



**Copley Hospital Community Health Needs Implementation Plan
Progress Report (October 2018-May 2019)**

Community Need Priority One: Preventative Care

| Action Item Specific Tactic | Current Progress Outcomes | Next Steps May 2019-May 2020 |
|---|--|---|
| Launch of Rise VT-Lamoille FY 2019 | 0.4 FTE funding continuation achieved for FY 19 and FY 20 FY 19 Rise VT Grant recipient- Bike Share/Bike Racks in Morristown | Oxbow Wednesday Night Live Music Continue with Grant funding awards to community organizations. Explore options for a local 5k Run |
| To increase Transportation Availability & Assistance to vulnerable populations | Provided transportation funding to assist Lamoille Community House support transportation services for vulnerable populations. December 2018-April 2019 <ul style="list-style-type: none"> • 414 Van Rides provided to 39 Unique Guests at the Lamoille Community House. | Assist to expand tracking to support increased services based on community needs. Assist Lamoille Community House staff develop more structure and a standardized tracking tool to assist in expansion of programs, training, and support services to this vulnerable population. |
| Implement a Fall Risk Program | Phase 1: Fall Risk Interdisciplinary Committee created. | Phase 2: Choose standardized risk screening tool. Develop assessment procedure for staff. Build screening tool into the Electronic Health Record Build tracking tool in SQSS occurrence reporting system. Rehab staff will host a free educational talk on Falls screening and reduction techniques for the community. Provide Fall prevention tips and tricks in Copley Community Newsletter. Phase 3: Work in collaboration with community organizations to develop falls education to collectively decrease falls. |
| Implement Social Determinants of Health (SDOH) Screening in the Emergency Department. | Referral Specialist Position- interviews for this position are currently taking place. This positions funding is shared with Community Health Services of Lamoille Valley (CHSLV), the Federally Qualified Health Center (FQHC). | We will continue to expand our tracking: # of Screenings done by Referral Specialist Type and # of referrals made # of positive screens |



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| Expand current screening process at The Women's Center. | In March screenings for (substance abuse, food in-security, housing in-security, and personal safety) were initiated at all pre-natal visits, transfer visits, and Annual exam visits. | Increase screening to include questions to identify patients who could benefit from a regular dentist. (Dental Home) # of referrals made to dentists. |
| Prevention/Education and awareness messaging via Social Media and LiveWellLamoille.com blog | Used as a technique to promote awareness and education. | Continue to track numbers of community reached using social media hits. |
| Increase Social Worker Referral Tracking | <ul style="list-style-type: none"> • A total of 271 referrals were made. <ul style="list-style-type: none"> ❖ 151 of those referrals were to connect patients with a Primary Care Practitioner. ❖ 120 referrals were made to assist with needs for : <ul style="list-style-type: none"> ❖ Financial assistance/Insurance ❖ Non- urgent substance abuse concerns ❖ Non- urgent mental health concerns ❖ Housing ❖ Home Health Needs ❖ Dental Service Needs • 85 unique patients were seen for one-on-one encounters with the Emergency Department social worker. | Continue to expand our tracking: # of referrals, type of referrals made |
| Provide in-kind laundry service for Lamoille Community House | December 2018-April 2019 <ul style="list-style-type: none"> • 1109 pounds of laundry was provided for Lamoille Community House | Continue to provide this services as well as continue to track. # of pounds of Laundry services provided |
| Blood Pressure (B/P) Screening to be implemented in Ortho clinics | Blood Pressure (B/P) Screening implemented in Waterbury and Morrisville Ortho Clinics. All new patients over the age of 50 will have a B/P screening done with referral based on screening results. | Expand tracking to include: # of patients referrals made # of patients who received pt education for high blood pressure screening results. |



