

Athol Hospital and Heywood Hospital Community Health Improvement Plan 2022-2024



ATHOL HOSPITAL | HEYWOOD HOSPITAL | HEYWOOD MEDICAL GROUP | QUABBIN RETREAT



Heywood Healthcare – Athol Hospital and Heywood Hospital

Athol Hospital and Heywood Hospital is part of Heywood Healthcare, an independent, community-owned healthcare system serving north central Massachusetts and southern New Hampshire. A local community Board of Trustees governs Heywood Healthcare. Heywood Healthcare employs over 1400 employees. The Medical Staff includes 400+ active, courtesy, and consulting physicians in primary care and many specialties. It is comprised of Heywood Hospital; Athol Hospital, a 25-bed not-for-profit, Critical Access Hospital in Athol, MA; Heywood Medical Group, with primary care physicians and specialists located throughout the region; The Quabbin Retreat, providing treatment of mental health and substance misuse. The organization also includes Heywood Rehabilitation Center, Heywood Family Medicine and Urgent Care in Gardner; Winchendon Health Center and Murdock School-based Health Center in Winchendon; Athol Community Elementary School-based Health Center and Tully Family Medicine and Walk-in in Athol; Miller’s River Health Center in Orange; and Heywood Medical Group Specialty Care in Rindge, NH. The organization also includes the Heywood Healthcare Charitable Foundation.

Our Vision: To be one of the best community health systems in America.

Our Mission: To be our communities’ trusted choice for exceptional patient-centered care.

Our C.A.R.E. Values:

- Compassion
- Attitude
- Respect
- Excellence

Athol Hospital Website: <http://www.atholhospital.org/>

Heywood Hospital Website: <http://www.heywood.org/>

Heywood Healthcare’s Service Area includes the city of Gardner, large towns (>10,000 population) of Athol and Winchendon, mid-sized towns (5,000-10,000) of Ashburnham, Orange, Templeton, and Westminster, and the rural towns (<5,000) of Hubbardston, Erving, New Salem, Petersham, Phillipston, Royalston, Warwick, and Wendell.

Community Benefits Mission: Athol Hospital and Heywood Hospital are committed to advancing our community’s well-being by intentionally addressing race, sexual orientation, and gender identity inequities and working collaboratively with community partners to increase prevention efforts, address social determinants of health, and improve access to care.

Community Health Needs Assessment and Community Health Improvement Planning Process

The 2021 Community Health Needs Assessment (CHNA), and Community Health Improvement Plan (CHIP) process was a collaborative effort conducted by Heywood Healthcare, the Montachusett Regional Planning Commission, HealthAlliance-Clinton Hospital, and the CHNA 9 Health Equity Partnership. Heywood Healthcare leadership assembled a CHNA Advisory Group to advise leadership on the process and the plan’s strategic objectives. The advisory members are well-versed in the region’s health needs. They include hospital department heads, patients, residents, community-based organizations and health service partners, community coalitions, public health officials, and local schools. The Montachusett

