

2025 RUTLAND COUNTY

Community Health Implementation Report

In Response to the 2024 Community Health Needs Assessment



2025 RUTLAND COUNTY

Community Health Implementation Report

Bowse Health Trust Staff

Jamie Bentley

Community Impact Coordinator, Rutland Regional Medical Center

Traci Moore

Senior Director of Development & Community Relations, Rutland Regional Medical Center

Community Health Needs Assessment Advisory Council Members

Renee Bousquet

District Direct Local Office of Health, Vermont Department of Health

Jessica Boutin

Director of Quality & Compliance, Visiting Nurse Association & Hospice of the Southwest Region

Laura Galster

Vice President, Planning & Information Services, Rutland Regional Medical Center

Monika Ganguly-Kiefner

Public Health Supervisor, Vermont Department of Health

Kathryn Jakubowski

School Nurse Liaison, Vermont Department of Health

Jill Jesso-White

Director of Communications & Development, Community Health Centers

Laura Kass

Chief Services Officer, Community Care Network

Chad Peterson

Epidemiologist, Vermont Department of Health

Amanda Richardson

Research Analyst and Community Member

Jonah Stroller

Public Health Specialist, Vermont Department of Health

Cindy Taylor-Patch

Certified Community Behavioral Health Clinic Project Director, Rutland Mental Health

For more information, please contact Jamie Bentley at jambentley@rrmc.org



Written and prepared by:

Jamie Bentley, MPH

Editorial design by: Christina Ryan

Photography by: Jamie Bentley,
Kassia Dutton, Real Rutland,
and Christina Ryan

Table of Contents

Introduction and Overview	4
Foundational Strategies	7
Access to Care.....	11
Community Connections	13
Community Safety.....	15
Universal Strategies.....	17
Funding Opportunities	18
Conclusion	19



