Advisory Committee/Board

Bowse Health Trust Committee

All members volunteer their time to support the mission and vision of Bowse Health Trust. For more information visit our website.

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Copyediting by: Matthew Roy
Designed by: Christina Ryan
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Implementation Strategy

Demographic Trends
The Community Health Needs Assessment (CHNA) report outlines the general health of the community served by Rutland Regional Medical Center and identifies four priority areas. Each priority area has unique challenges, needs, and gaps. A wide range of community leaders, service providers, and medical providers offered their expertise to help us understand the challenges, gaps, and needs within each priority area. This report will provide context to the 2021 CHNA and recommend strategies to address priority needs. In addition, measurable goals for each priority area will be outlined for the purpose of tracking progress.

IDENTIFIED PRIORITY AREAS

Housing
Limited access to services and care without technology, food scarcity

Mental Health
Lack of access to care and increase in overdoses, food insecurity

Childcare/Parenting
Food insecurity, remote schooling, day care providers

Aging Community
Food insecurity, access to telehealth, increased isolation, lack of tech/broadband

View the full 2021 Community Health Needs Assessment

Overview
In the winter and spring of 2021, 100 community leaders were solicited for opinions related to how the four priority areas impact their consumers and our community. Participating agencies represent consumers from a variety of populations, such as the medically uninsured, people with chronic conditions, and families receiving food subsidies. Community leaders ranged from correction officers to educators, housing coordinators to care managers, and recreation specialists to workforce development experts. In addition, medical providers from our local Federally Qualified Health Centers, Community Health, also provided input about community health from their unique perspective. Community Health provides care for the majority of residents, 70%, in our health service area.

Key informants most often stated that transportation, ease of access, and affordability were the reasons for consumers not accessing care (Figure 1). These three were closely followed by insurance status. While most of the community has health insurance, being underinsured coupled with affordability is still a major issue when individuals are faced with health-care needs.
In addition to identifying barriers to accessing care, we also asked why consumers may not seek services from other service providers. 60% of survey participants identified lack of consumer awareness of available services and 40% pointed to stigma as reasons people do not seek care from other support agencies. This sentiment was echoed in the community discussions and identifies a need for strong community partnerships and training on stigma for service providers.

Medical provider surveys pointed to similar issues, highlighting transportation, affordability, and being underinsured as the most prevalent barriers to accessing care (Figure 2). They also identified the fact that health was not a priority to their patients and a lack of internet access as other reasons their patients may not access care. When examining health priorities, many medical providers concluded that people facing housing issues are not able to prioritize health because other needs are more pressing.

As telehealth and remote learning increased due to the pandemic, the gaps in broadband coverage became more conspicuous. With the need for this service so closely tied to physical and mental health as well as learning, broadband access has emerged as a vital need in our community. As stated in the Community Health Needs Assessment, Rutland County has a high percentage of people with access to broadband but with limited provider choice and no options for low-cost plans. Without options for low-cost internet, there is no equity in access to this service.

In addition to key informant and medical provider surveys, existing community meetings were used to discuss these findings further. To better understand the gaps in services and include other voices, discussions about each priority area were held at Project Vision Health Committee meetings, Rutland Continuum of Care Housing Task Force meetings, Rutland Community Collaborative meetings, and Project Vision large group meetings. These meetings bring together a variety of organizations, agencies, and individuals who serve our community in multiple ways. Each of those discussions targeted the four identified priority areas.

With community discourse and discussions held at existing virtual meetings, we were able to meet regional leaders, service providers, and the community where they were already congregating. Using this virtual format enabled focused discussions as well as broader consultation. Recordings and notes from each meeting were helpful in capturing the themes, gaps, and needs discussed. After facilitating discussions at existing meetings, scheduled open meetings, one for each priority area, were held. These four meetings assisted in identifying current and potential strategies to address each issue. The combination of targeted discussions and open meetings allowed for current challenges and themes to emerge for each priority area.

