APPENDIX H

Dartmouth-Hitchcock Community Needs Assessment FY 2022

Dartmouth-Hitchcock

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

VNH
VISITING NURSE and HOSPICE for VERMONT and NEW HAMPSHIRE
A Dartmouth-Hitchcock Affiliate

Community Health Needs Assessment | Fiscal Year 2022









Community Input on Health Issues and Priorities, Selected Service Area Demographics and Health Status Indicators

Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for VT and NH

Community Health Needs Assessment

2022

Community Input on Health Issues and Priorities,
Selected Service Area Demographics and Health Status Indicators

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Partner organizations for the 2022 Community Health Needs Assessment include Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, Visiting Nurse and Hospice for VT and NH, Mt. Ascutney Hospital and Health Center, Valley Regional Healthcare, New London Hospital, and Lake Sunapee Region VNA & Hospice with technical support from the NH Community Health Institute/JSI.

Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for VT and NH
2022 Community Health Needs Assessment

Executive Summary

During the period February 2021 through October 2021 an assessment of Community Health Needs was completed by Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital and Visiting Nurse and Hospice for VT and NH in partnership with Mt. Ascutney Hospital and Health Center, New London Hospital, Valley Regional Healthcare, Lake Sunapee Region VNA & Hospice and the New Hampshire Community Health Institute. The purpose of the assessment was to:

- Better understand the health-related issues and concerns impacting the well-being of area residents;
- Inform community health improvement plans, partnerships and initiatives; and
- Satisfy state and federal Community Health Needs Assessment requirements for Community Benefit reporting.

For the purpose of the assessment, the geographic area of interest was 19 municipalities comprising the primary service area of Mary Hitchcock Memorial Hospital and Alice Peck Day Memorial Hospital with a total resident population of 69,612 people. Methods employed in the assessment included surveys of community residents made available through email, distribution at COVID-19 vaccination clinics, social media and website links through multiple channels throughout the region; a direct email survey of community leaders representing multiple community sectors; a set of eleven community discussion groups convened virtually across the region; and a review of available population demographics and health status indicators including summary social determinant of health characteristics.

All information collection activities and analyses sought to focus assessment activities on vulnerable and disproportionately served populations in the region including populations that could experience limited access to health-related services or resources due to income, age, disability, and social or physical isolation. The community health needs assessment also acknowledged the significant impact of the COVID-19 pandemic, which was an over-arching concern affecting both the community health needs assessment process and the content of community input. More than half of respondents to the community survey indicated that they were *currently* experiencing increased stress or anxiety because of the COVID-19 pandemic. The table on the next page provides a summary of the priority community health needs and issues identified through this assessment.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of mental health services	'Ability to get mental health care services' was the top priority identified by both community member and community leader survey respondents; 23% of community survey respondents indicated difficulty accessing needed mental health services in the past year.	Rates of Self Harm-related Emergency Department Visits, Self Harm-related Hospitalizations and Suicide in the service area are similar to overall statewide rates in Vermont and New Hampshire.	Mental health care was identified as a continuing and top priority for community health improvement by all community discussion groups including concerns for insufficient local capacity, particularly for higher levels of care, and increased need resulting from anxiety, stress and isolation impacts of COVID-19.
Cost of health care services, affordability of health insurance	Cost of health care services including health insurance and prescription drug costs were the next highest priorities identified by community member survey respondents and third highest priority identified by community leaders. Among respondents with household income less than $50K, 72% indicated difficulty accessing one or more type of health or human service in the past year.	The estimated proportion of people with no health insurance (4.9%) is similar to the overall percentage in NH (5.9%) and higher than in VT (4.0%). About 9% of White River Junction Health District residents reported delaying or avoiding health care because of cost.	Community discussion participants identified health care costs and financial barriers to care as significant and ongoing concerns. It was also the most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health'
Improved resources and environment for healthy eating, nutrition and food affordability	'Ability to buy and eat healthy foods' was the 4th highest priority among both community member and community leader survey respondents	An estimated 10% of service area households experienced food insecurity in 2019.	Food access was identified as a top priority in discussion groups including Behavioral Health Coordinators, Public Health and Prevention professionals. Impact of the CoV-19 pandemic on healthy food access was also described by older adult discussion group participants
Alcohol and drug use prevention, treatment and recovery	Prevention of substance misuse, addiction and access to substance misuse treatment and recovery services were top 10 issues identified by both community leaders and community respondents across age groups as priorities for community health improvement.	Vermont has experienced one of the highest increases in drug overdose deaths in the country during the COVID-19 pandemic; increasing by 39% in 2020 compared to the prior year. In Windsor County, the rate of opioid-related overdose fatalities more than tripled in 2020 compared to the prior year.	Participants identified improvements in resources for substance misuse prevention, treatment and recovery, but also noted that the need is still high, there are still issues with stigma in certain settings and gaps in services for detox and recovery housing. Concerns were identified for substantial disruption of recovery support by the COVID-19 pandemic.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Affordability and availability of dental care services	The second most commonly reported service people reported difficulty accessing in the past year was 'dental care for adults' (22%). Common reasons cited for access difficulties were 'cost too much', lack of dental insurance, wait times too long and 'service not available. Ability to get dental services was particularly a top issue among respondents over 65 years of age.	About 34% adults in the White River Junction Health District reported not having visited a dentist or dental clinic in the past year (pre-COVID statistic).	Access to affordable dental care was identified as a top priority – described as on often 'overlooked quality of life issue - in discussion groups with Public Health and Prevention professionals.
Socio-economic conditions affecting health and well-being such as housing affordability, livable wages and affordable, dependable child care	Affordable housing, living wages and access to affordable child care were identified as top resources supporting a healthy community that are in need of improvement. Affordable housing and other socio-economic issues was the second most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health'.	About 32% of households in the service area have housing costs >30% of household income. The service area is also characterized by a wide range in community wealth where median household income in the wealthiest communities is more than 160% higher than the communities with lowest median household incomes.	Affordability and availability of housing was a common denominator across discussion groups addressing concerns of aging, mental health and substance use recovery, jobs and economy. Disparities in access to other resources such as child care and transportation were described as significant problems pre-pandemic made much worse by the pandemic.

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A. COMMUNITY OVERVIEW WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total population of the primary service area of Mary Hitchcock Memorial Hospital and Alice Peck Day Memorial Hospital in 2019 was 69,612 according to the United States Census Bureau. The service area population has increased by approximately 0.2% or about 145 people over the last 3 years since the last Community Health Needs Assessment. Table 1 below and continued on the next page displays the distribution of the service area population by municipality, as well as the percentages of residents who are under 18 years of age and who are 65 and older.

Compared to Vermont or New Hampshire overall, the service area population has proportionally more seniors (about 20% are 65+ compared to about 18% in NH and 19% in VT). A substantial range is observed for this statistic within the region from about 13% of Hanover residents who are aged 65 or more years to about 29% of residents in Woodstock, Vermont.

TABLE 1: Service Area Population by Town

Town / City	2019 Population	% of Total Service Area Population	% Under 18 years of age	% 65+ years of age
Canaan NH	3,920	6%	18%	14%
Dorchester NH	401	1%	19%	25%
Enfield NH	4,545	7%	15%	21%
Grafton NH	1,362	2%	19%	20%
Hanover NH	11,467	16%	14%	13%
Lebanon NH	13,623	20%	16%	20%
Lyme NH	1,852	3%	24%	24%
Orange NH	264	<1%	10%	28%
Orford NH	1,444	2%	14%	19%
Piermont NH	868	1%	19%	20%
Grantham NH	2,945	4%	18%	22%
Plainfield NH	2,555	4%	19%	19%
Fairlee VT	994	1%	18%	28%

Town / City	2019 Population	% of Total Service Area Population	% Under 18 years of age	% 65+ years of age
Thetford VT	2,551	4%	20%	19%
Hartford VT	9,643	14%	17%	26%
Hartland VT	3,466	5%	19%	21%
Norwich VT	3,339	5%	21%	18%
Sharon VT	1,437	2%	20%	20%
Woodstock VT	2,936	4%	20%	29%
DH-APD Service Area	**69,612**	**100%**	**17.2%**	**20.0%**
State of New Hampshire	1,359,711		19.3%	17.5%
State of Vermont	624,313		18.7%	18.8%

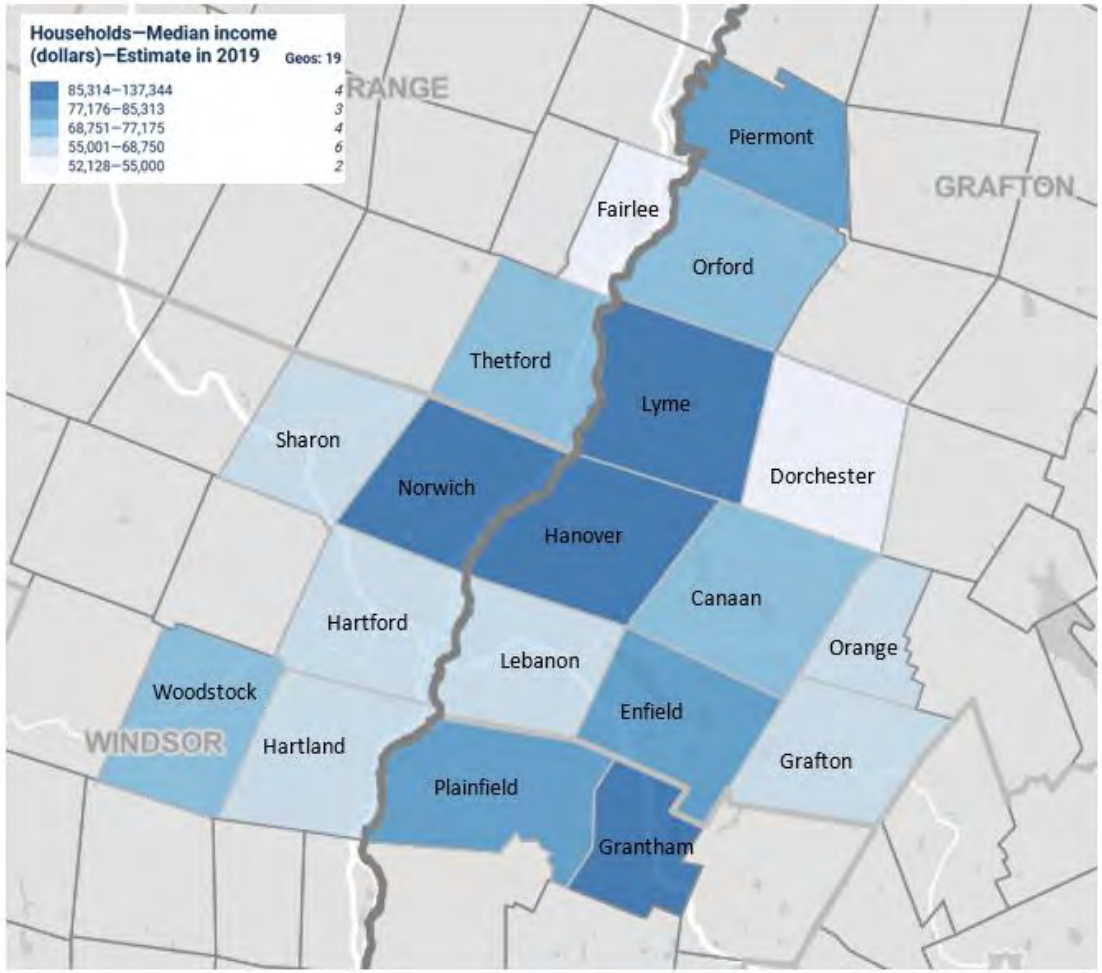
Table 2 on the next page displays additional demographic information for the municipalities of the primary service area of Dartmouth-Hitchcock and Alice Peck Day. As displayed the table, the region has median household income higher than both New Hampshire and Vermont overall. However, there is a substantial range within the region on this measure with the highest median household income community (Hanover) having median household income nearly three times higher than the lowest income communities (Fairlee and Dorchester). The percent of people living below the federal poverty level also varies across the region from about 2% of the population of Grantham, NH living in poverty compared to 16% in Sharon, VT. The map on page 8 displays the distribution of median household income across towns in the service area.

TABLE 2: Selected Demographic and Economic Indicators

	Median Household Income	% with income under 100% Poverty Level	% family households with children headed by a single parent	% population with a disability
Fairlee VT	$52,128	8%	37%	16%
Dorchester NH	$55,000	9%	11%	21%
Sharon VT	$61,285	16%	26%	12%
Grafton NH	$61,429	10%	47%	19%
State of Vermont	$61,973	10.9%	31.8%	14.5%
Hartford VT	$64,493	6%	23%	18%
Hartland VT	$66,085	6%	26%	15%
Lebanon NH	$67,698	11%	39%	14%
Orange NH	$68,750	7%	42%	20%
Woodstock VT	$73,380	8%	31%	13%
Orford NH	$73,636	10%	18%	9%
Thetford VT	$75,820	8%	18%	13%
State of New Hampshire	$76,768	7.6%	28.3%	12.8%
Canaan NH	$77,175	4%	17%	11%
Piermont NH	$82,083	3%	13%	14%
Enfield NH	$82,212	4%	26%	14%
Plainfield NH	$85,313	5%	24%	8%
DH-APD Service Area	**$86,576**	**7.3%**	**26.7%**	**12.4%**
Grantham NH	$108,571	2%	29%	12%
Lyme NH	$112,625	3%	7%	8%
Norwich VT	$121,563	6%	22%	8%
Hanover NH	$137,344	8%	26%	5%

Figure 1 – Median Household Income by Town, Dartmouth-Hitchcock and Alice Peck Day Memorial Hospital Service Area

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates



Median household income ranges from $52,128 in Fairlee to $137,344 in Hanover.