Community Health Improvement Plan



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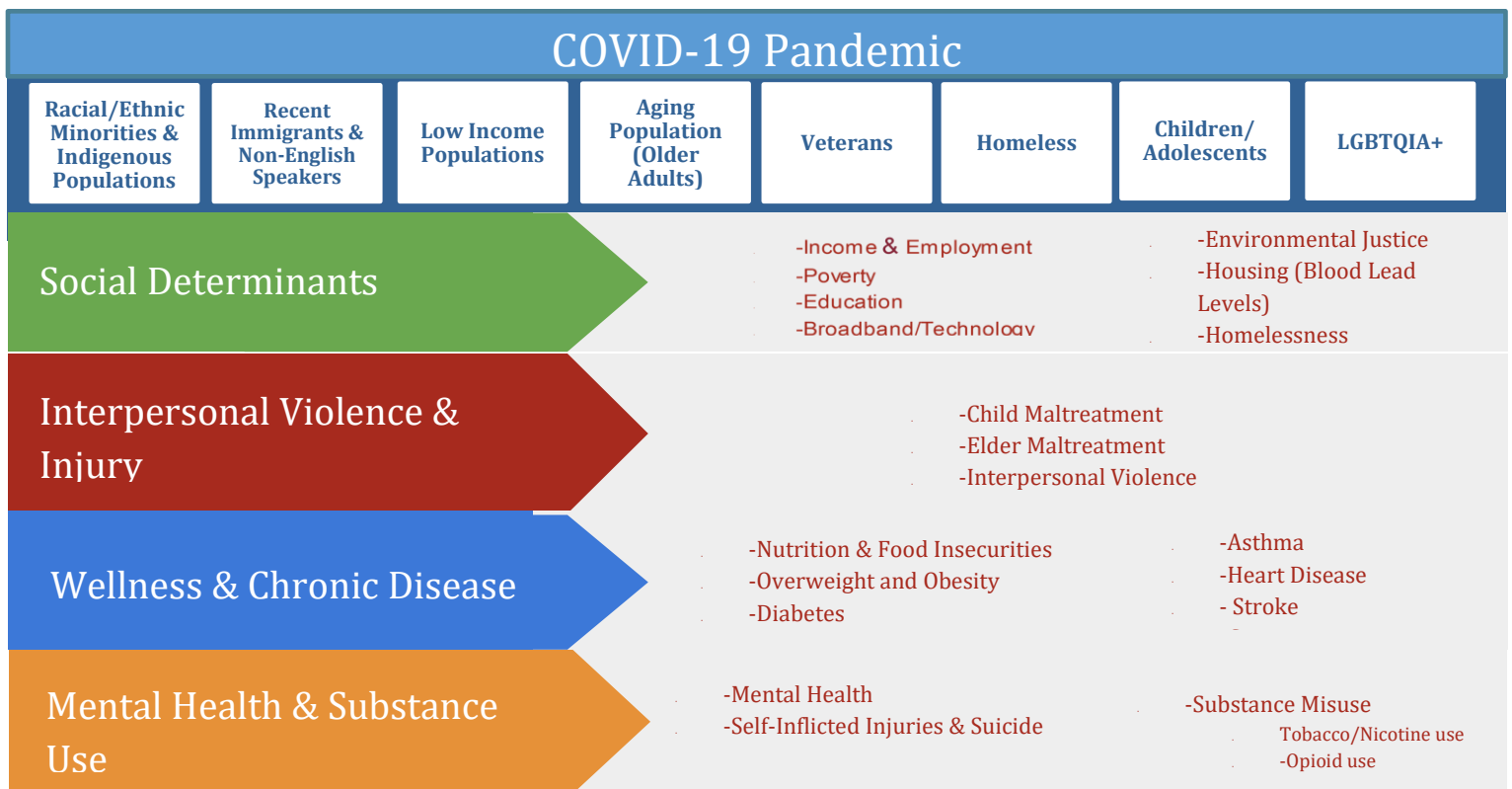
Regional Planning Commission (MRPC) staff were responsible for collecting and analyzing the data and drafting the CHNA.

The assessment and planning process engaged community members and local public health in focus group sessions, discussions, and surveys that informed insights for this report. Quantitative data came from Massachusetts Public Health Information Tool (Mass PHIT) data from the Massachusetts Department of Public Health (MassDPH); the Youth Risk Behavior Survey (YRBS) data; US Census data (including data from the American Community Survey); and other Commonwealth and Federal Government organizations and agencies. Throughout the process, special attention was paid to “communities within communities,” health disparities, health equity, and the impacts of the COVID-19 pandemic. Intentional planning was done to ensure information and insights from population groups under-represented by race, gender, class, disability, and geography were collected from surveys, focus groups, and State and National data.