Themes that cut across all four priority areas were food security, access to technology, workforce retention and recruitment, and COVID-19 impact.
## Childcare & Parenting

### HIGHLIGHTS: POVERTY

<table>
<thead>
<tr>
<th>Rutland County children under the age of 6 living in poverty</th>
<th>Number of students eligible for Free and Reduced Lunches over the last 10 years</th>
<th>HIGHLIGHTS: EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="house.png" alt="House icon" /> 36%</td>
<td><img src="graph.png" alt="Graph" /> 45%</td>
<td>Available slots out of 212 total infant slots</td>
</tr>
</tbody>
</table>

### HIGHLIGHTS: PARENTING

<table>
<thead>
<tr>
<th>Rutland County children living in single-parent households</th>
<th>Strong protective factors shown by parents in Vermont</th>
<th>Rutland County children (under 9) in custody of the Department of Children &amp; Families</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="circle.png" alt="Circle icon" /> 28%</td>
<td><img src="circle.png" alt="Circle icon" /> 93%</td>
<td><img src="chart.png" alt="Line chart" /> 40% increase</td>
</tr>
</tbody>
</table>

### HIGHLIGHTS: YOUTH BEHAVIOR

<table>
<thead>
<tr>
<th>1 in 4 high schoolers’ use cannabis (outside the pandemic)</th>
<th>Crisis Services accessed by youth in VT</th>
<th>COVID-19 HOW HAS THE PANDEMIC AFFECTED STUDENTS?</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="people.png" alt="People icon" /> 1 in 3 LGBTQIA high schoolers use cannabis</td>
<td><img src="up.png" alt="Up arrow" /> 35% increase between 2017 and 2019</td>
<td>Stated that their mental health on average, was “a bit or a lot worse”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students feeling sad or hopeless (majority of which are females and those who identify as LGBTQIA)</th>
<th>Two school districts in Rutland County surveyed 11th–12th graders and found:</th>
<th>Stated that family relationships on average, were “a bit or a lot worse”</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="graph.png" alt="Graph" /> 42% of students tried electronic cigarettes in 2020</td>
<td><img src="cannabis.png" alt="Cannabis icon" /> 30% used cannabis within the last year</td>
<td>50% of students</td>
</tr>
</tbody>
</table>

### Sources:
- https://www.countyhealthrankings.org/app/vermont/2020/measure/factors/65/data
- https://www.countyhealthrankings.org/app/vermont/2020/measure/factors/82/data
- https://vermontinsights.org/19-crisis-services/?f=search&i=3

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2021 COMMUNITY HEALTH IMPLEMENTATION STRATEGY BY THE RUTLAND REGIONAL MEDICAL CENTER
Community Input

Parental support emerged as an area of need within our community from the key informant survey and community discussions, pointing to the difficulty of parental participation in parent/school organizations, parenting classes, and accessing services because of limited time and capacity due to employment, health issues, or transportation.

Time constraints were also identified as why parents have difficulty accessing health care for children/youth. Medical providers also identified the lack of specialty care and parental/caregiver health issues as major barriers when accessing health care for children. Parents struggling with housing issues, employment, or substance use was also discussed as a barrier to accessing care for young dependents.

Health Equity

Adverse Childhood Experiences (ACEs) are also health issues discussed by community leaders and during community discussions. Divorce, living with a parent with substance use or mental disorder, and poverty are the most common ACEs experienced by Vermont children. The 2019 Youth Risk Behavior Survey also illustrates the need to address specific groups of youth in our community. LGBTQIA+ youth experience significantly higher rates of bullying, unwanted sexual contact, and intimate relationship violence. In addition, LGBTQIA+ youth also use substances and experience suicide ideation much more than heterosexual peers.

Research illustrates the connection between childhood trauma and adult chronic disease. Training current teachers and service providers in trauma-informed care will be essential in supporting our youngest population, parents, and all youth living in Vermont.

The pandemic has also highlighted the need for quality childcare and afterschool options. Many people, a majority being women, have reported leaving the workforce to take care of their children. This illustrates the need for family-friendly workplace policies and practices, like flexible work hours, employee onsite or subsidized childcare, and/or flexible emergency leave. COVID-19 has also illustrated the need for quality childcare options in the region. With limited opportunities for afterschool and summer programming, there was an impact on parental employment, parental and youth mental health, housing, and most other aspects of family life.