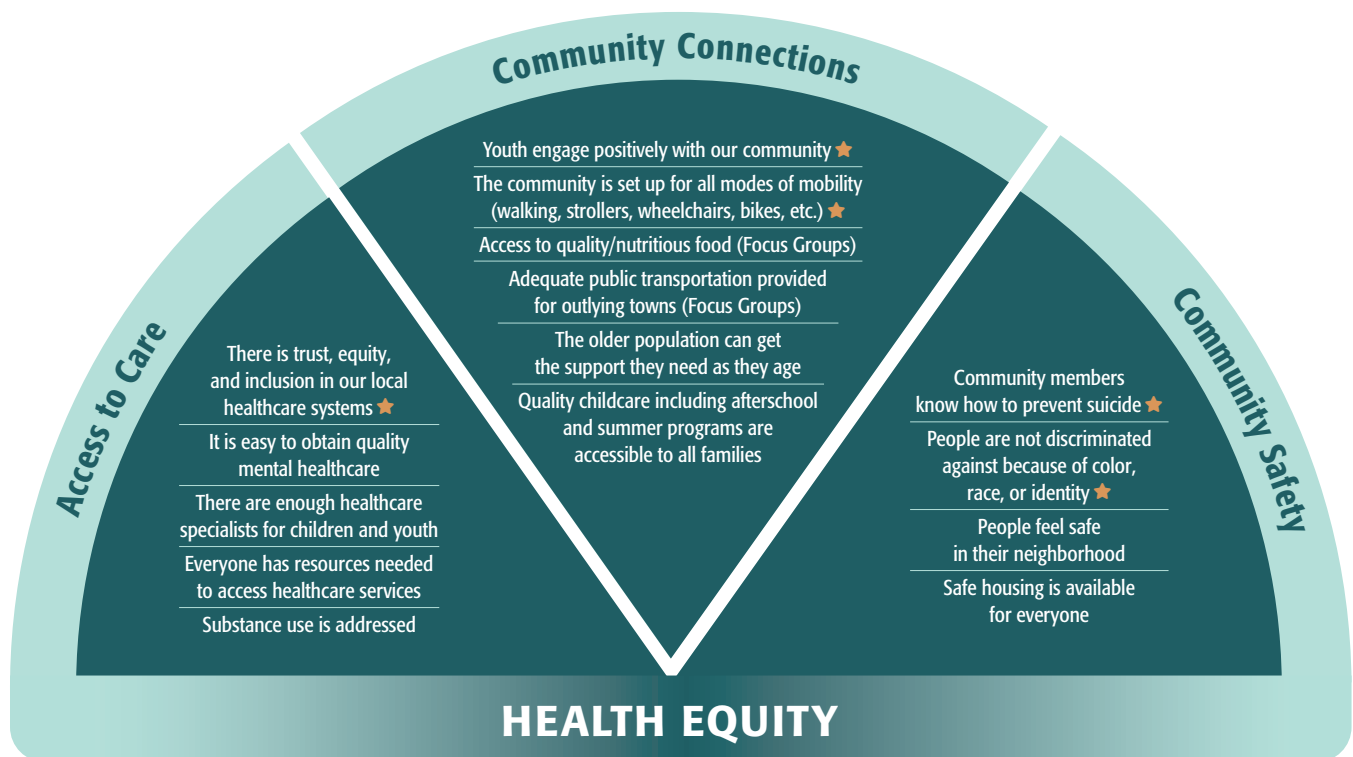
2025 Implementation Strategy

INTRODUCTION

The Community Health Needs Assessment (CHNA) report outlines the general health of our Rutland County community and has identified three priority areas. Rutland Regional Medical Center conducted this document in partnership with the CHNA Advisory Committee. The committee included a diverse range of community partners. Each priority area has its own specific challenges, needs, and gaps that must be addressed to reduce health disparities and improve overall community health effectively.

A wide range of community leaders, service providers, medical providers, and community members offered their expertise and experience to help us understand the challenges, gaps, and needs within each priority area. This report will provide context to the 2024 CHNA and recommend strategies to address priority needs. Additionally, measurable goals for each priority area will be outlined to track progress.

Each identified priority area has specific indicators, which are outlined below:



★ Indicates priority populations have identified these indicators as a high priority.

To view the full 2024 Community Health Needs assessment, please visit:
www.rrmc.org/about/community-health-needs-assessment/

ABOUT THE IMPLEMENTATION REPORT

This Implementation Report serves as a companion to the 2024 Community Health Needs Assessment (CHNA). It outlines strategic responses to the three priority areas identified through extensive community engagement: Access to Care, Community Connections, and Community Safety. The report integrates input from more than 650 participants, including community members, healthcare providers, and key informants, to highlight pressing needs and gaps in health and social services. It also identifies actionable, data-informed strategies rooted in foundational principles such as health equity, cross-agency collaboration, workforce capacity, and data sharing. Designed to guide local organizations, coalitions, and stakeholders, the implementation report offers a roadmap for collective action and ongoing improvement in community health outcomes across Rutland County.



In this document, you will find an overview of each priority area, supported by relevant data, community-identified needs, and recommended strategies. Each section includes strategy suggestions categorized by key characteristics, such as equity impact, data utilization, evidence base, and current progress. A concluding section offers guidance on how this report can be used to track progress and inform future decision-making. Appendices and links to supporting materials are included to provide additional context and resources.

CHNA SURVEYS

During the winter and spring of 2023-2024, 443 community members, 123 key informants, and 85 healthcare providers responded to surveys specifically tailored for each group. Participating key informants and healthcare providers represented consumers from varied focus populations, including medically uninsured people, people living with chronic conditions, families receiving food subsidies, and/or people experiencing housing challenges.

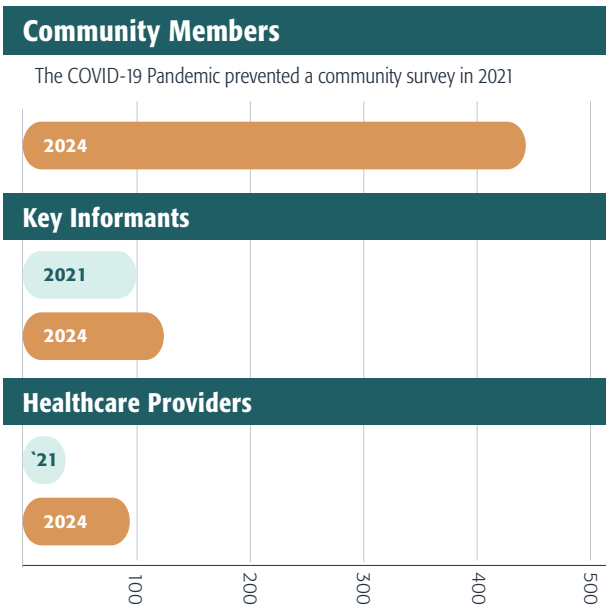
The healthcare provider survey included:

- primary care providers,
- nurse practitioners,
- mental health providers,
- specialists,
- as well as eye and dental care providers.