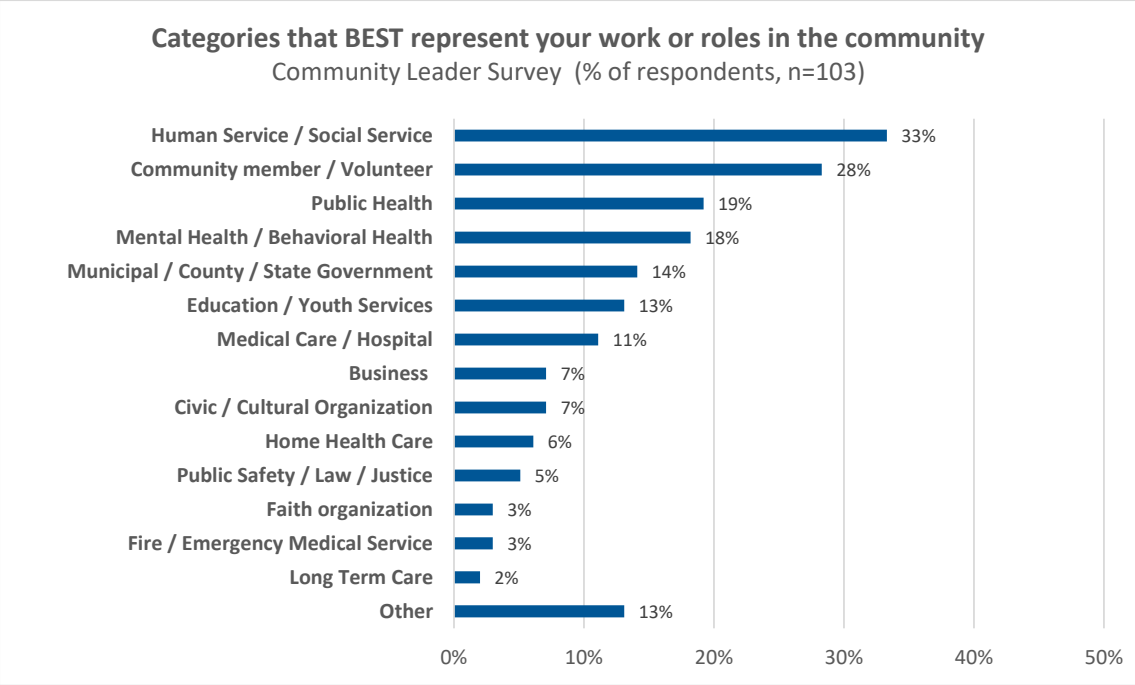
B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and September 2021, the Community Health Needs Assessment committee fielded two surveys: one with targeted distribution to community leaders and one broadly disseminated to residents across the region. The survey instruments were designed to have many questions in common to facilitate comparisons and contrasts in the analysis.

The community leader survey was distributed via unique email link to 352 individuals in positions of leadership in agencies, municipalities, education, civic and volunteer organizations serving the combined service areas of the partner organizations, which ranges from the New London area of New Hampshire to the Mt. Ascutney and Upper Valley areas of Vermont. The planning committee worked collaboratively to develop the survey distribution list and survey instrument. With the understanding that some organizational leaders may be more familiar with some areas of the wider region than other areas, the survey instrument asked respondents to identify 'the areas you primarily serve or are most familiar with'. Of the 352 partners invited to participate in the Community Leader Survey, 207 people completed the survey (59% response).

Of the 207 respondents to the Community Leader survey, 103 (50%) indicated being familiar with the 'Greater Lebanon, NH / Hartford, VT area'. The results included from the community leader survey in this assessment report are specific to that group of 103 respondents. Figure 2 displays the range of community sectors represented by these individuals. (Note: Respondents could identify as representatives of more than one sector).

| Figure 2 |



The community member survey was distributed electronically through email and social media communication channels, promoted through posters and fliers with links and QR codes posted around the region, and by paper copies made available at a variety of distribution points throughout the region including vaccination clinics. Electronic and paper versions of the survey were also available in Spanish. A total of 1,642 community members completed the Community Resident Survey, representing all 19 towns of the primary service area as well as a number of other communities.

Table 3 displays the grouping of respondents by community. Among respondents who provided information on their current local residence, about one third are residents of Lebanon, Hanover or Grantham. A relatively large number of responses were received from residents of towns outside the primary service area. While this result is not unexpected considering the wider referral region of DHMC as a tertiary care institution, it is a higher proportion than in previous assessments. An additional factor likely affecting geographic response distribution in the current assessment cycle was the broad reach of survey distribution through COVID-19 vaccine clinics in collaboration with the Regional Public Health Networks. The most frequent locations outside the primary service for survey responses were Claremont (5% of survey responses), Bradford (3%), Newport (2%) and Windsor, New London, Newbury, Cornish, Charlestown, Groton (VT), South Ryegate, Wells River, and Sunapee each with about 1% of total respondents.

| Table 3 |

Town	# of respondents	% of total*
Lebanon	226	17%
Hanover	110	8%
Grantham	100	8%
Enfield	90	7%
Hartford	79	6%
Canaan/Orange	68	5%
Norwich	49	4%
Thetford	39	3%
Lyme	34	3%
Orford	24	2%
Plainfield	20	2%
Hartland	17	1%
Grafton	15	1%
Fairlee	10	1%
Woodstock	5	<1%
Sharon	5	<1%
Piermont	4	<1%
Dorchester	4	<1%
Other Locations	428	32%

*Percent of respondents who provided information on the location of their residence. About 19% of respondents did not provide this information.

| Table 4 |

Age < 65 years	Female	Black, Indigenous and People of Color	Current military service or veteran
84%	66%	11%	9%
Household Income < $50K	**Currently Uninsured**	**Currently has Medicaid coverage**	**Hard to do some Daily Tasks without help**
23%	3%	11%	9%

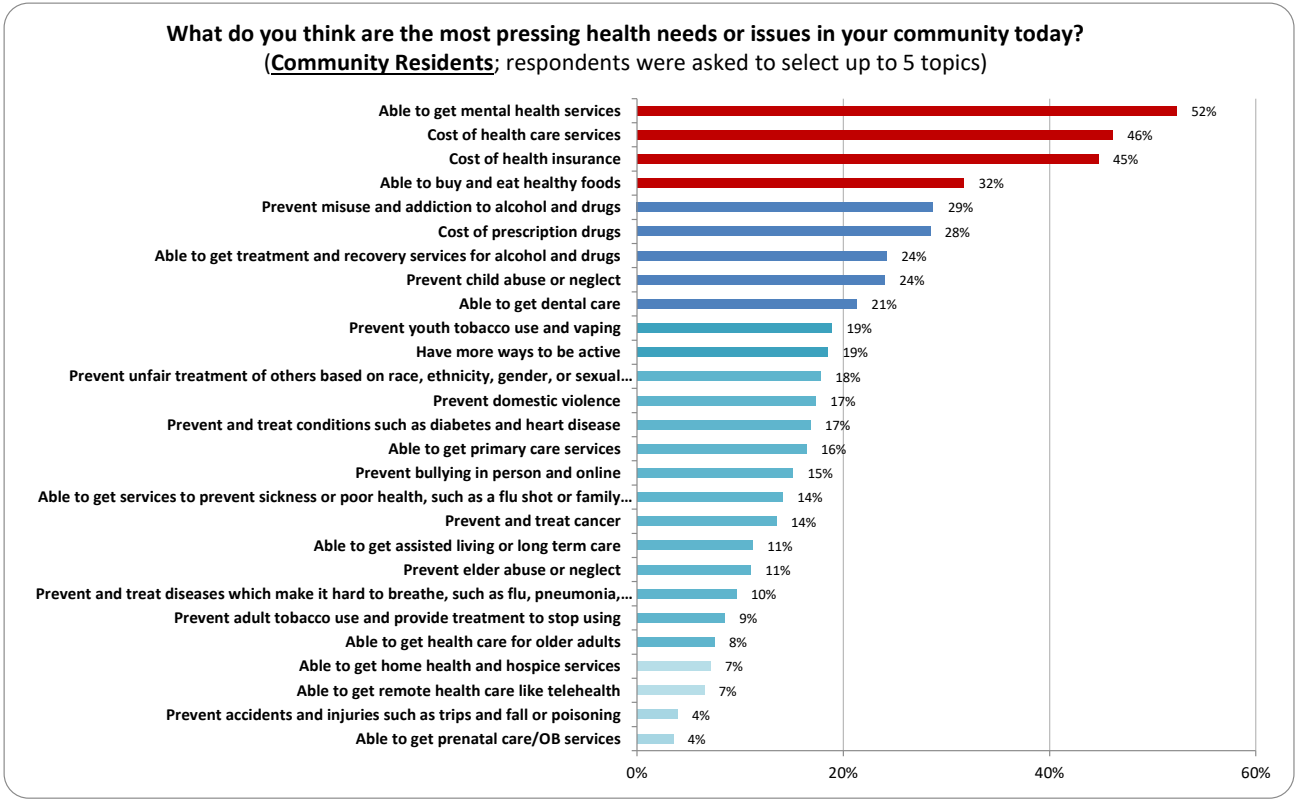
Table 4 on the previous page displays selected characteristics of respondents to the community survey. Survey respondents were proportionally more likely to be female (66%). About 12% described their race or ethnicity as people of color including African American or Black (2%), American Indian or Alaska Native (2%), Asian or Asian American (4%), Hispanic or Latina(o) (3%), Middle Eastern or North African (1%) or Native Hawaiian or Pacific Islander (<1%). Approximately 23% of respondents have household income of less than $50,000, about 11% received health insurance coverage through Medicaid and about 3% were uninsured.

1. Priority Community Health Issues

Respondents to the community leader and community resident surveys were asked to select the top 5 most pressing health needs or issues in the community from a list of 27 potential topics (plus an open-ended 'other' option). On the survey instrument, the topics were organized into 6 overall conceptual groups with 'plain language' descriptions as follows: Prevent Poor Health or Injury, Make Health Care Services Easier to Get, Address Costs of Care, Prevent and Treat Substance Misuse, Prevent and Treat On-going Conditions, Prevent Abuse and Violence. Survey respondents could select any of the individual topics from across the different topic groups.

As displayed by Figure 3, 'Able to get mental health services' was the most commonly selected health need by

| Figure 3 |



respondents to the community member survey (52% of respondents selected this as a top 5 issue). The related issues of 'cost of health insurance' (46%), 'cost of health care services' (45%) and 'cost of prescription drugs' (28%) were also all among the top issues identified overall along with 'ability to 'buy and eat healthy foods' (32%) and 'prevent misuse and addiction to alcohol and drugs' (29%). When the analysis is limited only to respondents who reported their residence to be one of the 19 towns in the primary DHMC-APD service area, the top concerns were the same:

- Able to get mental health services (selected by 57% of service area respondents)
- Cost of health care services (48%)
- Cost of health insurance (45%)
- Able to buy and eat healthy foods (31%)
- Cost of prescription drugs (31%)
- Prevent misuse and addiction to alcohol and drugs (29%)

Table 5 displays the top priorities by age group. The most frequently selected needs or issues were similar across age groups with ability to get mental health services and cost of care / insurance at the top. Respondents under the age of 65 were more likely to prioritize "Able to buy and eat healthy foods"; while older respondents more frequently selected 'Cost of prescription drugs' and also ability 'to get dental care' among the most pressing community health needs or issues.

| Table 5: Top Priorities by Age Group |

Age 18-44 (n=626)		Age 45-64 (n=544)		Age 65+ (n=227)	
Able to get mental health services	56%	**Able to get mental health services**	55%	**Able to get mental health services**	45%
Cost of health care services	50%	**Cost of health insurance**	49%	**Cost of health care services**	44%
Cost of health insurance	44%	**Cost of health care services**	44%	**Cost of health insurance**	41%
Able to buy and eat healthy foods	36%	**Prevent misuse and addiction to alcohol and drugs**	35%	**Cost of prescription drugs**	36%
Prevent child abuse or neglect	29%	**Able to buy and eat healthy foods**	33%	**Able to get treatment and recovery services for alcohol and drugs**	24%
Prevent misuse and addiction to alcohol and drugs	29%	**Cost of prescription drugs**	30%	**Able to get dental care**	24%

The chart below displays the results from the Community Leader survey on the same question with the same response options. Community Leaders also identified 'Able to get mental health services' as the top health need with 67% of respondents selecting this issue. Similar to community member respondents, community leaders also identified 'cost of health care services', ability to 'buy and eat healthy foods' as Top 5 issues. Community leader respondents were somewhat more likely to select 'get treatment and recovery services for alcohol and drugs' and ability to 'get dental care as top issues overall.