Workforce Development

Infrastructure was also a common theme when discussing needs and gaps within this priority area. There is a large need for early childhood educators. This workforce also needs wages that reflect the importance of their work while simultaneously not becoming too costly for families.
## Housing

### Highlights

<table>
<thead>
<tr>
<th>HALF of renters in Rutland County spend 30% or more of their income on housing</th>
<th>Average number of days homeless households in Rutland County receive emergency housing services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>144 DAYS</td>
</tr>
</tbody>
</table>

### Race and Ethnicity

<table>
<thead>
<tr>
<th>WHITE HOUSEHOLDS</th>
<th>BLACK HOUSEHOLDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeownership rate</td>
<td>71% VS 22%</td>
</tr>
<tr>
<td>Median household income</td>
<td>$58,244 VS $41,553</td>
</tr>
</tbody>
</table>

### Vermonters in emergency housing

![Graph showing increase in Vermonters in emergency housing from 2020 to 2021](chart.png)

**664% increase**

### Gaps/Needs Identified by Community Input and Survey Results

1. Increase temp and permanent housing for people experiencing homelessness or precarious housing situations
2. Provide a common application process across agencies to streamline support and decrease barriers to access
3. Provide wrap-around services and navigation of services needed for individual needs

### Sources:
- [https://www.rentdata.org/rutland-county-vt/2021](https://www.rentdata.org/rutland-county-vt/2021)
- [https://www.housingdata.org/profile/snapshot](https://www.housingdata.org/profile/snapshot)
- [https://www.housingdata.org/documents/images/Chapter%2021_Rutland%20County.pdf](https://www.housingdata.org/documents/images/Chapter%2021_Rutland%20County.pdf)
Community Input

Community leaders overwhelmingly discussed affordability, safety, and availability as the major housing issues our community faces. They often cited transitional housing as a need and noted the safety issues related to older, substandard housing stock and concern over the use of motels as emergency shelters. During community discussions, more low-barrier housing options, more day centers, and a common application process were seen as steps in addressing housing issues in our community.

When examining housing and access to health care, medical providers stated lack of or inadequate housing as a factor that limits individuals and families from accessing health care. They also noted that nutrition, mental health, and hygiene are often impacted by housing challenges.

Health Equity

Rent prices in Rutland County have stayed relatively the same from 2019 to 2021, with the Fair Market Rent (FMR) amount for a one-bedroom totaling $778/month in 2019, $797/month in 2020, and $779/month in 2021. The FMR in Rutland County is more expensive than 53% of Vermont. However, we know that half of the renters pay 50% of their monthly income on rent. We also know that non-White residents are more likely to face housing challenges. Only 22% of Black households are homeowners compared to the national rate of 42%. Additionally, in the 2019 Point-in-Time count Black Vermonters accounted for 8% of the homeless population. Considering this population accounts for only 1% of the total Vermont population, 8% of homeless population is considerably high.

It is also important to note the lack of safe and well-maintained housing that is also affordable. The 2020 Vermont Housing Needs Assessment identified Rutland County as having the oldest stock of houses of any Vermont county. Old homes can pose major health risks to residents of the county, including illness from lead and asbestos. Older housing stock also increases cost of heating and cooling. Enlarging the gap between renters and owners, the cost of housing has increased but wages in our state have been stagnant. A living wage for a single adult in Rutland County would be approximately $14.50 an hour. However, for a single adult with one child, a living wage would need to double to just over $30 to equal close to $62,000 a year. When examining the average individual income in our region, we see that most people make close to $30,000 a year and the average household makes $56,000 a year. This illustrates a clear gap in equity related to wages and housing affordability.