Overall, our process enhanced our connection to and participation from all community stakeholders, including healthcare providers, service providers, law enforcement, and general community members. Responses from the community survey were limited in terms of demographic diversity, prompting the use of focus groups to enhance the voices of underrepresented groups. For more information on the Key informant and Healthcare, see Figure 1.

Providers surveys can be found at www.rrmc.org/about/community-health-needs-assessment/

FIGURE 1: NUMBER OF PARTICIPANTS IN THE 2021 & 2024 COMMUNITY HEALTH NEEDS ASSESSMENTS



Strategies & Data

Hubbardton Battlefield State Historic Site, Vermont
Photo by Christina Ryan



Foundational Strategies

CONSIDERATIONS

As we address each priority area, we must consider the essential qualifications of the chosen strategies. Based on the strategies and projects our community focused on, we suggest the following foundational components: health equity, cross-agency collaboration, workforce/community capacity, and data collection.

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 are centered on specific populations or communities within our local region. Creating programs, policies, protocols, and training that reduce barriers and increase access to services will help individuals within the target populations.

- ➡ **Health Equity is a foundational component.**
 - a. Address accessibility to services, including transportation, childcare/afterschool programming, specialty services for children and youth, and disability supports.
 - b. Include populations of focus in the planning of programs and development of policies and protocols.
- ➡ **Training and education for service and healthcare providers can help them to identify, request pertinent information from, support, and address the needs of people from populations of focus.**
 - a. Implement universal screenings with sufficient training on implementation, documentation, and response to positive screens for the workforce.
 - b. Provide ongoing training for the workforce; focusing trainings on specific populations of focus and areas of need will support the workforce in understanding and serving specific populations of focus.

Cross-Agency Collaboration

Cross-agency collaboration is essential when supporting individuals and families, as no single organization can address all the complex and interconnected challenges individuals face. By working together, agencies can share resources, expertise, and data to provide more comprehensive and coordinated care. This collaboration helps reduce service gaps, prevent duplication of efforts, and create more efficient pathways for individuals to access the support they need. Ultimately, a unified approach leads to better outcomes, ensuring that people receive comprehensive and sustainable solutions to enhance their well-being.

•

- ➡ **Breaking down silos by:**
 - a. Increasing agency communication through multi-agency meetings and follow-up
 - b. Enhancing transparency in the collaboration process
 - c. Promoting the universal release of information forms to share information
 - d. Providing support and training for current and new staff

Workforce/Community Capacity

Workforce/Community Capacity is vital when exploring potential strategies. We must account for the existing capacity of our current workforce and community. Reinforcing and supporting the individuals and families who are currently working and exploring new and 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.

- ➡ **Address workforce retention through a health-equity lens (family-friendly work policies)**
- ➡ **Address workforce development and recruitment**
- ➡ **Reprioritize where necessary to meet existing capacity (reassess programs and projects)**

Data Collection

Data Collection is an important tool that helps us better understand the status and/or health of our local region. 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 create services and programs to address the needs of specific groups of people.

- ➡ **Share data between groups to support all agencies and the entire community, fostering a better understanding of the community's health.**

STRATEGIES, CURRENT PRIORITY AREAS, & ONGOING EFFORTS

Each priority area has stand-alone indicators that the community has identified as areas for improvement. As each of these indicators intersects with other priorities, drivers of health, and community capacity, we know the work being done impacts each area of need.

The following information provides a snapshot of the coordinated efforts within our community to address the needs identified in the CHNA. These groups of stakeholders, agencies, and community members work together using the foundational strategies to inform their projects, programs, and passion. This is not an exhaustive list of the work being done in our community—it simply aligns the groups or agencies with the identified indicators and foundational strategies they are using to impact the health of our community.