| Figure 4 |

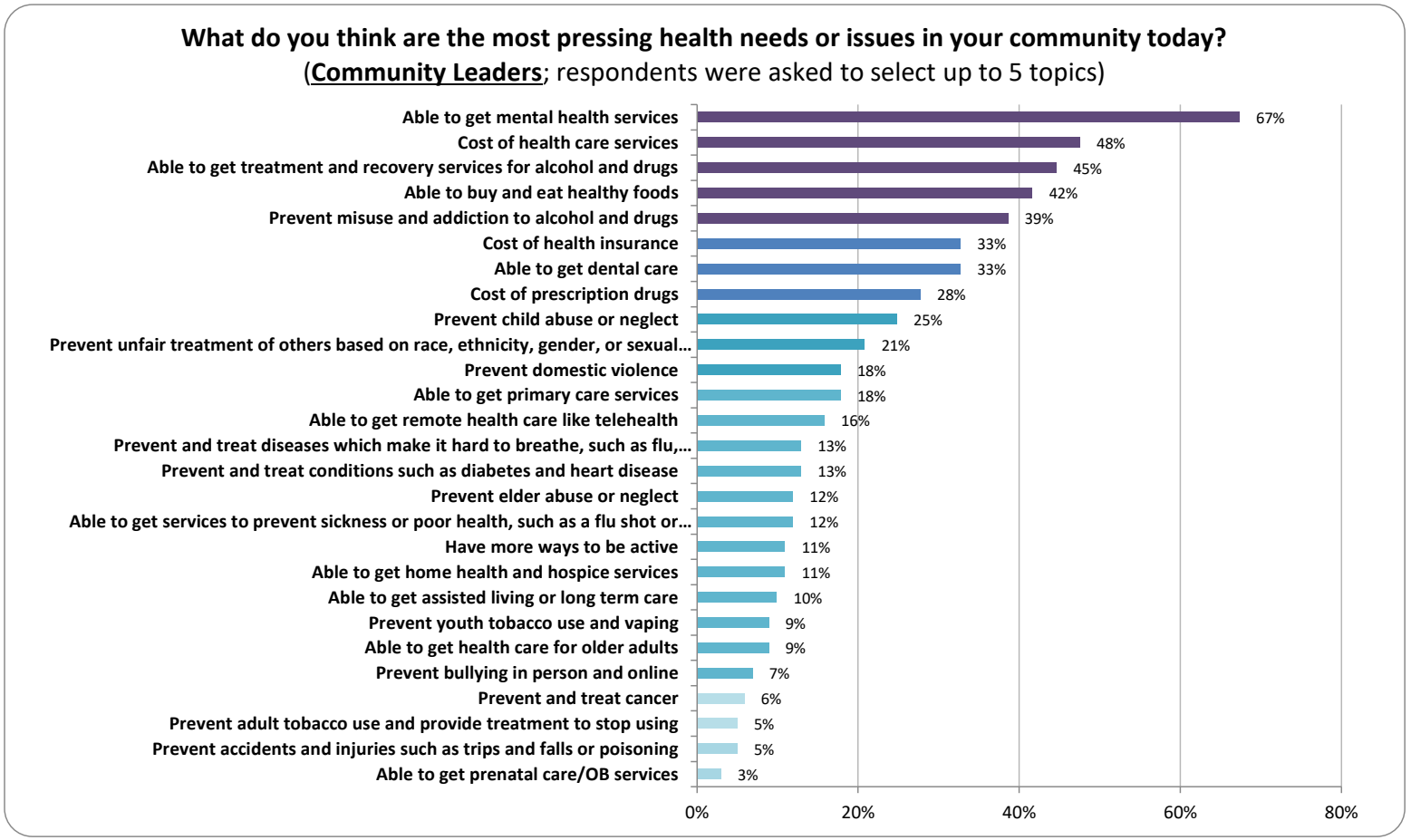
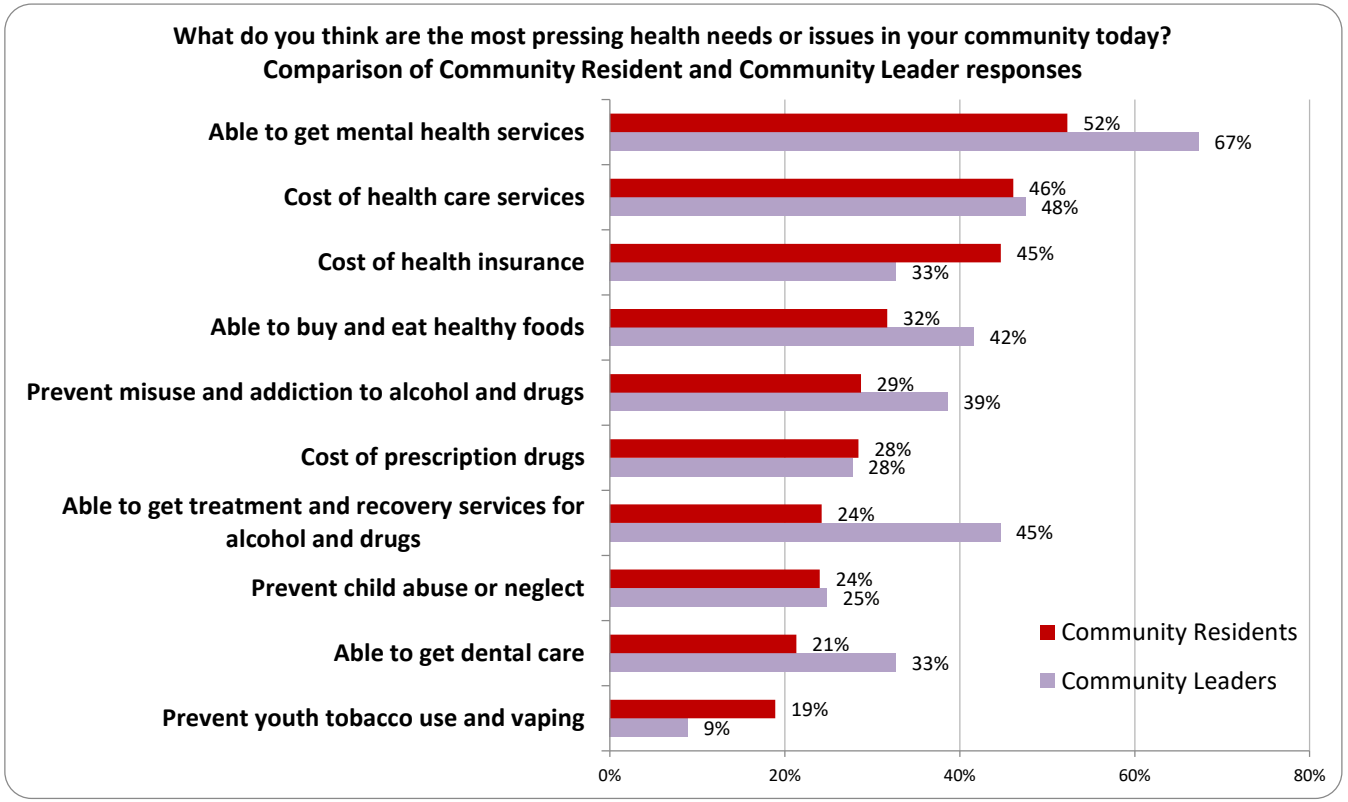


Figure 5 displays a comparison of the top 10 most pressing health issues selected by Community Resident survey respondents compared to the responses from Community Leaders on the same topics. Nine (9) of the top 10 issues identified were the same between the two groups of respondents. The one topic selected by Community Resident respondents ahead of other issues compared to Community Leader respondents was 'Prevent youth tobacco use and vaping'. The 10th most frequently selected issue by Community Leaders was 'Prevent unfair treatment of others based on race, ethnicity, gender, or sexual orientation' – selected by 21% of community leaders and 18% of community member respondents.

The top issues identified in this 2022 assessment were similar to those identified in 2019 when the top 3 issues were: *Access to mental health services; Access to affordable health insurance, health care services and prescription drugs;* and *Alcohol and drug misuse prevention, treatment and recovery.*

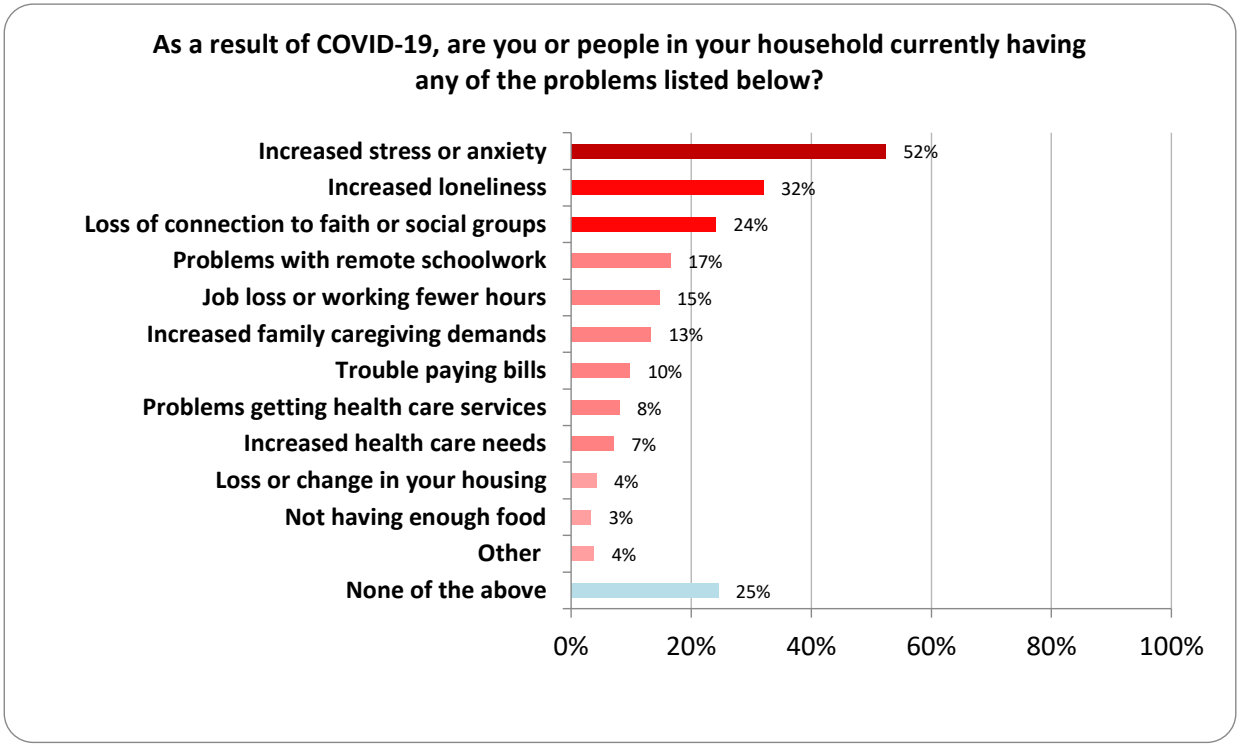
| Figure 5 |



2. COVID-19 Pandemic Impact

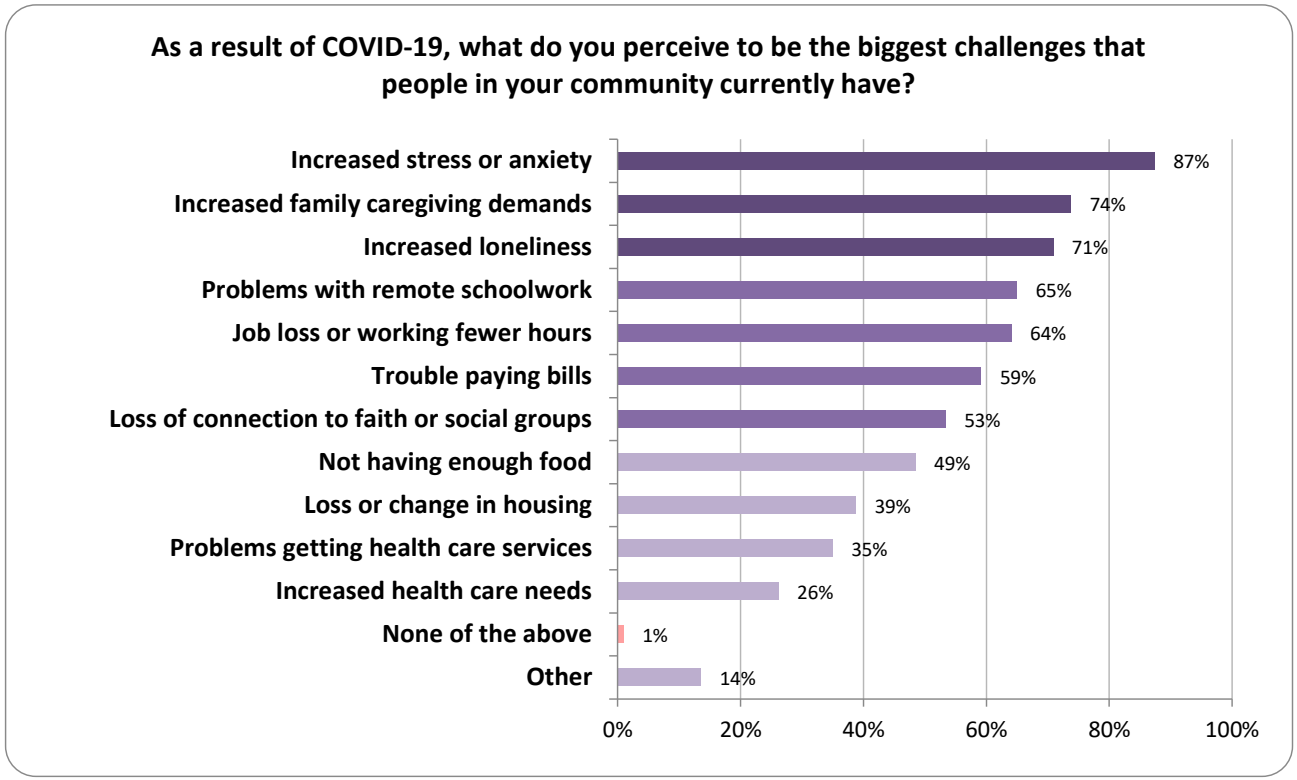
The COVID-19 pandemic has clearly had a significant impact on many community members and was an over-arching concern affecting both the community health needs assessment process and the content of community input. Consequently, the planning committee felt it important to specifically ask community members for input on how COVID-19 was *currently* affecting them or people in their household. About 1 of every 2 survey respondents indicated that they were *currently* experiencing increased stress or anxiety as a result of the COVID-19 pandemic. (Most community survey responses were received between May and July 2021). About 1 in every 3 respondents were currently experiencing loneliness or and 1 in 4 reported loss of connection to faith or social groups. About 7% of respondents indicated problems getting health care services or increased health care needs. Only about a quarter of respondents (25%) indicated *not currently* experiencing any of the impacts of COVID-19 listed as options on the question.

| Figure 6 |



The Community Leader survey asked a similar question about the current impact of the COVID-19 pandemic on people in the community. Community Leaders also identified '*Increased stress or anxiety*' most frequently as the 'biggest challenge' of the pandemic; along with '*Increased family caregiving demands'*, '*Increased loneliness'* and '*Problems with remote schoolwo*rk'. (Respondents could select all that apply).