Workforce Development

Workforce development continues to be an issue in all sectors across our country, state, and region. One aspect that hinders recruiting people to our region to bolster our workforce is available and affordable housing. With a lack of housing available for our most vulnerable populations we also have a lack of housing for new people and families interested in moving to our region. Workforce development is also impacted by major infrastructure deficiencies like lack of childcare options, afterschool programs, mental health providers, and a robust health-care labor force.
Mental Health, Including Substance Use

**HIGHLIGHTS**

- Residential segregation between non-White and White Rutland County residents: Value nearly doubled.
- Adults that reported binge or heavy drinking in the last 30 days: 21%.
- Rutland County mental health provider ratio: 310:1. Ranking 9th place in Vermont for available mental health providers, despite being the second-most populated county.
- Average poor mental health days per month: As reported by Rutland County residents.
- Rutlanders that reported experiencing 14 or more poor mental health days within the last month: 16%.
- Year to date ED visit rate* for opioid overdose: Rutland County 69.2 vs. Statewide 32.9.
- Year to date ED visit rate* for suicidal ideation: Rutland County 391.7 vs. Statewide 228.9.
- 115% increase in youth using the emergency department for mental health crises from 2020–2021.

**Sources:**
- https://vtdigger.org/2021/06/29/rutland-mental-health-lands-600000-for-pilot-program-for-young-people/
- https://www.countyhealthrankings.org/app/vermont/2021/measure/factors/49/data
- https://www.countyhealthrankings.org/app/vermont/2021/measure/factors/142/data

**GAPS/NEEDS IDENTIFIED BY COMMUNITY INPUT AND SURVEY RESULTS**

1. Supporting current clinicians and recruiting new providers to the area with livable wages.
2. Supporting youth mental health needs in our community.
3. Providing services to address barriers associated with accessing mental health needs: cost, stigma, and transportation.
Community Input

Creating systems that decrease barriers and increase access to mental health was discussed widely in community discussions and in key informant surveys, with transportation, wait times, and access to technology as areas of improvement. Telemental health was discussed as an avenue of addressing ease of access, with the added caveat of the need for technology to use this method of care. In addition, the majority (87%) of medical providers who completed the survey stated a shortage of providers or waitlists as the number one reason their patients might not seek mental health services. Medical providers also pointed to stigma (77%), substance use (71%), and transportation challenges (57%) as patient barriers to accessing mental health care.

Health Equity

After availability, affordability and being underinsured are common themes in accessing mental health care. Often this type of care is only partially covered by insurance policies and still requires payment, making it difficult to access for many people. Additionally, wait times to see a counselor have increased due to high demand. For many children and youth, emergency mental health situations have required long stays in emergency departments while waiting for space at youth facilities to become available. Local data from the youth risk behavior survey also indicates that youth who identify as LGBTQIA+ are more likely to experience mental health issues, use substances, and experience sexual violence. Furthermore, there are insufficient services, programs, or groups in our region providing direct services for adults and youth who identify with this group. In addition, with limited providers and long wait times for mental health care, there could be serious implications for that specific community in our region. Moreover, people with disabilities who may want to seek mental health care have additional barriers such as physical access, poverty, and being underinsured. Again, telemental health services may be one way to address this issue and make this type of care more accessible and easier to recruit new providers; however, it still requires people to have access to equipment and internet services.

Opiate overdoses and deaths have increased since the start of the pandemic all over the state and in our region. Addressing this issue is not unfamiliar for our region. Easy access to treatment and recovery programs is essential to supporting people with substance use disorder (SUD). To increase access, we must ensure that our health-care and local service providers are trained in trauma-informed care and issues related to the stigma associated with SUD. Also, substance use can create ripple effects in a community by impacting neighborhood safety, decreasing housing value, and reducing connection to the community. This ripple effect impacts both the people experiencing substance use disorder and the greater community. Providing support to adversely affected neighborhoods could increase connectivity and strengthen neighborhood relations and safety.

Workforce Development

The need for mental health counselors has increased. The wait time to see a counselor has increased since the pandemic and offering a living wage is increasingly difficult because of reimbursement payments from insurance. According to Zip Recruiter, the average yearly salary for a mental health worker in Vermont is just over $32,000 with an hourly rate of $15.46. People working in behavioral health make on average $28 an hour, which still does not meet the living wage requirement for a single parent with one child. Organizational and agency evolution to adopt family-friendly workplace policies that provide flexibility, job sharing, desired benefits, and ongoing staff training could help increase recruitment and retention within this field.
Supporting Aging Community