The Rutland Community Collaborative

The Rutland Community Collaborative operates through several specialized subcommittees that consist of multiple stakeholders who focus time and effort on specific areas related to the CHNA and healthcare needs. This group is facilitated by the Blueprint for Health Quality Care Manager. It prioritizes health equity, focusing on specific populations and areas of care that require coordination and collaboration for successful outcomes. The acting sub-committees and stakeholder groups collaborate to create, implement, and provide information and programs, including:

- Collecting and analyzing universal Social Drivers of Health information and data from multiple healthcare agencies in the region.
- Sharing disease surveillance and prevalence statistics.
- Educating stakeholders and promoting fair access to healthcare and addressing disparities.
- Developing and providing educational information for patients and community members.
- Focusing on improving health outcomes and access to care for children.
- Accessing mental health and substance use disorder services.

Project VISION

Project VISION is a community-driven coalition with a primary goal of fostering cross-agency collaboration, communication, and connection to enhance the community's health. This work is facilitated by the Rutland City Police Department and is grounded in four core pillars of collaboration to address substance use, community safety, and health. The unique group of stakeholders includes law enforcement, service agencies, community members, and lawmakers.

- **Prevention:** Implementing proactive measure to reduce community risk factors.
- **Intervention:** Offering timely support to individuals at risk.
- **Accountability:** Ensuring that all stakeholders take responsible actions.
- **Support:** Providing necessary resources for recovery and well-being.

Sub Committees: Health, Community Policing, Training and Education

Continuum of Care

The Continuum of Care is the Rutland County coalition that meets monthly to address housing issues. This system helps organize and deliver housing services to meet specific needs of people who are experiencing a variety of housing issues. The Homeless Prevention Center facilitates the coalition and convenes numerous service agencies that address and support individuals with housing challenges.

- Identifying and addressing service gaps within the housing continuum.
- Coordinating care and services for individuals and families.
- Discussing and advocating for policy changes that address housing challenges.
- Sharing and analyzing aggregate data to inform decision-making.

Rutland Belonging Collective

The Rutland Belonging Collective was developed and is facilitated by Social Tinkering. This group of stakeholders works to reduce barriers to meaningful social connection by centering on lived experiences, bringing people together, and removing obstacles. The group consists of service agencies and community members who work collaboratively to:

- Identify the complex causes and impacts of isolation and loneliness.
- Build and sustain spaces for compassionate belonging in Rutland County.
- Remove the barriers to connection through collaboration.

Building Bright Futures

Building Bright Futures Rutland Early Childhood Regional Council brings together community members committed to young children and families. Vermont's Early Childhood Action Plan guides regional councils, and they identify annual priority actions based on community needs and gaps in services, including:

- Addressing critical needs within early childhood education and care.
- Ensuring young children and their families have access to high-quality learning opportunities and support services.
- Developing pathways to increase qualified early childhood educators in our area.

Access to Care

Access to care is essential to a healthy and thriving community. When people can easily get the care they need—whether it’s for physical health, mental health, or substance use support—they are more likely to live longer, healthier lives. Access means more than just having services available; it means care is affordable, timely, culturally respectful, and close to home. Without access to care, preventable conditions go untreated, stress and illness increase, and health disparities grow. Prioritizing access to care strengthens families and communities, reduces long-term healthcare costs, and builds trust in the systems meant to serve us all.

Access to Care Indicators Identified by Rutland County Residents

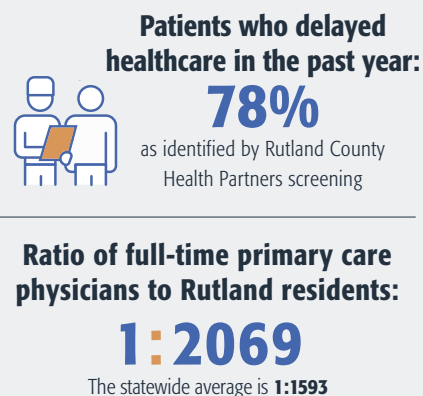
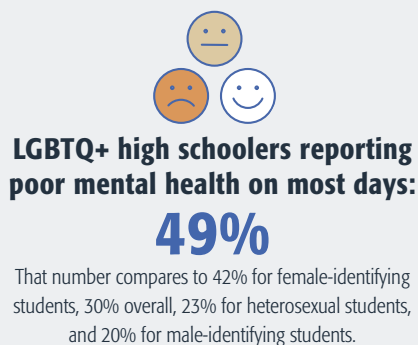
The following indicators were used in the community survey and during focus group sessions. They were identified by participants as important and needing improvement.