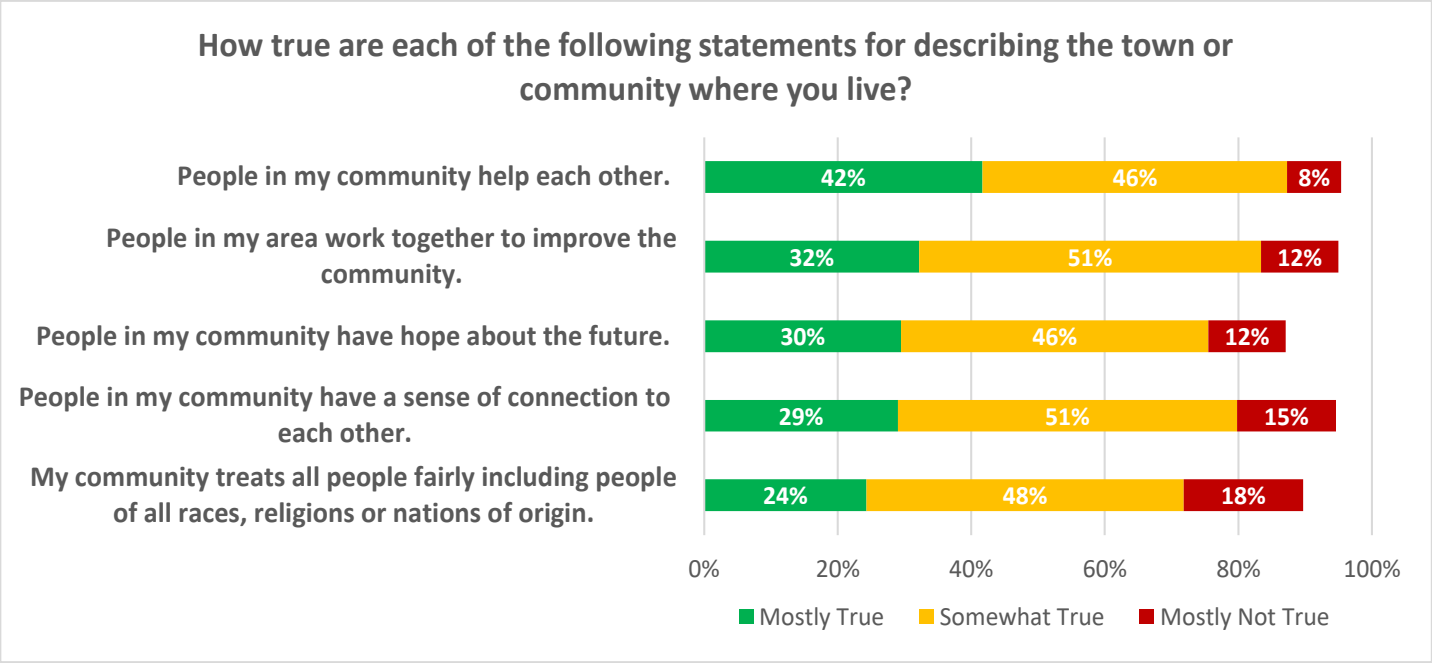
| Figure 7 |



3. Characteristics of a Resilient Community

The Community Resident survey asked people to indicate how true certain characteristics of a resilient community were for the community in which they live. As displayed by Figure 8, 42% of respondents thought the statement, "People in my community help each other" is 'mostly true' and 46% thought the statement was 'somewhat true'. About 1 in 3 respondents indicated that it is 'mostly true' that "People in my area work together to improve the community"; about 18% of respondents think it is 'mostly not true' that 'My community treats all people fairly including people of all races, religions or nations of origin'.

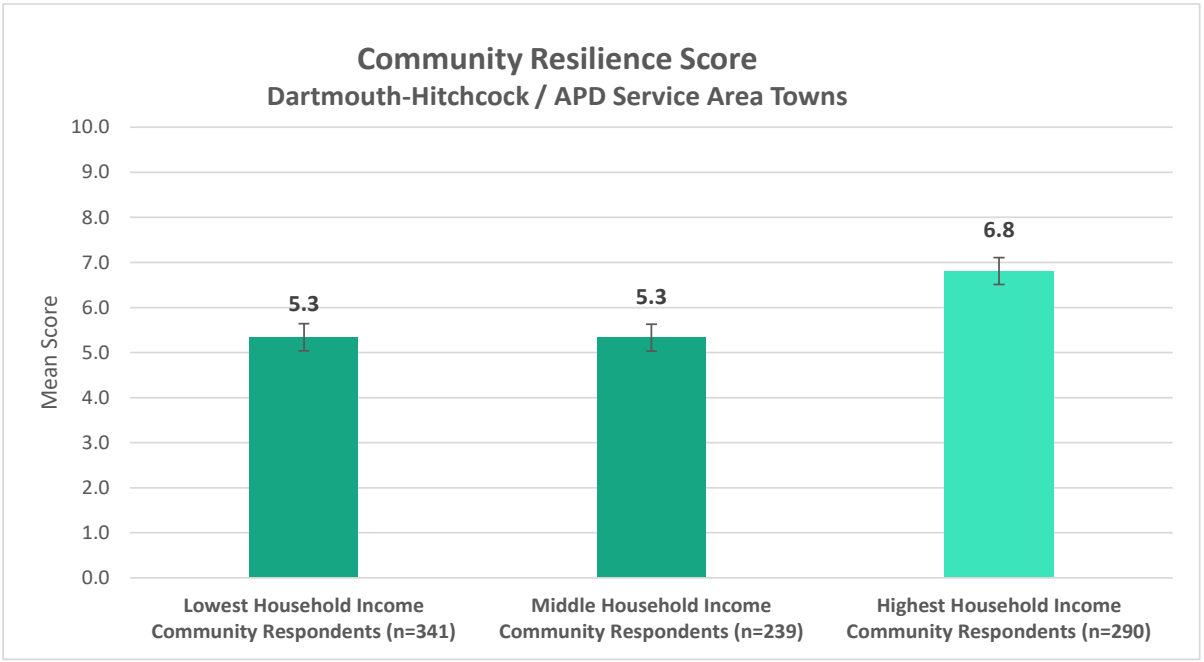
| Figure 8 |



Totals do not equal 100%. Response choice of "Don't Know" not displayed.

Further analysis of this set of questions was conducted by calculating a composite 'Community Resilience Score' for each respondent with possible scores ranging from 0 to 10 (5 questions, each question with possible values of 2, 1 or 0) where a score of 10 results when a respondent indicates that each of the 5 statements describing a resilient community are 'Mostly True'. Scores were then aggregated for 3 sets of communities within the DH-APD service area: (1) communities with the lowest median household income (below $70,000: Fairlee, Dorchester, Sharon, Grafton, Hartford, Hartland and Lebanon); (2) middle household income communities (Woodstock, Orford, Thetford, Canaan/Orange, Piermont, Enfield and Plainfield); and (3) communities with the highest median household incomes (above $100,000: Grantham, Lyme, Norwich, and Hanover). The chart displays the mean Community Resilience Score calculated from the responses from residents for each of these community groupings. The mean scores for the lowest and middle income groups are not significantly different from each other, while the mean score for the highest median household income group is significantly higher than both of the other town groupings (One-Way ANOVA, p>.001). (Note: Responses were excluded from this analysis from respondents not reporting a residential location or who reported locations outside the DH-APD service area or who did not provide a response on all 5 questions comprising the composite score).