**HIGHLIGHTS**

- **The Vermont Department of Health estimates a 114% increase in people 70 years or older by 2030 in Rutland County.**
- **Vermont ranks 13th in senior health by the United Health Foundation, a ranking that has steadily decreased since 2015, when Vermont ranked 1st.**
- **Vermont scores 5th out of 51 by AARP on long-term services and supports for people 65+, people with physical disabilities, and family caregivers.**

<table>
<thead>
<tr>
<th>Caregivers that stated they could not afford respite care</th>
<th>Respondents that had food security concerns sometimes or often</th>
<th>Respondents that utilize Meals on Wheels</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>30%</td>
<td>36%</td>
</tr>
</tbody>
</table>

**Southwestern Vermont Council on Aging region**

**GAPS/NEEDS IDENTIFIED BY COMMUNITY INPUT AND SURVEY RESULTS**

1. Recruit and retain staff and caregivers assisting aging in place (family caregivers, home health aides, etc.)
2. Specialized care for older adults, SUD Clinicians, Geriatricians
3. Support for aging in place, assessments, and preparing for aging
4. Providing affordable care with limited barriers to access

**Community Input**

Medical providers detail isolation, chronic disease, affordability of care, and lack of caregivers as the most challenging aspects of health for our oldest Vermonters. The most common themes from the key informant survey pointed to isolation, housing needs like aging in place, and transportation (Figure 3). In addition, key informants stated that this
population is also not valued, which equates to less funding for programs that would support this growing community in our region. The survey also found that supporting the aging community was ranked as the least important priority area for both medical providers and key informants. It is essential for our region to prioritize support services for this segment of our population as Rutland County has the fastest growing number of aging residents in the state and has a higher than average rate of people living with disabilities and chronic disease compared to other counties.

Health Equity

As we have seen a significant upward trend of older Vermonters in our demographics, services to support our aging population have struggled to keep up. For example, there is only one primary care physician who has specialized training as a geriatrician located in Rutland County. Our local Council on Aging is struggling to replace an elder care mental health clinician, making it difficult to start a new caregiver support program. As our aging population grows, so will the need to provide unique specialized care. Also worth noting is the intersection of mental health and housing issues with this particular population. The stigma of asking for help, low income, and availability of providers could create major health challenges for this population without considerable investment and resources.

It is also important to mention that Rutland County has a higher rate of adults with disabilities than the state as a whole. Furthermore, adults 65 and older are more likely to have a disability. State data also reveals that Rutland County has a higher rate of people living with chronic disease like COPD and hypertension. As we explore the needs within our aging population, acknowledging and addressing the access of services for people with disabilities and chronic conditions will be paramount.

Workforce Development

Caregivers for our aging population are in great need in both the clinical and home-based fields. In addition, many of our caregivers are family members who are not getting compensated for the time, compassion, and work it requires to care for an ailing or sick loved one. Respite care and opportunities for unpaid caregivers to care for themselves are important and must be considered when exploring strategies to address this area of need.
Strategy Considerations

As we look to address each priority area, we must consider the essential qualifications of chosen strategies. Of the strategies and projects our community focuses on, we suggest the following foundational components:

1. HEALTH EQUITY
2. DATA COLLECTION
3. A MULTI-FACETED APPROACH
4. CURRENT CAPACITY OF WORKFORCE AND/OR COMMUNITY

Health Equity

Health equity is when all people have a fair and just opportunity to be healthy—especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation, and disability. With a focus and foundation on health equity, strategies can hone in on specific populations or communities within our community. Creating programs, policies, protocols, and training that will reduce barriers and increase access to services will help not only individuals within target populations but all people needing support.

Health equity is a foundational component

- Address accessibility to services, including technology, transportation, childcare, and disabilities
- Include targeted populations in the planning of programs and development of policies and protocols

Training and education for service providers and health-care providers to identify, ask, support, and address people from vulnerable populations

- Implement universal screenings with sufficient training on implementation and documentation for the workforce
- Provide ongoing training for the workforce: implicit bias, understanding stigma, cycles of poverty, substance use disorder, and addressing racism, ageism, misogyny, and homophobia
Data Considerations

Data is an important tool that helps us better understand the state or health of our community. Using data to improve how we support vulnerable populations is key to securing funding, resources, and knowledge about impact. Providing and sharing data will not only support individuals in our community but also help partner organizations develop and form services and programs to address the needs within groups of people.