- ✓ There is increased trust in our local healthcare systems
- ✓ It is easier to obtain quality mental health care
- ✓ There are enough healthcare specialists for children and youth
- ✓ All residents have information and resources to access needed healthcare services
- ✓ Substance use is addressed through increased access to care and services

DATA POINTS: The following metrics were selected due to their availability, and proximity to our health service area. These metrics are not casually related to the indicators or strategies but will offer context for the identified health priorities.

DATA POINTS

Sources: 2024 America’s Health Rankings by the United Health Foundation, 2024 SDoH Screening Data, 2023 YRBSS Data from Rutland County, 2022 Physician Census Statistical Report by the VT Dept of Health



ACCESS TO CARE STRATEGY CONSIDERATIONS

Identified Strategies	Health Equity	Data Driven	Evidence based	In Progress
Provide mobile health and social services to people with complex needs	✓	✓	✓	✓
Implement a rapid triage model of cross agency coordinated care (situation table)	✓	✓	✓	✓
Offer a Certified Community Based Integrated Health Center model to increase access to mental healthcare	✓	✓	✓	✓
Complete an in-depth examination of early pediatric intervention specialty providers and feasibility of a Pediatric Developmental Clinic		✓	✓	
Increase telehealth options for rural areas for primary, acute, and mental health services	✓	✓	✓	
Allow or increase primary care and hospital student clinical rotations	✓		✓	
No wrong door mental health referral system	✓		✓	



Community Connections

Community connectivity is a powerful driver of health and well-being. When people feel connected to their neighbors, can move safely and easily through their environment, and have access to basic needs like nutritious food, childcare, and transportation, they are more likely to thrive. Strong community connections reduce isolation, support youth development, and help to ensure older adults can age with dignity and support. These connections also foster a sense of belonging and shared responsibility, which improves health outcomes across all age groups. Investing in community infrastructure and relationships is not just beneficial for individuals—it strengthens the entire community’s resilience and overall well-being.

Community Connections Indicators Identified by Rutland County Residents

The following indicators were used in the community survey and during focus group sessions that were identified by participants as important and needing improvement.

- ✓ Youth engage positively with our community.
- ✓ The community is set up for all modes of mobility (walking, strollers, wheelchairs, walkers, bikes, etc.).
- ✓ Access to quality/nutritious food.
- ✓ Adequate public transportation provided for outlying towns throughout Rutland County.
- ✓ Seniors receive necessary support as they age.
- ✓ Quality childcare including afterschool and summer programs are accessible to all families.



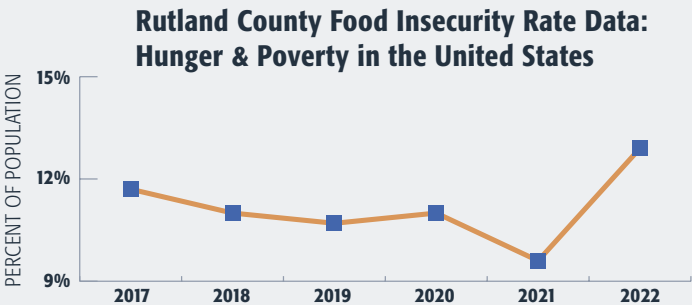
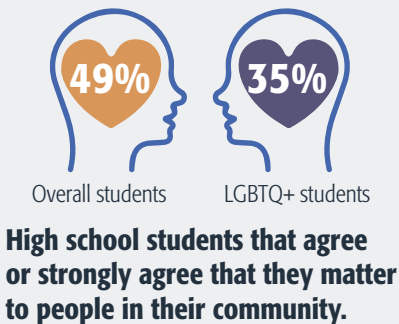
Photo by Real Rutland

COMMUNITY CONNECTIONS

DATA POINTS: The following metrics were selected due to their availability, and proximity to our health service area. These metrics are not casually related to the indicators or strategies but will offer context for the identified health priorities.