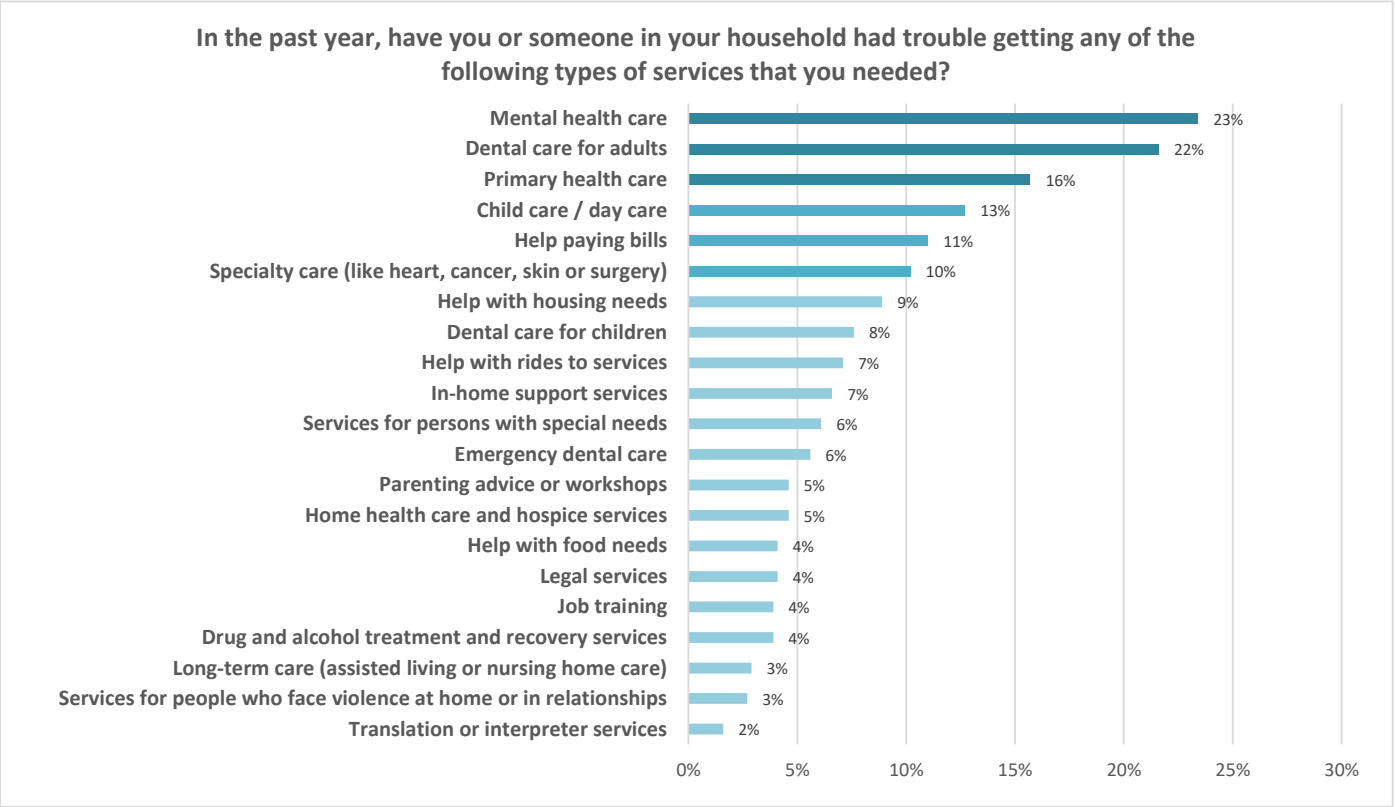
| Figure 9 |



4. Barriers to Services

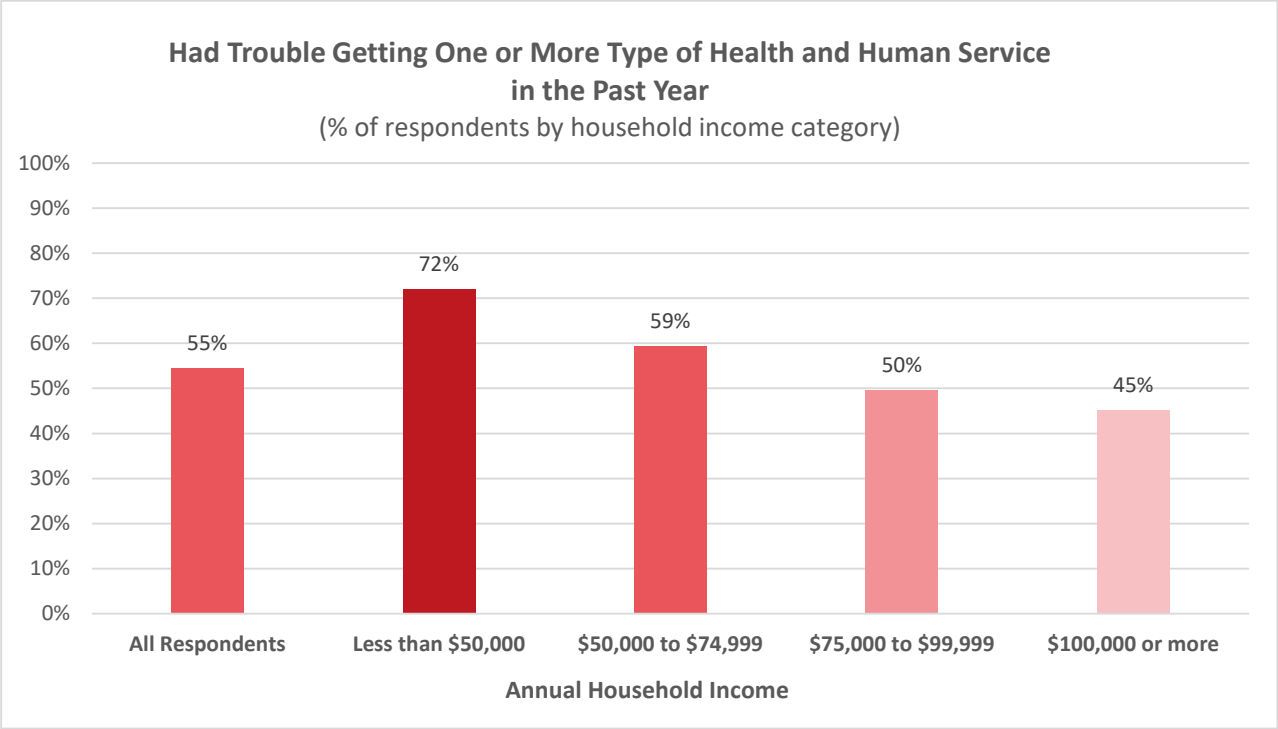
Respondents to the Community Resident survey were presented with a list of potential health and human services and asked, "In the past year, have you or someone in your household had trouble getting any of the following types of services that you needed?" As displayed by the chart below, about 23% of respondents indicating have difficulty getting 'Mental health care'; 22% had difficulty getting 'Dental care for adults'; and about 16% had difficulty getting 'Primary health care services' over the past year. Overall, about 55% of all respondents indicated having difficulty getting at least one type of service for themselves or someone in their household over the past year. This statistic is substantially higher than in past community health needs assessments and may be reflective of the impact of COVID-19 on need, availability, and accessibility of some health and human services.

| Figure 10 |



There is a significant relationship between the likelihood that respondents reported having difficulty accessing services and household income. While a high proportion of respondents in all income categories reported difficulty accessing at least one type of service, respondents with annual household income less than $50,000 were most likely to report access difficulties (p<.001).

| Figure 11 |



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 6, among respondents who indicating difficulty accessing Dental Care for Adults or Child Care / Day Care services, the top reason reported for difficulty accessing services was 'Cost too much'. Among respondents indicating difficulty accessing Mental Health Care or Primary Health Care services, the top reason cited was 'Wait time too long'.

| Table 6: Top Reasons Respondents Had Difficulty Accessing Services by Type of Service |

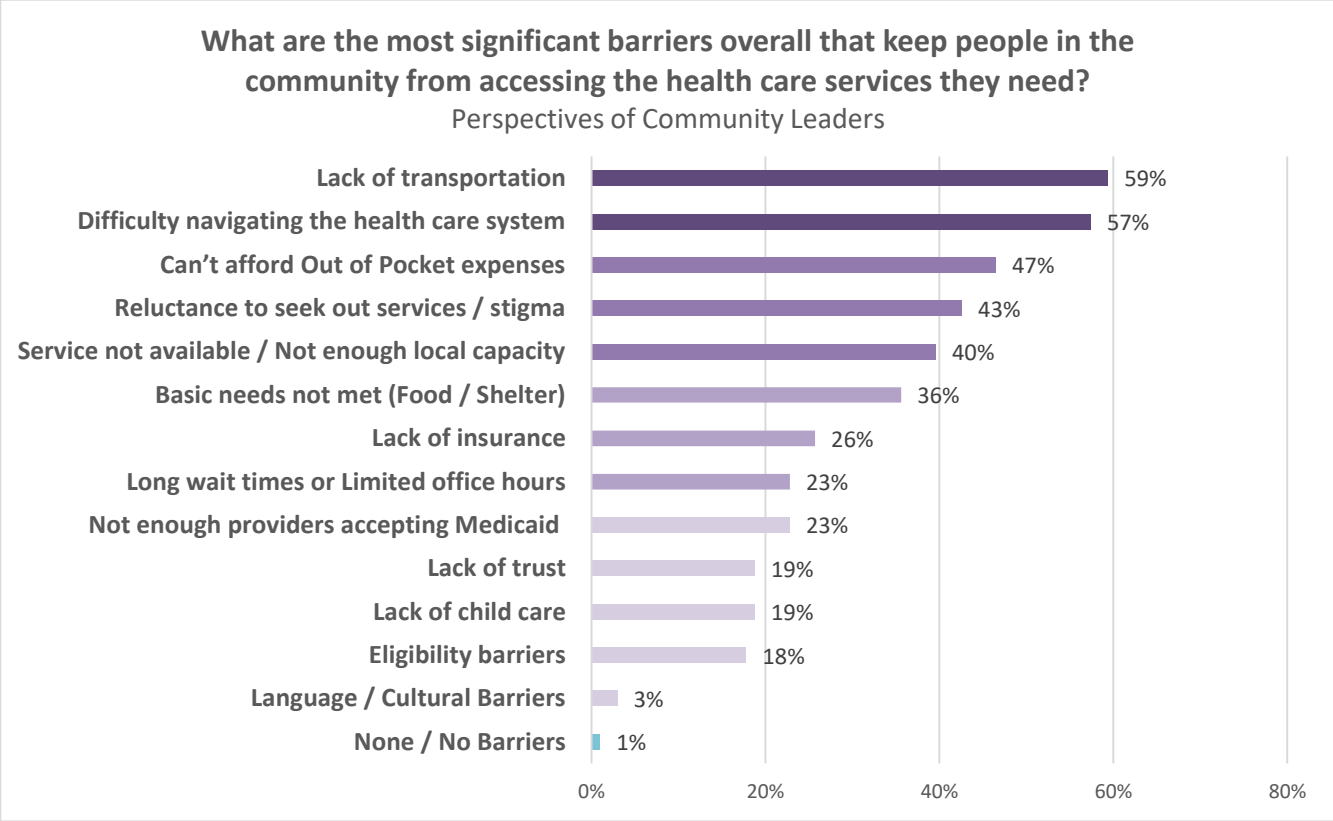
(Percentage of respondents who reported difficulty accessing a particular type of service)

MENTAL HEALTH CARE (n=349, 23% of respondents)	DENTAL CARE FOR ADULTS (n=322, 22% of respondents)	PRIMARY HEALTH CARE (n=234, 16% of respondents)	CHILD CARE / DAY CARE (n=190, 13% of respondents)
38% of respondents who indicated difficulty accessing Mental Health Care also selected **"Wait time too long"** as a reason	**34%** of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Cost too much"** as a reason	**30%** of respondents who indicated difficulty accessing Primary Health Care also selected **" Wait time too long "** as a reason	**44%** of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason
Service not available (33%)	**No dental insurance or not enough dental insurance (32%)**	**Not accepting new patients (25%)**	**Service not available (40%)**
Not accepting new patients (32%)	**Wait time too long (25%)**	**Cost too much (24%)**	**Not accepting new clients (32%)**
Cost too much (32%)	**Service not available (16%)**	**Service not available (23%)**	**Wait time too long (29%)**

In a separate question, Community Survey respondents were asked: ***"In the past year, how often has anyone in your household missed getting health care or social services because of unfair treatment?"*** 'Unfair treatment' was further specified as "discrimination or stigma based on your race, ethnic group, gender, sexual orientation, age, disability, language, or education". Overall, **1.8%** of respondents indicated that they or someone in their household had **"Often"** missed getting health care or social services because of unfair treatment, **7.1%** indicated **"Sometimes",** and **91.0%** indicated **"Never"** missing health care or social services because of unfair treatment. Respondents indicating their race or ethnicity as Black, Indigenous People, or People of Color (BIPOC) were more likely to indicate that they or someone in their household had missed getting health care or social services because of unfair treatment. Among BIPOC respondents, **3.6%** indicated unfair treatment occurred **"Often", 15.3%** indicated **"Sometimes"** and **81%** indicated **"Never"**.

Respondents to the Community Leader survey were asked to identify the most significant barriers overall that prevent people in the community from accessing needed health care services. The top issues identified by this group were ‘lack of transportation‘ and ‘difficulty navigating the health care system’; followed by ‘Can’t afford out of pocket expenses’, and ‘Reluctance to seek out services / stigma’.

| Figure 12 |

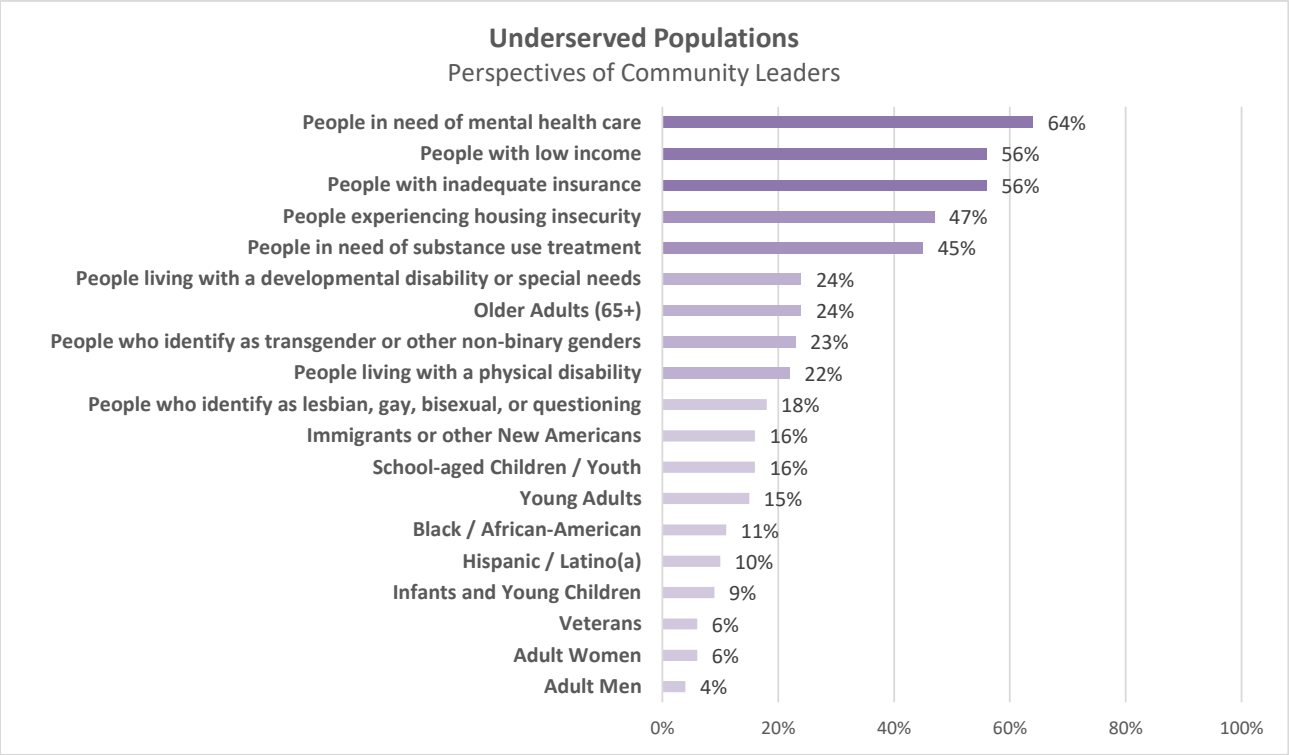


Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. As displayed by Figure 13, populations most frequently identified by Community Leader respondents (64%) as underserved were *'people in need of mental health care'*; followed by *'people with low income', 'people with inadequate health insurance', 'people experiencing housing insecurity'* and *'people in need of substance use treatment'*.

In a related question, Community Leaders were asked, "Are there particular types of health providers, specialties or services that are needed in the community due to insufficient capacity or availability?" About 72% of community leaders responded affirmatively with mental health and dental care the most commonly cited providers with insufficient capacity or availability.