Sharing data between groups in order to help all agencies and community have a better understanding of the health of the community

- Development of data collection methods that ensure fidelity across organizations
- Data highlighting how services are or are not being utilized by targeted populations
- Systematized and methodical universal screening process within agencies collecting data
- Understanding health outcomes of vulnerable populations through data
- Aggregate Data sharing agreements between agencies

Data needs for targeted populations

- Disability status
- Socioeconomic status
- Race
- Environmental factors (social determinants of health)—universal screening

Prioritize Intersecting Strategies

While each priority area has unique needs and challenges, taking a multi-faceted approach to addressing our priority areas will be helpful. As each priority area interacts with other priority areas, our strategies should address more than one area. As our community works to improve health, we must engage individuals and groups of people in ways that will minimize the need for multiple programs or projects to address different health inequities. By prioritizing strategies that target more than one area of need, we can decrease the burden on specific groups of people and potentially improve health outcomes.
Addressing Workforce

COVID-19 has exacerbated our deficient workforce needs. There were multiple fields within our community that were already experiencing shortages of experienced professionals, such as the early childhood education professionals, mental health providers, and skilled weatherization laborers. As we explore potential strategies, we have to account for the existing capacity of our current workforce. Reinforcing and supporting the individuals and families who are currently working and looking at innovative ways to recruit new employees is essential. This issue also intersects within each priority area differently and impacts the ability to recruit new people to our region.
Strategy Recommendations

Recordings, notes, and jamboards from each discussion and open meeting allowed for a comprehensive look at the gaps and needs within our community. For each priority area, the major needs were identified and helped target strategy discussion. Each priority area has unique and intersecting challenges to address. Our community in many instances has already begun addressing needs through projects and programs. Some of this can be attributed to the past three years of work which also focused efforts on these priority areas.

### 2021 CHNA Strategies

**CHILDCARE AND PARENTING**

**Gaps/Needs identified by Community Input and Survey Results:**
- Increase quality childcare slots, infants high priority
- Recruit and retain Early Childhood Educator workforce/livable wages
- Support for youth in third spaces
- Providing avenues for parent/guardian connections with community, youth, and agencies

<table>
<thead>
<tr>
<th>Identified Strategies</th>
<th>Health Equity</th>
<th>Multi Area</th>
<th>High Impact</th>
<th>In Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit and retain workforce</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provide quality, affordable childcare slots*</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provide 3rd space for social engagement*</td>
<td>✔️</td>
<td>✔️</td>
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</tr>
<tr>
<td>Standardize SDOH screenings</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Develop youth leadership opportunities</td>
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<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Create trauma-informed communities</td>
<td>✔️</td>
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<tr>
<td>Preschools with wrap-around services</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
</tr>
</tbody>
</table>

* Indicates support from BHT
## 2021 CHNA Strategies

### HOUSING AS HEALTH CARE

**Gaps/Needs identified by Community Input and Survey Results:**
- Increase temporary and permanent housing for people experiencing homelessness or precarious housing situations
- Provide a common application process across agencies to streamline support and decrease barriers to access
- Provide wrap-around services and navigation of services needed for individual needs

### Identified Strategies

<table>
<thead>
<tr>
<th>Identified Strategies</th>
<th>Health Equity</th>
<th>Multi Area</th>
<th>High Impact</th>
<th>In Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop family shelter</td>
<td></td>
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</tr>
<tr>
<td>Bridge housing with wrap around services*</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Increase access to services: meet people where they are</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Increase permanent housing for chronic homeless</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Create a common application process</td>
<td>✓</td>
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<tr>
<td>Increase youth shelter and support</td>
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<tr>
<td>Provide landlords incentives to approve “risky” renters</td>
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* Indicates support from BHT

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2021 COMMUNITY HEALTH IMPLEMENTATION STRATEGY BY THE RUTLAND REGIONAL MEDICAL CENTER

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### 2021 CHNA Strategies

**MENTAL HEALTH**

#### Gaps/Needs identified by Community Input and Survey Results:
- Supporting current and recruiting new clinicians and providers to the area with livable wages
- Supporting youth mental health needs in our community
- Providing services to address barriers associated with accessing mental health needs: cost, stigma, transportation