DATA POINTS

Sources: Map the Meal Gap (<https://map.feedingamerica.org/county/2022/overall/vermont/county/rutland>), 2024 Let's Grow Kids Stalled at the Start



Additional Childcare Slots Needed to Meet Demand in Rutland County

Infant Slots Needed	LTNC Infant Population	Toddler Slots Needed	LTNC Toddler Population	Preschool Slots Needed	LTNC Preschool Population
570	775	164	395	447	842

LTNC = Likely to Need Care

COMMUNITY CONNECTIONS STRATEGY CONSIDERATIONS

Identified Strategies	Health Equity	Data Driven	Evidence Based	In Progress
Connecting Youth with positive 3 rd places	✓	✓	✓	✓
Address social isolation in older adults with cross age peer mentoring or intergenerational community sites	✓	✓	✓	✓
Initiate a transportation coalition to assess access gaps and needs	✓		✓	✓
Use Complete Streets concepts to assess walking and biking accessibility throughout the county	✓	✓	✓	
Reestablish Adult Day Respite Care programs	✓		✓	
Provide professionally trained medical interpreters for out and inpatient healthcare settings	✓	✓	✓	

Community Safety

Community safety is a cornerstone of public health. When people feel safe—physically, emotionally, and socially—they are more likely to participate in community life, seek help when needed, and support one another. Safety includes more than the absence of violence; it means living in neighborhoods free from discrimination, with access to stable housing and supportive resources. It also means fostering environments where people are informed and empowered to prevent crises like suicide. A safe community fosters trust, promotes mental and physical well-being, and enables residents to live with dignity and peace of mind.

Community Safety Indicators Identified by Rutland County Residents

The following indicators were used in the community survey and during focus group sessions that were identified by participants as important and needing improvement.

- ✓ Community members know how to prevent suicide.
- ✓ Residents are not discriminated against because of color, race, or identity.
- ✓ Residents feel safe in their neighborhood.
- ✓ Safe housing is available for all residents.

DATA POINTS: The following metrics were selected due to their availability, and proximity to our health service area. These metrics are not casually linked to the indicators or strategies but will offer context for the identified health priorities.

DATA POINTS

Sources: 2025-2029 Vermont Housing Needs Assessment, 2023 Annual Homelessness Assessment Report, 2023 YRBS Data from Rutland County, 2022 VT Dept. of Health Repeat Visitors to ED for Suicide-Related Reasons



Percent of renters who pay 30% or more of their income to housing:

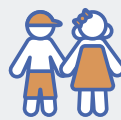
50%

in Rutland County

High school students who felt they were treated badly/unfairly in school because of their race or ethnicity:

62% of BIPOC Students

14% of White Non-Hispanic Students



Rutland County youth under age 12 living in poverty:

29%

2023 Data



People that return to the emergency department for suicide-related concerns:

28%

Rutland County

24%

Statewide



62%

Decrease in fatal and non-fatal overdoses in Rutland City

Reported by Rutland City Police Department

Rutland region housing deficit:

711 homes

3rd highest in State



COMMUNITY SAFETY STRATEGY CONSIDERATIONS

Identified Strategies	Health Equity	Data Driven	Evidence Based	In Progress
Replicate Community Resource Officer Program in other areas of the county	✓		✓	✓
Promote Environmental Design Policing		✓	✓	✓
Increase number of emergency shelter beds and transitional housing units within the county	✓	✓	✓	✓
Integrated suicide prevention training for teachers and school staff (CSSRS)		✓	✓	
Provide HEALS (Halt, Engage, Allow, Learn, and Synthesize) training for communities and workspaces			✓	



Universal Strategies

Implementing universal strategies that impact all three priority areas—Access to Care, Community Connections, and Community Safety—would provide the best use of resources for the greatest impact. The strategies should focus on integrating mobile health services, expanding universal screenings, and enhancing cross-agency collaboration.