The CHNA provides a comprehensive review of Heywood Healthcare’s Service Area, used to inform the CHIP. The CHNA findings were reported to the hospital leadership, the Community Benefits Committee, and community members. Discussions with these groups informed the prioritization of health needs and strategy development. These priority categories continue from the previous CHNA-CHIP process, as they represent ongoing, critical needs, especially for key populations, and several initiatives are still in progress to address them. The CHIP strategies address the pandemic's broader social and economic impacts highlighted in the 2021 CHNA. The 2021 CHNA is accessible at:

<https://www.heywood.org/about-us/community-benefit>

Priority Population, Health Area, and Indicators



Strategy Approach

Heywood Healthcare’s community health improvement work is informed by the Bay Area Regional Public Health Framework for Reducing Health Inequities. This framework shows a pathway for health for people and communities. The far right of the graphic depicts the farthest downstream part of the health pathway where the traditional medical model on treating disease focuses. Although critical to our work, Heywood Healthcare recognizes the importance of moving our community health improvements efforts further upstream to prevent disease. Some CHIP strategies include prevention efforts that focus on individual risk and support behavior change. Other CHIP strategies move further upstream and address the policy, systems, and environments impacting health outcomes for entire populations exposed to them. Going all the way upstream, on the far left, are the structural drivers of health: institutional and social inequities like structural racism and the inequitable distribution of power, money, opportunity, and resources. The farthest left is the “groundwater,” referring to the policies and interconnected systems perpetuating inequities. Heywood convenes strategic partnerships across sectors, policy work, and advocacy necessary to implement these upstream strategies.



Community Health Implementation Plan

The CHIP will serve as a foundation for the next three years (2022-2024) and describes how Heywood Healthcare plans to address significant community health needs. Heywood Healthcare continues to build and maintain relationships with partner organizations in the community to ensure their community health improvement work is carried out collaboratively. The following pages outline the goals, objectives, strategies, target population, outcome measures, and partners for the four (4) health priority areas outlined in the CHIP.

Workplan Overview

Priority Area 01	Interpersonal Violence & Injury
<p>Goal: Improve identification and provide comprehensive services and resources for individuals affected by self-inflicted injury and suicide, interpersonal violence, elder abuse and neglect, trauma, and child maltreatment within the region</p>	
<p>Target Population: Youth/Adolescents, Older Adults, 'High Risk' Suicide Groups(Veterans)</p>	
Community Health Improvement Strategies	
<p>1.1 Convene Suicide Prevention Task Force to prevent suicide by providing education and resources to help those who struggle with depression, survivors of suicide, and those who have lost loved ones to suicide.</p>	
<p>1.2 Offer community education on recognizing the signs and symptoms of suicide crisis and how to respond.</p>	
<p>1.3 Provide support groups for survivors of suicide and those who have lost loved ones to suicide and education on self care techniques for individuals suffering from mental health and substance abuse disorders.</p>	
<p>1.4 Participate on Collaboratory to Address Elder Maltreatment to implement care model that improves identification of elder mistreatment and increases connections to community support.</p>	
<p>1.5 Expand Handle With Care (HWC), an initiative to address and minimize child trauma and its adverse effects by developing systems and collaboration between area schools, law enforcement, medical and behavioral health providers, and social service agencies to support youth/families.</p>	
Priority Area 02	Mental Health & Substance
<p>Goal: Expand access to mental health and substance use disorder treatment services.</p>	
<p>Target Population: Working-aged Men, Older Adults, Veterans, Youth/Adolescents, Low Income, Pregnant Women, LGBTQ+</p>	
Community Health Improvement Strategies	
<p>2.1 Conduct support groups and education on self care techniques for individuals suffering from mental health and substance abuse disorders. Such as MENders- Men's support group promoting healthy living and offering coping skills for managing symptoms associated with mental illness and substance use</p>	
<p>2.2 Connect individuals struggling with mental health and substance use issues to peer recovery support services.</p>	
<p>2.3 Continue and expand collaborations with school districts to creatively utilize telehealth services to improve access to medical, behavioral health, and substance use prevention and treatment services.</p>	
<p>2.4 Explore new collaborations to improve fragmented systems and fill in local mental health, and substance use needs gaps.</p>	
Priority Area 03	Wellness & Chronic Disease
<p>Goal: Reduce and prevent the occurrence of chronic diseases through programs and collaborative approaches that address the built environment.</p>	
<p>Target Population: Older Adults, Youth/Adolescents, Low Income, Food Insecure Communities</p>	
Community Health Improvement Strategies	
<p>3.1 Participate in community wellness events to educate and promote wellness and chronic disease prevention and management.</p>	
<p>3.2 Provide Education and Support Groups focused on prevention and helping individuals manage symptoms related to chronic conditions and infectious disease.</p>	
<p>3.3 Continue collaborations with schools to provide the Weekend Backpack Program: A backpack of nutritious and easy to prepare food items provides over the weekend when kids are likely to be most hungry. The foods are discreetly and conveniently distributed at the school.</p>	
<p>3.4 Implement Food as Medicine collaborations to link individuals with community food resources ie Farmacy prescriptions and subsidies to support fruit and vegetable shares and purchase of healthy food items</p>	
<p>3.5 Support Age Friendly initiative focused on policy, system, and environmental changes that promote aging in place and dementia friendly communities.</p>	
<p>3.6 Support food system partnerships and planning with the North Central MA Local Food Works and Quabbin Food Connector to</p>	

