance measures:

Progress:

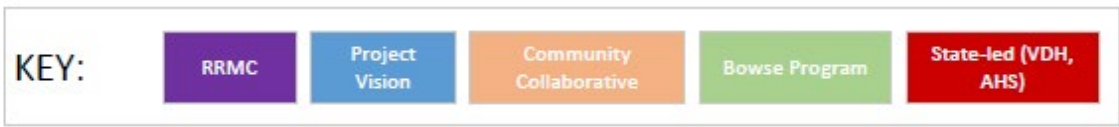
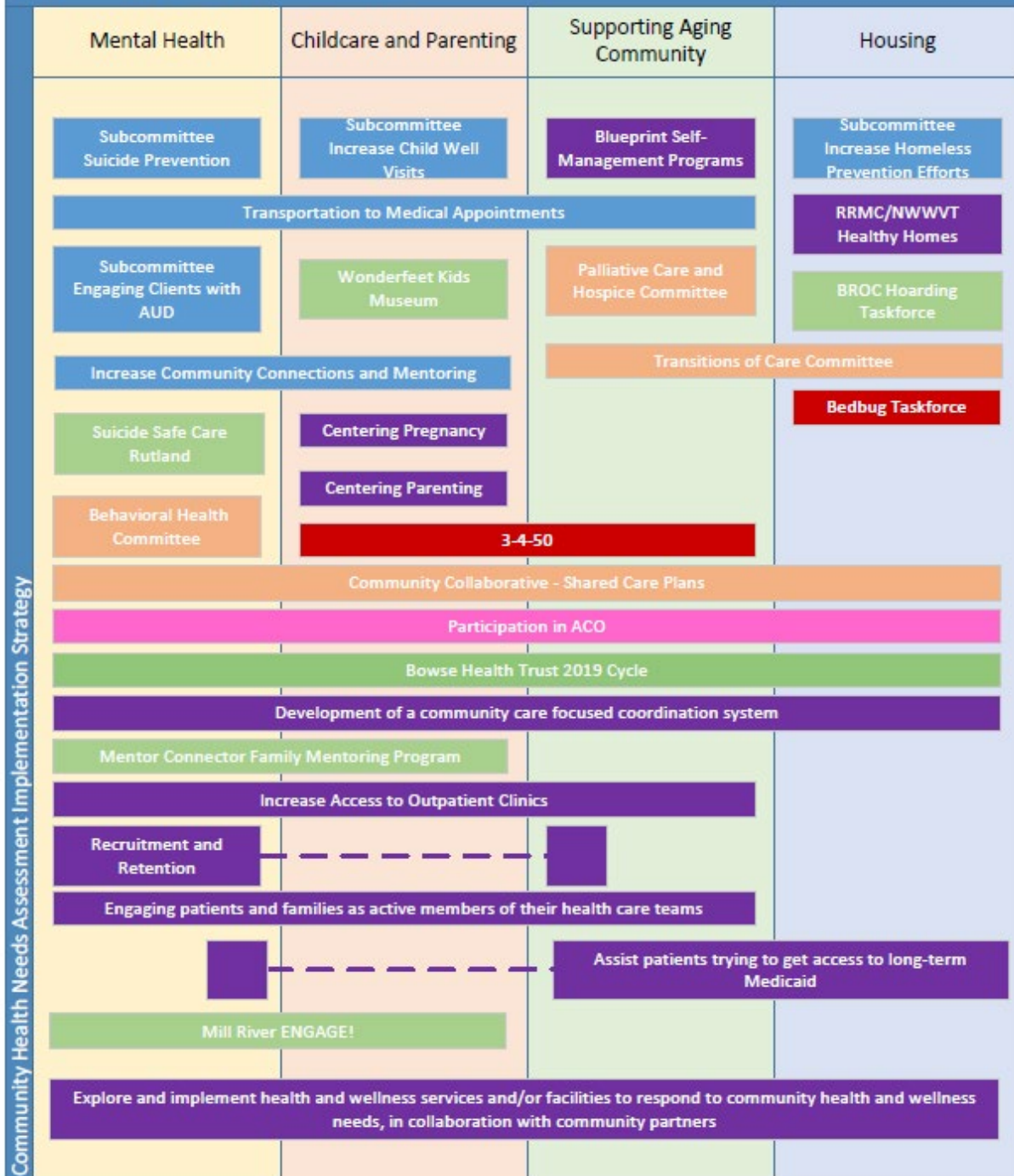
**Centering Parenting**

RRMC Pediatrics

Number of attendees

The program has been implemented for one year and has served 9 families. Recruiting families can be difficult as each session is 90 minutes and finding a time for working families is difficult.

# Alignment of Current Activities



# Alignment of Proposed Activities

	Mental Health	Childcare and Parenting	Supporting Aging Community	Housing
Community Health Needs Assessment Implementation Strategy	Mental Health First Aid for Community	Make Early Education Careers More Attractive	Develop Older Vermonter Appreciation Event	Create Master List of Supportive Housing
			Recruit Geriatric Psychiatrists	Increase Emergency Housing
			Decrease Length of Hospital Stays due to Behavioral Issues	Create Master Lease Program
	Implement SBINS			
	Develop More Community Interaction Opportunities	Provide Free Local Trainings to Anyone Requesting on Early Childhood/Education	Medication Reconciliation and Management Programs	Create Communal Space for People to Interact
	Teach and Support Volunteerism and Community Engagement	Engage People in Discussion on Early Childhood at School Meetings, Town Meetings	Reframing Aging – The Frameworks Institute	Provide Noncategorical Case Management
	Build a Sharing Community	Develop Programs to Help Parents Become Equipped	Create Opportunities to Record Stories and History	
	Create Multi-disciplinary Mobile Response Team			Create Home-Share Program
	Create Data-Informed, Sober Supportive Space and Resources	Increase Provider Knowledge on Needs and as Health Focus		
	Involve the Private Sector as a Partner in Activities			
	Become Trauma-Responsive Community, Not Just Trauma-Informed			
	Create Multi-Disciplinary Service Outreach Network			
	Create Peer Support Phone Network			
	Create Support Systems for Providers of Services			
	Take a Proactive Approach More Than Reactive; Try to Prevent Crises			
Creation of a Volunteer Database				