Mobile health clinics can bring essential medical, mental health, and social services directly to underserved areas, ensuring accessible care. Universal screenings for social drivers of health (SDoH), including mental health, substance use, and social isolation, can help identify at-risk individuals early and connect them with appropriate support. Cross-agency collaboration can be strengthened through multi-agency meetings, shared data agreements, and universal release of information forms, ensuring seamless support for individuals across different service sectors. Additionally, training healthcare and service providers in trauma-informed care, cultural competency, and stigma reduction can enhance the quality of care for all populations. Strategies such as rapid triage models for coordinated care, increasing access to affordable housing, and implementing community resource officer programs for community safety are also crucial to building a safer, healthier, and more connected community.

Data Considerations

- ➡ Number of agencies sharing SDoH data: Four = Rutland Regional Medical Center, Community Health, Rutland Mental Health, and Rutland County Health Partners
- ➡ Number of rental homes in Rutland County: 7,304
- ➡ Number of patients served by a mobile health clinic: Zero

STRATEGY CONSIDERATIONS that cut across all priority areas:

Identified Strategies	Health Equity	Data Driven	Evidence Based	In Progress
Training healthcare and service agency workforce in specific topics around populations of focus, trauma, social drivers of health, and poverty	✓	✓	✓	✓
Mobile health clinics in rural areas	✓	✓	✓	✓
Increase all types of housing to meet housing needs for all individuals and families	✓	✓	✓	✓
Social drivers of health screening implementation and data sharing	✓	✓	✓	
Use of complete streets and streetscape design initiatives	✓	✓	✓	

RUTLAND COUNTY FUNDING OPPORTUNITIES

The following regional entities use a competitive grant process to allocate funding. While there are other funding opportunities within the Rutland region, these specific opportunities are directly linked to the priority areas identified in the 2024 Community Health Needs Assessment.

Bowse Health Trust

The Bowse Health Trust (BHT) is a grant funding department of Rutland Regional Medical Center with a mission to fund collaborative, community benefit programs that measurably improve the health of the people in Rutland County. Each year, the Trust awards grants to new projects that align programs with the identified priority areas from the most recent *Community Health Needs Assessment*. More information about the funding process can be found at www.rrmc.org/about/bowse-trust/.

United Way of Rutland County

The United Way of Rutland County (UWRC) is an independent, non-profit organization dedicated to advancing the common good, focusing on health, education and financial stability for Rutland County since 1943. Community Impact Grants provide needed funding to local Rutland County organizations that address challenges and needs related to health, education, and basic needs. More information about the funding process can be found at www.uwrutlandcounty.org/grants/.

Vermont Prevention Lead Organization Region 2

The Vermont Prevention Lead Organization Region 2 (VPLO2) is a Vermont Department of Health, Division of Substance Use Program, funded through cannabis excise dollars. The VPLO2 serves community organizations by coordinating a regional advisory structure with district partners to allocate substance misuse prevention funding in the designated region. Allocations are based on community assessments, risk and protective factors, and community readiness. More information about the funding process can be found at www.vplo2.org/get-funding.

Conclusion

Addressing our priority areas is a complex and multifaceted process. There are many considerations to explore and discuss as our community develops strategies. This report presents key considerations for each agency, organization, and coalition throughout our local region to inform the development of plans and projects addressing our most pressing needs. Ongoing collaboration and breaking down silos will be essential to our success.

As our community addresses priority areas over the next three years, tracking our progress will be important. Utilizing existing coalitions and agency connections to analyze and understand the impact of our efforts is a key component 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 reports and data. Transparency in our progress as well as in our challenges will only help to strengthen our ability to address the health needs of our region.

It is also important to remember that these reports are a snapshot from a specific time, and our community is constantly evolving. However, the considerations listed above will continue to be useful as our needs change and grow.

Over the next three years, the Community Health Needs Assessment and the annual implementation reports will be integral to the development of programs and strategies to address the priority areas. The information from each report can guide for our community when making decisions about the allocation of resources and how to address areas of need. It is also important to remember that these reports are a snapshot from a specific time, and our community is constantly evolving. However, the considerations listed above will continue to be useful as our needs change and grow.



Pine Hill Park in Rutland, Vermont
Photo by Jamie Bentley



Healthy You. Healthy Together.