Priority Area 04	Social Determinants
Goal: Alleviate the burdens of adverse social determinants on health through collaborations and expanded services.	
Target Population: Low Income, Veterans, Racial/Ethnic Groups, Underinsured and burdened with medical debt	
Community Health Improvement Strategies	
4.1 Provide psychosocial supports for individuals and families to address needs and overcome barriers. Direct support includes health coverage enrollments; transportation; legal services; and information and referral.	
4.2 Provide high school and college students with opportunities to explore and gain skills for employment in health care.	
4.3 Lead and actively participate in multisector partnerships that seek to address identified health needs and gaps in services and are focused on addressing health disparities and social determinants of health. For example Diversity and Inclusion Task Committee, Gardner Area Interagency Taskforce	
4.4 Collaborate on the North Central Mass Anchor Collaborative to work with community-based organizations to address systemic inequities and strengthen the local economy. Anchor collaborative will work in three areas: 1. Local skill development, hiring, retention, and advancement strategies; 2 Local purchasing and investment; 3. Diversity, equity, and inclusion in the institutions and local community.	
4.5 Continue and expand HEAL (HOPE, EMPOWER, ACCESS, LIVE) Winchendon model focused on three interdependent areas: Economic Empowerment, Equitable Food Access and Social Inclusion to address the root causes for health disparities.	

Workplan

Priority Area 01	Interpersonal Violence and Injury
Goal: Improve identification and provide comprehensive services and resources for individuals affected by self-inflicted injuries and suicide, interpersonal violence, elder abuse and neglect, trauma, and child maltreatment within the region	
Target Population: Youth/Adolescents, Older Adults, 'High Risk' Suicide Groups(Veterans)	
1.1 Convene Suicide Prevention Task Force is a multi-sector, regional task force providing education and resources to help those who struggle with depression, survivors of suicide, and those who have lost loved ones to suicide.	
<i>Objective</i>	Increase the access services to prevent suicide
<i>Metrics</i>	<ul style="list-style-type: none"> - # of meetings attended - # of active members - # of events held - # of trainings held - # of services provided - # PSE changes made - # suicides reduced
1.2 Offer community education to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond.	
<i>Objective</i>	Increase knowledge on recognizing the signs and symptoms and how to respond to a suicide risk by providing community education.
<i>Metrics</i>	<ul style="list-style-type: none"> - # of trainings offered - # of individuals who attended trainings - # of individuals who increased their knowledge
1.3 Provide support groups for survivors of suicide and those who have lost loved ones to suicide	
<i>Objective</i>	Increase coping skills for managing symptoms related to self-inflicted injuries and suicide