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Community Need **Priority Two: Mental Health**

| Action Item Specific Tactic | Current Progress Outcomes | Next Steps May 2019-May 2020 |
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| Develop Patient Sitter program | October 2018 -March 2019 <ul style="list-style-type: none"> • 941.8 sitter hours used Patient Sitter program policy, procedure, and forms created. Staff training program in development. | Continue to educate, support and train staff. Continue to track # of Copley staff utilized to be sitters. |
| Develop mental health safer room in Emergency Department | “Safer Room” created in Emergency Department “Safer Room” roll-out in the Acute Care Nursing Unit (ACNU) being investigated at this time. | Roll out of “Safer Room” in the ACNU |
| Partner with Lamoille County Mental Health on the Zero Suicide Program (screening, intervention, safe transition of care). | Working to develop process for measuring and tracking for Zero Suicide Program. Copley participating on Community Partners for Zero Suicide committee. Trained 4 Staff in Collaborative Assessment and Management of Suicidality (CAMS) | Continue to track : # of patients screened using the Columbia Suicide Risk Assessment Tool # of (+) screenings # of referrals made. |
| Offer Management of Aggressive Behavior (MOAB) “de- escalation” training to targeted hospital staff | 74 Copley Staff attended MOAB training. | Continue to offer and support staff training in MOAB de-escalation techniques. |



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Community Need Priority Three: Chronic Health Conditions

| Action Item Specific Tactic | Current Progress Outcomes | Next Steps May 2019-May 2020 |
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| Increase available telemedicine services available. | Telemedicine options implemented: Nephrology, Rheumatology, and Pulmonology through Dartmouth Hitchcock's Connect Care. | Increase communication and education around availability of new services. |
| Workforce Wellness Health Fairs & Screenings, Flu Clinics, Corporate Cup. | <ul style="list-style-type: none"> • 489 Community Flu Vaccines given • 192 Community Screenings done • 287 Community members attended the Corporate Cup | Continue to offer and expand on available services to improve community wellness. |
| Copley Employee Wellness Screening programs, group activities. | Sponsored May 2019 Corporate Cup <ul style="list-style-type: none"> • Copley Staff Attendance-58 • 295 Employee Flu Vaccines given • 120 Employee Screenings done | Continue to offer and expand on available services to improve Copley staff wellness. |
| Install Prescription drug "drop- box" for people to safely dispose of unused and/or expired prescription drugs | Since 10/26/2018 <ul style="list-style-type: none"> • 155 pounds of prescription drugs have been disposed of. • Copley continues to destroy an estimated 1 box a month. | Continue to educate staff, patients, and community about the prescription drop box. # of pounds of prescription drugs being disposed of |



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Community Need Priority Four: Substance Use/Abuse

| Action Item Specific Tactic | Current Progress Outcomes | Next Steps May 2019-May 2020 |
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| <p>The Women’s Center (TWC) will include Substance Abuse to the screening done at all annual exams and pre- natal intake appointments.</p> | <p>The paper screening tool answers were incorporated into the electronic health record to expand ability to mine the data fields for aggregate data collection. Screening was expanded to add electronic collection on substance abuse, food in- security, housing in- security, and personal safety responses.</p> <p>A Social Worker continues to be part of The Women’s Center practice staff funded through the Women’s Health Initiative.</p> | <p>Continue to track and expand on data collection: # of referrals to Medical/Social Worker # of screenings completed # of positive Screenings # of Face-to Face Type of referral/reason will be tracked</p> |
| <p>Recovery Coaching Program</p> | <p>Established the Recovery Coaching Program in collaboration with North Central Vermont Recovery Center which offers an alternative approach to providing support to those in recovery. This partnership brings a peer coaching model directly to patients in the Emergency Department that may need assistance with substance abuse issues.</p> | <p>Track the # of Referrals from this program. # of peer coaching sessions used by ED patients. # of Patients referred to FQHC Primary Care Medication Assisted Treatment Team (MAT) upon Discharge.</p> |
| <p>Prescribe and/or distribute Naloxone through the emergency department.</p> | <p>Planning is in progress to prepare for this initiative. Goal is to roll-out by Fall 2019</p> | <p>Start tracking # of Naloxone doses dispensed by Recovery Coaches.</p> |