> ***"Access for mental health services is not sufficient to meet the needs of the community, especially for people with complex, chronic or acute mental health needs."***
>
> - ***Community Leader Respondent***

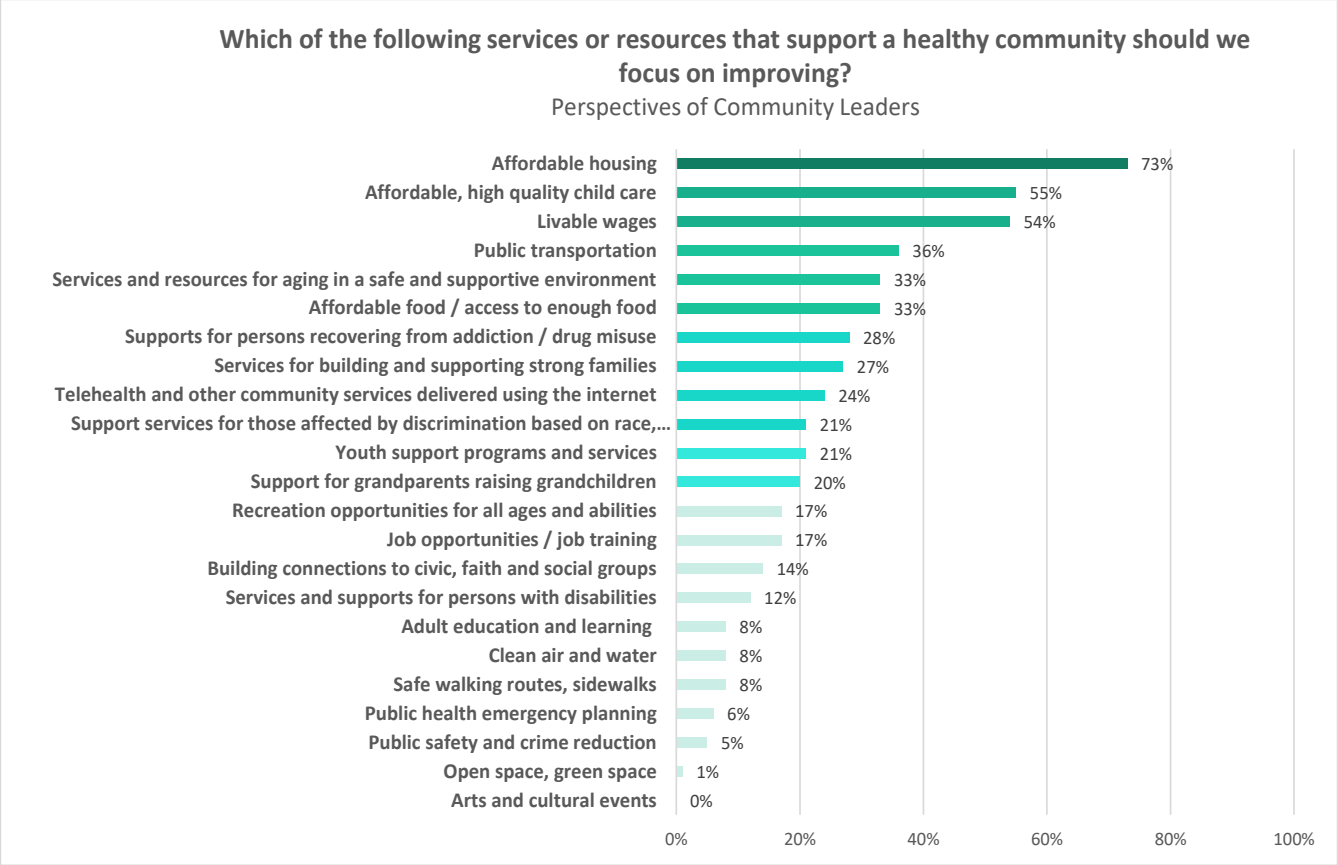
| Figure 13 |



5. Services and Resources to Support a Healthy Community

Community leaders were asked to select the top 5 services or resources supporting a healthy community that should be focused on from a list of 23 potential topics (plus an open-ended 'other' option). Sometimes described as social determinants of health, the items included in this question generally describe underlying community attributes that indirectly support the health and well-being of individuals and families. On the survey instrument, the topics were organized into six overall conceptual groups described as: Basic Needs; Community Safety; Family Services and Supports; Infrastructure and Environment; Jobs and Economy; Welcoming Community. Survey respondents could select any of the individual topics from across the different topic groups. As displayed by the chart, *Affordable Housing* was identified nearly 3 of every 4 community leader respondents (73%) as top priority area the community should focus on to support community health improvement. Other top focus areas, selected by a majority of respondents, were *Affordable, high quality child care* and *Livable Wages*.

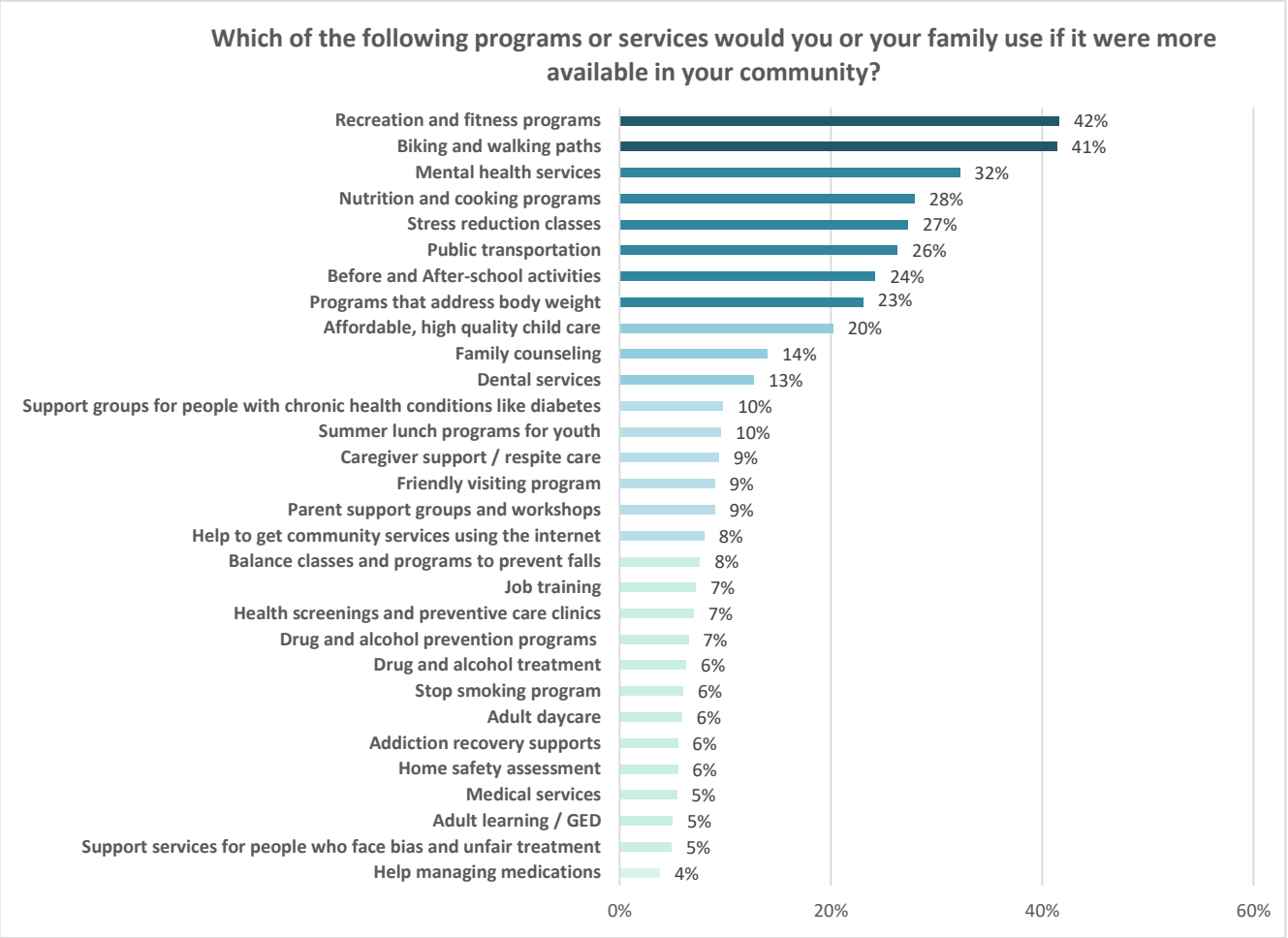
| Figure 14 |



6. Interest in Specific Community Health Programs or Services

Community members were asked a variation on the question of community services or resources to support health. Community residents were asked what **programs or services *they would use* if more available** in the community. The survey instrument included a list of 30 topics organized into six overall conceptual groups: Services for Children and Parents; Services for Older Adults; Healthy Lifestyle Programs; Counseling and Mental Health Services; Health Care Services; Community Services and Supports. Survey respondents could select any number of individual topics from across the different topic groups. As displayed by the chart, the highest amount of interest was reported for using *Recreation and Fitness programs* and *Biking and Walking Paths*. Other services most frequently mentioned included *mental health services, nutrition and cooking programs, stress reduction classes, public transportation,* and *programs that address body weight*. The table on the next displays the top resources of interest by age group.

| Figure 15 |



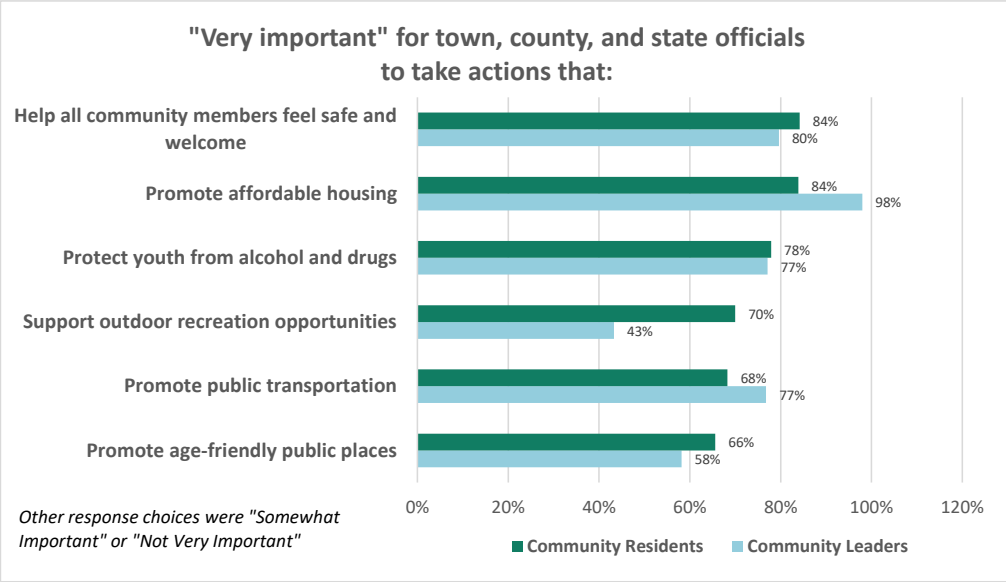
| Table 7: Top services or resources people would use if more available, by Age Group |

Age 18-44		Age 45-64		Age 65+	
Recreation and fitness programs	49%	**Biking and walking paths**	46%	**Recreation and fitness programs**	28%
Biking and walking paths	44%	**Recreation and fitness programs**	41%	**Public transportation**	25%
Mental health services	42%	**Mental health services**	29%	**Biking and walking paths**	25%
Before and After-school activities*	36%	**Public transportation**	29%	**Programs that address body weight**	19%
Nutrition and cooking programs	36%	**Nutrition and cooking programs**	28%	**Mental health services**	17%
Stress reduction classes	33%	**Stress reduction classes**	28%	**Balance classes and programs to prevent falls**	15%

**30% of Age 18-44 respondents also selected 'Affordable, high quality child care'*

Respondents to the community resident and community leader surveys were asked how important it is for town, county, and state officials to take certain actions associated with community health. As displayed by Figure 16, 98% of community leader respondents and 84% of community member respondents indicated it was "very important" for officials to take actions that 'promote affordable housing'. Community residents were somewhat more likely than community leaders to indicate it was very important to 'Support outdoor recreation opportunities'.

| Figure 16 |



The 2021 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you believe would improve health in your community, what would you change?"* A total of 780 survey respondents (48%) provided written responses to this question. Table 8 provides a summary of the most common responses by topic theme.

TABLE 8

"If you could change one thing that you believe would improve health in your community, what would you change?"