<i>Metrics</i>	<ul style="list-style-type: none"> - # of support groups offered - # of individuals participating - # of individuals with increased skills
1.4 Participate in Collaboratory to Address Elder Maltreatment to implement a care model that improves identification of elder mistreatment and increases connections to community support.	
<i>Objective</i>	Improve screening and coordinated care for elders neglected and/or abused and for victims of sexual assault.
<i>Metrics</i>	<ul style="list-style-type: none"> # of active partners # of screening conducted # of trainings conducted # of elders assisted
1.5 Expand Handle With Care (HWC), an initiative to address and minimize child trauma and its adverse effects by developing systems and collaboration between area schools, law enforcement, medical and behavioral health providers, and social service agencies to support youth/families.	
<i>Objective</i>	Improve identification and coordinate trauma-informed care for children exposed to trauma.
<i>Metrics</i>	<ul style="list-style-type: none"> # of active partners # of trainings conducted # of PSE changes # of youth and families assisted
Partners: North Central Correctional Institution, Gardner Community Action Team (GCAT), Quabbin Retreat, School Districts, Police Departments, Early-Childhood educators, Mount Wachusett Community College, Behavioral Health Providers	
Priority Area 02	Mental Health and Substance Misuse
Goal: Expand access to mental health and substance use disorder treatment and prevention services.	
Target Population: Working-aged Men, Older Adults, Veterans, Youth/Adolescents, Low Income, Pregnant Women, LGBTQ+	
2.1 Conduct support groups and education on self-care techniques for individuals suffering from mental health and substance abuse disorders.	
<i>Objective</i>	Increase coping skills for managing symptoms related to mental illness by offering support groups for 'high risk' populations for mental health
<i>Metrics</i>	<ul style="list-style-type: none"> - # of support groups offered - # of individuals participating - # of individuals with increased skills - # demonstrate behavior change
2.2 Connect individuals struggling with mental health and substance use issues to peer recovery support services and effective prevention programs.	
<i>Objective</i>	Increase connections for those suffering from mental health issues and substance misuse to peer support in non-clinical settings to promote a resilient, self-sufficient lifestyle
<i>Metrics</i>	<ul style="list-style-type: none"> - # of individuals connected - # of programs developed - # participate in social, educational, employment opportunities

2.3 Continue and expand collaborations with school districts to creatively utilize telehealth services to improve access to medical, behavioral health, and substance use prevention and treatment services.	
<i>Objective</i>	Improve access to behavioral health and social services for high-risk school-aged youth/adolescents and their families
<i>Metrics</i>	<ul style="list-style-type: none"> - % of satisfied parents, students, staff, and clinicians - Improved outcomes (academic performance & improved behavioral health) - # of students in the program - # of behavioral health sessions conducted - # of social services referrals made - # of families assisted
2.4 Explore new collaborations to improve fragmented systems and fill in local mental health, and substance use needs gaps.	
<i>Objective</i>	Improve the systems and infrastructure focused on improving behavioral health and preventing substance use through community participation/ community-building initiatives
<i>Metrics</i>	<ul style="list-style-type: none"> - # of new partnerships formed - # of services provides - # PSE changes made
Partners: Community-based Behavioral Health Providers, Veteran serving organizations, School Districts, Community based social service organizations, Coalitions (North Quabbin Community Coalition, GCAT), FQHCs, Substance use prevention, and treatment providers	
Priority Area 03	Wellness & Chronic Disease
Goal: Reduce and prevent the occurrence of chronic diseases through programs and collaborative approaches at the individual and community level	
Target Population: Older Adults, Youth/Adolescents, Low Income, Food Insecure Communities	
3.1 Participate in community wellness events to educate and promote wellness and chronic disease prevention and management.	
<i>Objective</i>	Increase awareness of services to support wellness and chronic disease management.
<i>Metrics</i>	<ul style="list-style-type: none"> - # of informational events attended - # of people receiving health information - # screening conducted
3.2 Provide Education and Support Groups focused on prevention and helping individuals manage symptoms related to chronic conditions and infectious disease.	
<i>Objective</i>	Increase knowledge and access to services that support wellness and chronic disease management.
<i>Metrics</i>	<ul style="list-style-type: none"> - # of trainings/support groups offered - # of individuals participating - # of individuals with increased skills - # demonstrate behavior change
3.3 Continue collaborations with schools to provide the Weekend Backpack Program: A backpack of nutritious and easy to prepare food items provided over the weekend when kids are likely to be most hungry. The foods are discreetly and conveniently distributed at the school.	