<table>
<thead>
<tr>
<th>Identified Strategies</th>
<th>Health Equity</th>
<th>Multi Area</th>
<th>High Impact</th>
<th>In Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit and retain workforce</td>
<td>✅</td>
<td></td>
<td>✅</td>
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<tr>
<td>Provide 3rd space for social engagement*</td>
<td>✅</td>
<td>✅</td>
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</tr>
<tr>
<td>Increase access to services: meet people where they are*</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Implement mobile mental health services</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>Offer telemental health services</td>
<td>✅</td>
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<td>✅</td>
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<tr>
<td>Stigma training and awareness</td>
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<tr>
<td>Offer free public transportation</td>
<td>✅</td>
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<td>✅</td>
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</tbody>
</table>

* Indicates support from BHT
### 2021 CHNA Strategies

**SUPPORTING AGING COMMUNITY**

Gaps/Needs identified by Community Input and Survey Results:
- Recruit and retain staff and caregivers assisting aging in place (family caregivers, home health aides, etc.)
- Specialized care for older adults, SUD Clinicians, Geriatricians
- Support for aging in place, assessments, and preparing for aging
- Providing affordable care with limited barriers to access

<table>
<thead>
<tr>
<th>Identified Strategies</th>
<th>Health Equity</th>
<th>Multi Area</th>
<th>High Impact</th>
<th>In Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit specialty providers</td>
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<tr>
<td>Increase support caregivers (paid/unpaid)*</td>
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<tr>
<td>Develop intergenerational communities</td>
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<tr>
<td>Standardize SDOH screenings</td>
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<tr>
<td>Support aging in place and assessments</td>
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<tr>
<td>Provide activity programs for older adults</td>
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<tr>
<td>Offer telehealth support for older adults</td>
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</table>

* Indicates support from BHT
**Conclusion**

Addressing our priority areas is complicated and layered and there are many considerations to explore and discuss as our community develops strategies. This report provides important considerations for each agency, organization, and coalition in our community to use as they develop plans and projects to address our greatest needs. Continuing collaboration and breaking down silos will be essential to our success.

Over the next three years, the Community Health Needs Assessment and the tactics outlined in the Implementation Report will be integral to the continuance and development of programs and strategies to address the priority areas. The information from each report can be used as a roadmap or guide for our community when making decisions on where to spend resources and how to address areas of need. It is also important to remember that these reports are a snapshot at a specific time and our community is ever changing. However, the considerations listed above will continue to be useful as our needs change and evolve.

As our community addresses priority areas over the next three years, tracking our progress will be important. Using existing coalitions and agency connections to analyze and understand the impact of our efforts is part of the Community Health Needs Assessment process. In addition to understanding our impact, disseminating this information to key stakeholders and the community is vital and creates meaning behind the written reports. This will allow agencies to tell their stories with the support of recognized community documents and data. Transparency of our progress and challenges will only strengthen our ability to address the health needs of our region.

**Acknowledgments**

On behalf of the authors and Core Team, we would like to thank the following organizations and people for their assistance with the CHNA report:

<table>
<thead>
<tr>
<th>2021 CHNA creators:</th>
<th>Selected pictures provided by:</th>
</tr>
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<tbody>
<tr>
<td>Marjanna Barber-Dubois, Rosa Wallace, Sasha Rosen and Amanda Beatty</td>
<td>Real Rutland</td>
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<tr>
<td>NAACP Rutland VT Chapter</td>
<td>Slate Valley Trails</td>
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<td>Outright VT</td>
<td>Unsplash</td>
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<td>Project Vision</td>
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<tr>
<td>Richard Clark, PhD, Castleton University</td>
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<tr>
<td>Bradly A. Berryhill, MD, Rutland Region Community Health Centers</td>
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<tr>
<td>Phillip Lapp, MD, Rutland Regional Medical Center</td>
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<tr>
<td>Rick A. Hildebrant, MD, Rutland Regional Medical Center</td>
<td></td>
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<tr>
<td>Southern Vermont Area Health Education Center</td>
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