Affordability of health care/low cost or subsidized services; health insurance cost; health care payment reform	**13% of all comments**
Affordable housing; cost of living and wages; taxation, welfare and spending priorities	**12%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**10%**
Availability / affordability of mental health services; mental health awareness / stigma	**9%**
Health care provider availability including certain specialties; health care delivery system improvements, quality and options; health equity, diversity and inclusion	**9%**
Caring community / culture; community diversity and acceptance; facilities and opportunities for social interaction	**8%**
Improved resources, programs or environment for healthy eating / nutrition / food affordability	**8%**
Accessibility/availability of substance use treatment services; substance misuse prevention including tobacco; illegal drug availability	**6%**
Services or resources for youth and families; affordable child care	**5%**
Healthy lifestyle awareness and education; overall focus on wellness and prevention; personal accountability	**3%**
Community Safety; physical infrastructure and accessibility	**3%**
Senior services / concerns of aging / home health care / assisted living	**3%**
COVID-19 Prevention, Policy	**3%**
Improved transportation services / public transportation; medical transportation	**3%**
Affordability / availability of dental services	**2%**
Sustainable community / environment; climate change, pollution	**1%**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

Convening community discussion groups was challenging during the 2021 Community Health Needs Assessment. Due to the ongoing Covid-19 pandemic, discussion groups had to be held virtually to protect the health and safety of participants. The Community Health Needs Assessment Committee worked with community partners to identify and recruit a variety of groups and participants intended to represent a broad cross-section of the region and different community interests. In spite of the challenging context of the ongoing pandemic, the committee and our community partners successfully convened 11 different community discussion groups representing the following sectors, attributes or topics:

- Behavioral Health Coordinators (6 participants)
- Community Health Workers (4 participants)
- Food Insecurity (2 participants)
- Regional Public Health (2 participants)
- Substance Use Recovery Coaches (7 participants)
- Medication Assisted Treatment (5 participants)
- Chamber of Commerce Directors (5 participants)
- Rural Community Residents (6 participants)
- Individuals with Complex Health Needs (4 participants)
- Seniors (6 participants)
- Prevention Network Grantees (a Mt. Ascutney initiative; 3 participants)

The purpose of each of the discussion groups was to get more in-depth qualitative input on health issues that matter to the community, descriptions of ongoing challenges including the COVID-19 pandemic, observations on past community health improvement efforts, and suggestions for new or continuing areas of focus. In addition, the assessment committee worked with students from The Dartmouth Institute's Master of Public Health (MPH) program to facilitate and take notes for many of the community discussion groups using a semi-structured discussion group guide to foster consistency and comparability across the different discussion groups. The following paragraphs summarize the main themes with illustrative quotes for some of the core questions included in the discussion guide such as the impact of the COVID-19 impact, opportunities for more effectively addressing inequities and discrimination, and resources needed to support healthy aging.

Following these summary paragraphs is a table with additional information from each of the discussion groups on overall community health improvement priorities.

1. Impact of COVID-19

Many discussion group participants spoke of the social isolation, loneliness separation, and anxiety. Other impacts of COVID-19 included:

- Significant impacts on family finances, unemployment, food insecurity, juggling work, child care, remote schooling; "COVID has impacted just being able to get things done in general."
- COVID has had a big impact on family mental health; "The impact of remote schooling on child mental health seems to have been largely dismissed."
- Reduced access to care and delayed care; "I have clients who are going without routine medical care or mental health because they have no one to watch their child and they're not allowed to bring them."

> ***"It's had a huge impact on everybody. The most painful one is financial for sure. It's been hard on mental health and hard on a lot of parents to find child care when schools went to remote learning or hybrid schedules."***
>
> - ***Food Insecurity Group Participant***

- Reduced or eliminated transportation services, which has impacted seniors in particular; and also a problem with Medicaid transportation providers canceling scheduled rides with no backup causing patients to miss important visits, especially an issue for rural residents in winter
- Difficulties navigating virtual visit technology
- Not being able to meet in support groups for mental health and substance use recovery; not being able to have social interaction has been very detrimental to recovery.
- "Everyone is being affected multiple ways all the time . . . . There has been incredible pressure to get information out as rapidly as possible. It's been a really long year. A lot of stress. A lot of pressure."

> ***"The biggest thing among the people we work with has been financial. A lot of people have taken a financial hit. And also the isolation and loneliness. We're seeing an increase in drug involvement and we lose a participant every month or two to an overdose and I think a lot of it has to do with just the isolation and added to the fact that there's no terrific public transportation to help people make the connections they need to stay healthy."***
>
> - ***Prevention Network Participant***

2. Resources to Support Aging in Place

Community discussion group participants were asked what additional community resources are needed to help people plan ahead for aging in place? Aging in place was defined as the ability to live in one's own home and community safely, independently and comfortably. Some of the ideas and suggestions included:

- A community nurse or a health coordinator in rural towns; someone who helps people navigate services or can check in on them periodically;
- More resources to help people assess and retro-fit homes for age-related safety (e.g. ramps, handrails); 'When you have your annual Medicare review, it would be helpful to have an annual at-home evaluation by the occupational therapist';
- There is a need to start educating people about financial planning early on;
- There is a lot of discussion about workforce shortages in senior serving organizations. It is difficult enough to find home care services in the daytime and overnight care is a "huge, incredibly challenging issue";
- Home-based, non-health care related supports such as home maintenance, cleaning, shopping and other non-health care social supports are key, but not broadly available. "There are a lot of resources in the community for helping older adults remain vibrant, but much of it is for well-resourced seniors"; "We have a lot of seniors in more rural communities who are struggling";
- There are lengthy wait lists - several years - for subsidized senior housing; it was observed that many seniors are not planning that far ahead;
- "Council on Aging is a great resource; can borrow medical equipment, can get rides to appointments, there are also activities that you can participate in to keep you moving forward, to keep you functioning and keep you happy."

> ***"It is very challenging at this time and even prior to COVID to find care for somebody to age in place. We know that that is part of success in aging and staying in the familiar environment and enhancing those services. So we do have a significant challenge in that area . . . . There's just a shortage of that workforce."***

> ***"Being able to stay in one's home sometimes could just mean needing a home health aide to come in and assist with specific aspects of being at home. And while we do have some organizations in the area providing those services, we don't have enough to go around especially considering the increasing number of people who are going to need those services over the next 5 to 10 years."***
>
> - ***Chamber of Commerce Group Participant***

3. Addressing Discrimination and Stigma

Community discussion group participants were asked what health care providers or other organizations serving the community could be doing better to address barriers related to discrimination or stigma. Some of the ideas and suggestions included:

- Provider education around stigma is needed, 'A Lot of Education'; and more employee engagement
- Discussing issues of race and discrimination and doing something to address them should be happening all the time, not only because of a holiday or what is happening in the news.
- More mindfulness on some basic things, such as how questions are phrased. For example, when asked about marital status, assumptions are made that responses will fit a heterosexual norm.
- Be aware of language barriers. Patients may not speak up if they are not understanding what is being said. Others may not want to speak to anyone because of fear of deportation. 'How do we work around this so patients don't fall into that situation? So we don't cause harm?'

> ***"Some people just don't understand how difficult this is for some patients. And I wish there was a way to really impress on them that it's not as easy. You know, I've had people say, well, why don't they just get it right? Or why don't they just do this? Some more education is needed to help them understand it's just not that easy for some people."***
>
> - ***Community Health Worker Group Participant***

- Perceptions of age discrimination resulting from poor communication or application of some clinical preventive service guidelines, for example colon cancer screening guidelines and protocols
- Don't assume that everyone has good internet access
- 'In general it feels like issues of discrimination and prejudice are getting better. The way you get treated is largely based on how much money you have.'
- Less stigma is perceived in the community about substance use disorder, however broader education is still needed that addiction is an illness like other illnesses.

> ***"We have discussions among the staff, especially in the last couple years about how we are received by professionals in a hospital setting. As professionals ourselves, I feel like we're extended a kind of courtesy that we have not in the past . . . . I don't think as a pure recovery coach we would have had quite the credibility that we have now."***
>
> - ***SUD Recovery Group Participant***

- Need for more diverse workforce in general and resources to support a more diverse population.

4. High Priority Issues from Community Discussion Groups

For most of the community discussion groups convened in 2021, the discussion group facilitator read top priority areas identified in previous Community Health Needs Assessments in the region. The priorities named in the discussion groups were:

- Access to mental health services
- Cost of health care services including the cost of health insurance and prescription drugs
- Alcohol and drug misuse including prevention, treatment and recovery
- Community conditions affecting health like affordable housing, job opportunities, poverty and family stress
- Child neglect and domestic abuse

> ***"There needs to be a better system for tracking and sharing information on who has openings for mental health services. There is a lot of time wasted and missed opportunities that could be fixed more systematically with some sort of shared electronic database of available treatment slots."***
>
> - ***Community Health Worker Group Participant***

Participants were then asked: a) if they thought these are still the most important issues for the community to address, with recognition that COVID-19 was a major overarching concern for most people; b) if there are new, different priorities; and c) if any improvements have happened in these areas over the past several years. With some additions - - most notably transportation, access to dental care, affordable child care, and supportive services for aging in place - - most participants in each group expressed the overall opinion that the priorities identified previously were still the most important issues to focus attention on for community health improvement (see table starting on the next page).

> ***"We have been preaching transportation for I don't even know how many years. But transportation would solve, in my opinion, so many issues. At least it would be the first step."***
>
> - ***Behavioral Health Coordinator Group Participant***

> ***"In general, I think there's something lacking - the lack of community. You know, we have all these services but there really isn't a lot of common spaces or recreational spaces and this is before COVID-19 where people can get together and bond"***
>
> - ***Rural Resident Group Participant***

The table below displays overall priorities, concerns and areas of improvement identified by each set of discussion groups. As noted on the previous page, the community discussion groups convened in 2021 generally endorsed the same set of priorities as identified in 2018 with the major caveat of COVID-19 as an overarching concern with both direct impacts and exacerbating effects on pre-existing community health disparities. Some additional themes emerged in these discussions and are noted in this table as well.

TABLE 9 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Behavioral Health Coordinators	• Housing, insurance, medication costs are still major issues • Difficult to get mental health patients in higher level of care in a community setting than private practitioners can provide • Housing is a huge issue, affordability and also substandard housing	• "Transportation is the number one barrier to everything" • Food insecurity • Supportive services for aging population, in home or skilled nursing; difficult to find care for somebody to age in place; there is a workforce shortage in this service area	• Access to general mental health services has improved with the integration of behavioral health and primary care. • Wraparound services, because of the integration work; communicating with partners a lot better. • But still struggling with the actual ability to access the services needed • Access to alcohol and drug misuse, prevention, treatment, recovery has been enhanced • Prevention program in Claremont, the needle exchange program, has been a great addition. The Center for Recovery Resources has also been huge.
Chamber of Commerce Directors	• Mental health is still a major health issue that needs to be addressed and costs go hand in hand with that. • Mental health providers are very stressed right now. The whole list is still very top of mind. • Don't have good health insurance options for small businesses, for some people who are falling through the cracks.	• Can't separate the COVID epidemic from these issues. Or the current environment of social unrest. • Incorporate wellbeing as priority in the workplace. • Lack of affordable, dependable child care is another example of something that was an issue long before COVID and has been exacerbated because of COVID.	• For mental health, a lot more recognition and appreciation for services and people reaching out for those resources. A lot more acceptance in our community and lot more sharing of information on social media • Pre-pandemic substance misuse services seemed to be headed in the right direction with lots of support groups in place and counselors available. A lot of that had to pivot and has been a challenge.

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Community Health Workers	• All of those issues are relevant still regardless of COVID • Access to mental health services is definitely up there if not #1. Nowhere for anybody to go. • Extremely long waitlists which puts a burden on primary care. • Housing shortages and costs; cost of living; family stress • Services for child protection, domestic violence are understaffed, resources exhausted. Especially shelter capacity and housing. • The cost of healthcare services is something very high on the list of priority issues.	• The need for subsidized housing is much greater than the need for affordable housing • Homelessness • Affordable child care	• There are more resources, like community health workers as an example. • Collaborative care and integrated health and things like that have been improved. • But at the same time the amount of behavioral health that we can offer in the clinic isn't always enough for what the people need.
Food Insecurity	• "Definitely." • Affordable health care is still challenging; • The area has a pretty big drug problem, which leads to a lot of mental health issues. • Still need more support for people who are having substance abuse issues.	• More effective strategies for substance use treatment and recovery • Youth-focused community resource center is needed; many kids are bored, feel stuck, not receiving guidance at home • Starting the same cycle of unhealthy behaviors they see at home	• There are more resources available in the community than there used to be • Since COVID started, there's been a little bit more help out there. Especially with food • The resources for substance use are better. There's still a stigma around it. Past use = Less likely to get hired for a job; Impairs ability to get help
Substance Use Recovery Coaches	• Captures all of the most urgent needs in our community. • There are certain areas that are gaps, but if these are target groups then all of those gaps can be addressed within those bigger categories. • They all connect and are all important.	• More specific focus on alcoholism is needed • Big needs for people with substance use disorder are opportunity for vocational training, job placement and transitional and recovery housing	• There have been improvements in addressing stigma • Improvements in incorporating the work of recovery coaches in hospital settings • More emphasis on overdose prevention and Narcan availability