<i>Objective</i>	Increase access to healthy food and food assistance programs
<i>Metrics</i>	<ul style="list-style-type: none"> - # of backpacks distributed - # of individuals receiving food assistance
3.4 Implement Food as Medicine collaborations to link individuals with community food resources, i.e., Farmacy prescriptions and subsidies to support fruit and vegetable shares and purchase of healthy food items	
<i>Objective</i>	Increase access to healthy food and food assistance programs
<i>Metrics</i>	<ul style="list-style-type: none"> - # of individuals receiving food assistance - # of Farmacy prescriptions prescribed - # enrolled in SNAP/HIP
3.5 Support the Age-Friendly initiative focused on policy, system, and environmental changes that promote aging in place and dementia-friendly communities.	
<i>Objective</i>	Increase community liveability for older adults to age safely and healthy
<i>Metrics</i>	<ul style="list-style-type: none"> - # of partnerships - # of older adults participating - # of services provides - # PSE changes made
3.6 Support food system partnerships and planning with the North Central MA Local Food Works and Quabbin Food Connector to increase access to healthy foods and strengthen our local and regional food economy.	
<i>Objective</i>	Improve the systems and infrastructure to increase access to healthy food
<i>Metrics</i>	<ul style="list-style-type: none"> - # of meetings attended - # of active members - # PSE changes made
Partners: Food Access Organizations, Aging Service Providers, FQHC’s, Local Boards of Health, School Districts	
Priority Area 04	Social Determinants
Goal: Alleviate the burdens of adverse social determinants on health through collaborations and expanded services.	
Target Population: Low Income, Veterans, Racial/Ethnic Groups, Underinsured and burdened with medical debt	
4.1 Provide psychosocial supports for individuals and families to address needs and overcome barriers. Direct support includes health coverage enrollments, transportation, legal services, and information and referral.	
<i>Objective</i>	Improve patients' and families' ability to overcome barriers and address needs by providing psychosocial supports
<i>Metrics</i>	<ul style="list-style-type: none"> - # of individuals provided information - # of referrals made - # of legal services provided - # of individuals counseled on health insurance coverage and financial assistance - # of health insurance applications completed - # provided transportation assistance
4.2 Provide high school/college students and incumbent workers with opportunities to	

explore and gain skills for employment in health care.	
<i>Objective</i>	Increase the availability of trained healthcare workforce and increased opportunities for good-paying jobs
<i>Metrics</i>	<ul style="list-style-type: none"> - # of students precept - # of staff hours dedicated to mentorship - # of students advance - # of students hired post internship
4.3 Lead and actively participate in multi-sector partnerships that seek to address identified health needs and gaps in services and are focused on addressing health disparities and social determinants of health. For example, Diversity and Inclusion Task Committee, Gardner Area Interagency Taskforce	
<i>Objective</i>	Improve the systems and infrastructure to advance community benefit through community participation/ community-building initiatives.
<i>Metrics</i>	<ul style="list-style-type: none"> - # of meetings held - # of active members - # of events held - # of trainings held - # of projects/services provided - # of PSE changes
4.4 Collaborate on the North Central Mass Anchor Collaborative to work with community-based organizations to address systemic inequities and strengthen the local economy. Anchor collaborative will work in three areas: 1. Local skill development, hiring, retention, and advancement strategies; 2 Local purchasing and investment; 3. Diversity, equity, and inclusion in the institutions and local community.	
<i>Objective</i>	Anchor Collaboratives align anchor institutions to create jobs, increase incomes, invest in communities, and spur communities to invest in themselves.
<i>Metrics</i>	<ul style="list-style-type: none"> - # of active partners - # of initiatives started - # of PSE changes
4.5 Continue and expand HEAL (HOPE, EMPOWER, ACCESS, LIVE) model focused on three interdependent areas: Economic Empowerment, Equitable Food Access, and Social Inclusion to address the root causes for health disparities.	
<i>Objective</i>	Improve community equity and economic stability, and mobility
<i>Metrics</i>	<ul style="list-style-type: none"> - # of resident-led initiatives - # of participants - # of PSE changes
Partners: Community coalitions (NQCC, Health Equity Partnership), community-based organizations that address social determinants; School Districts, Higher Ed Institutions, Workforce Development Orgs., Chamber of Commerce. Transportation Providers	