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Medication Assisted Treatment	• Those are still important. May not be the only ones, but they are important • Health insurance: There's a real huge gap between being at the very bottom, and then actually being able to afford good insurance, there's nothing in the middle. There's really an incentive to not make more money.	• Transportation is a huge issue for people. Have to rely on relatives or a friend • Need more awareness of all things that are available and improved wrap around services. • Sometimes people have a lot of trouble navigating the systems to find the things that they need. Wrap around does happen, but still room for improvement.	• Addiction treatment has gotten way better. Easier to get, better quality, different styles. • Electronic health record has helped a lot. Don't have to tell the same story over and over. And helpful for not duplicating services or procedures.
Regional Public Health	• May be some different ordering of priorities, but these are still the most important issues. • With COVID, problems with alcohol and drugs, for example, and the related effects on children and families have just gone underground / are somewhat less visible during this time. The pandemic has probably exacerbated that.	• Dental care • Early childhood development and enrichment • Addressing health equity and health disparities • Youth vaping • Supports for seniors, aging in place • Access to reliable internet is an equity issue that has left many people vulnerable during the pandemic	• Increased funding for opioid related work has led to improved access. • Focus on behavioral health and primary care through the Integrated Delivery Network has led to some improvements in the way of care is provided and how people are able to engage in their care, particularly for Medicaid populations. • In the area of family strengthening, there has been more coalition development and coordination of care across provider groups. • The relatively strong economy helps in a broad sense to deal with issues of food insecurity and housing insecurity. • In general the region continues to benefit from strong partnerships, collaboration and cooperation

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Rural Community Residents	• They are still very relevant and very much in need of further attention. • There are probably a whole other list of other things to add to but if it's too long It's not useful	• Suicide Prevention • Aging in place with dignity and with the right supports • Transportation • Access to ambulance services in rural towns • High speed internet access ("20 years behind other communities") • Perinatal care / birthing services • Homelessness	• Haven't seen any real improvements • Participated in a similar needs assessment last year, 'don't know what became of that' • Just think there has been a lot of talk, but we don't do anything.
Individuals with Complex Health Needs	• Yes, those are still priorities although would include transportation • There's a great need for mental health services; see a lot seniors who could use some help, but they would have no idea how to reach out and get it. • Health care is expensive.	• Transportation for a lot of people is a huge barrier	• Everybody is working harder together to solve a problem. Instead of working against each other, each doing their own thing.
Seniors	• Not asked / discussed	• The COVID situation has highlighted concerns that people already had. "Something as simple as obtaining groceries. For people who can no longer drive or are disabled to the point that they have to use a walker or use a wheelchair, obtaining food and other necessary items such as prescriptions is a challenge."	• Not asked / discussed

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Prevention Network Grantees	• 'The basic needs are still access to mental health, access to substance misuse treatment and housing 'is a really big one' • 'Child abuse and neglect should be permanently on the list.' • Cost is a big issue that includes a lot of areas including health care, dental and prescription drugs.	• Add a topic on chronic disease including a focus on food access and its relationship to chronic disease management • See a lot of dental needs; lack of dental insurance. • 'Dental, vision, and hearing are all quality of life issues that don't always get addressed' • Improved coordination and referral to existing services.	• "The conversations between organizations over the last couple years have become more in depth and connected and that helps them do their jobs better. I see that happening through both the chip workgroups, and just in general on other levels."

D. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2022 Community Health Needs Assessment report provides information on key indicators and measures of community health status. Some measures associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 19 town service area identified as the primary service area of Mary Hitchcock Memorial Hospital and Alice Peck Day Hospital (identified in the following tables as DH-APD Service Area). In some instances, population health data are only available at the county or health district / regional level. For example, some indicators included here report statistics for the White River Junction Health District in Vermont. All 7 Vermont municipalities in the DH-APD service area are part of the White River Junction Health District along with 15 other Vermont municipalities. For the 12 New Hampshire municipalities in the DH-APD service area, most population health information is reported for the Upper Valley Public Health Region, which is completely congruent with those 12 municipalities and comprises 65% of the total service area population.

1. Demographics and Social Determinants of Health

A population's demographic and social characteristics, including such factors as prosperity, education, and housing influence its health status. Similarly, factors such as age, disability, language and transportation can influence the types of health and social services needed by communities.

a. General Population Characteristics

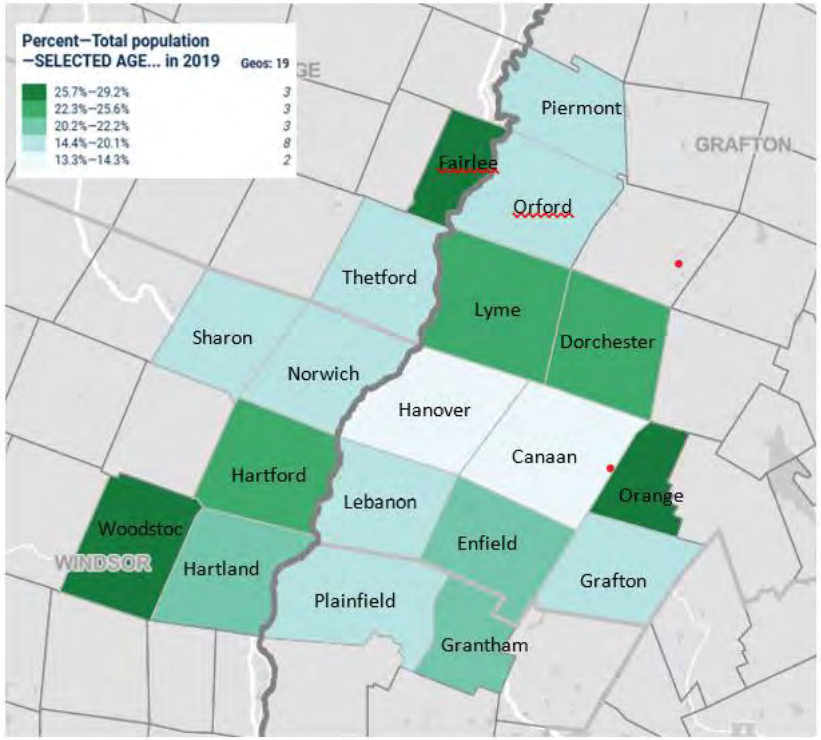
According to the 2019 American Community Survey, the population of the DH-APD Service Area is somewhat older on average than in Vermont and New Hampshire overall. The service area map on the next page displays the percent of the population 65 years of age and older by town. Between 2016 and 2019, the population of the DH-APD Service Area was essentially unchanged, similar to Vermont overall, while the New Hampshire population grew by approximately 2%.

Population Overview	DH-APD Service Area	Vermont	New Hampshire
Total Population	**69,612**	624,313	1,327,503
Age 65 and older	**20.0%**	18.8%	17.5%
Under age 18	**17.2%**	18.7%	19.3%
Change in population (2016 to 2019)	**+0.2%**	-0.3%	+2.2%

Data Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

Figure 17 - Percent of Population 65 years of age and older, DH-APD Service Area

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates



The proportion of the population age 65 years or more ranges from about 13% in Hanover to 29% in Woodstock.

b. Poverty

The correlation between economic prosperity and good health status is well established. Inversely, the lack of economic prosperity or poverty can be associated with barriers to accessing health care, healthy food, and healthy physical environments that contribute to good health. Information describing household income and poverty status was included in the first section of this report. The table below on the page shows the percent of people in the DH-APD Service Area living in households with income below the federal poverty level and the percent of children under age 18 in households with income below the poverty level. Five communities have estimated child poverty of 20% or more: Orford (20%), Lebanon (20%), Woodstock (21%), Sharon (25%), and Orange (27%).

Area	Percent of people with household income below the federal poverty level (Income < 100% FPL)	Percent of children (under 18) in households below the federal poverty level (Income < 100% FPL)
DH-APD Service Area	**7.3%**	**8.6%**
Vermont	10.6%	13.0%
New Hampshire	7.6%	9.2%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

c. Education

Educational attainment is also considered a key driver of health status with lower levels of education linked to both poverty and poor health. A similar proportion of the population of the DH-APD Service Area have earned a high school diploma or equivalent compared to New Hampshire and Vermont overall. The table below displays data on the percentage of the population aged 25 and older with a high school diploma (or equivalent) or higher level of education.

Area	Percent of Population Aged 25+ with High School Diploma or Equivalency
DH-APD Service Area	94.7%
Vermont	92.7%
New Hampshire	93.1%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

d. Language

An inability to speak English well can create barriers to accessing services, communication with service providers, and ability to understand and apply health information (health literacy). The table below reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well".

Area	Percent of Population Aged 5+ Who Speak English Less Than "Very Well"
DH-APD Service Area	**0.9%**
Vermont	0.8%
New Hampshire	1.4%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

e. Housing

Housing characteristics, including housing quality and cost burden as a proportion of income, can influence the health of families and communities. Households that spend a high proportion of their income on housing are less likely to have adequate resources for food, clothing, medical care, or other needs. Characteristics of "substandard" housing include lacking complete plumbing facilities or kitchen facilities, and mortgage or rental costs exceeding 30% of household income. The table below presents data on the percentage of occupied housing units in the service area that have 1 or more of these characteristics. About a third of households in the region report housing costs exceeding 30% of their household income.

Area	Percent of Households with Housing Costs >30% of Household Income	Percent of Occupied Housing Units Lacking Complete Plumbing Facilities	Percent of Occupied Housing Units Lacking Complete Kitchen Facilities
DH-APD Service Area	31.9%	0.5%	0.9%
Vermont	32.8%	0.5%	1.0%
New Hampshire	31.3%	0.5%	0.8%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

f. Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services including health care appointments, and more challenges to leading independent, healthy lives. As displayed on the next table, about 5% of households in the DH-APD service area report not having no vehicle available.

Area	Percent of Households with No Vehicle Available
DH-APD Service Area	5.2%
Vermont	6.9%
New Hampshire	5.1%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

g. Disability Status

Disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. The US Census Bureau identifies people reporting serious difficulty with six basic areas of functioning – hearing, vision, cognition, ambulation, self-care or independent living. Compared to VT and NH overall, similar percentages of residents across age groups in the DH-APD service area report having at least one disability.

Percent of Population Reporting Serious Activity Limitations Resulting from a Disability			
Age Group (years)	**DH-APD Service Area**	**Vermont**	**New Hampshire**
Percent with a disability, <18	**5.1%**	6.1%	4.7%
Percent with a disability, 18-64	**9.0%**	11.9%	10.3%
Percent with a disability, 65+	**29.4%**	32.0%	31.4%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

2. Access to Care

Access to care refers to the ease with which an individual can obtain needed services. Access is influenced by a variety of factors including affordability of services and insurance coverage, provider capacity in relationship to population need and demand for services, and related concepts of availability, proximity and appropriateness of services.

a. Insurance Coverage

Table 10 on the next page displays estimates of the proportion of residents who do not have any form of health insurance coverage by municipality, as well as the proportion of residents with Medicare, Medicaid or Veterans Administration coverage.

Compared to estimates from the last community health needs assessment in 2019, the percentage of uninsured residents has decreased (7.1% uninsured estimate in 2019; 4.9% current estimate). In combination, the percentage of the service area population with Medicaid or no insurance coverage (17.2%) is similar to New Hampshire overall (19.2%) and substantially lower than in Vermont overall (28.6%).

It should be noted that the data source for these municipal level estimates is a 5-year span of the American Community Survey. A combination of five years of data is required to produce reasonably stable estimates on these and other measures from the survey samples. As such, the estimates may not fully reflect shorter term economic or policy conditions influencing fluctuations in insurance benefit coverage.

Table 10: Health Insurance Coverage Estimates

Area	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Orford	23%	23%	13%	4%
Canaan	13%	15%	14%	2%
Dorchester	10%	31%	21%	4%
Grafton	9%	25%	14%	4%
Lyme	7%	25%	5%	1%
New Hampshire	5.9%	19.1%	13.3%	2.7%
Piermont	6%	22%	12%	2%
Hartland	6%	23%	20%	2%
Hartford	6%	28%	20%	4%
Lebanon	5%	22%	14%	3%
DH-APD Service Area	**4.9%**	**21.2%**	**12.3%**	**2.9%**
Orange	4%	28%	3%	1%
Vermont	4.0%	21.0%	24.6%	2.6%
Woodstock	4%	30%	13%	4%
Fairlee	4%	30%	19%	3%
Enfield	3%	23%	5%	5%
Thetford	2%	18%	17%	3%
Norwich	2%	19%	7%	1%
Hanover	2%	12%	4%	2%
Plainfield	2%	20%	11%	2%
Grantham	1%	22%	5%	6%
Sharon	1%	21%	28%	4%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.

**Coverage alone or in combination*

b. Delayed or avoided health care visit because of cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a health care visit in the past year because of cost. A higher rate on this measure is reflective of limitations of household income or health insurance benefits inhibiting access to care. The most recently available data for this measure suggests that the percentage of adults in the Upper Valley Public Health Region delaying or avoiding health care because of cost is lower than in Vermont or New Hampshire overall, however the sample size is not large enough to determine that this difference is statistically significant.

Area	Percent of adults who report having delayed or avoided health care because of cost in the past year
White River Junction Health District	9.0%
Upper Valley Public Health Region	4.5%
Vermont	8.0%
New Hampshire	9.3%

Data Sources: Behavioral Risk Factor Surveillance System, VDH 2017-2018, NHDHHS 2017.

Regional rates are not significantly different from the overall state rates.

c. Physician Capacity

This indicator reports the number of Full Time Equivalent (FTE) physicians in active practice with specialties in primary care or in psychiatry (NH). Access to high quality, cost-effective healthcare is influenced by adequate physician availability in balance with population needs. As displayed by the table, the Upper Valley Public Health Region is reported to have substantially more FTE capacity of primary care physicians compared to Vermont or New Hampshire overall; a likely reflection of the regional referral center and medical training center role served by the Dartmouth-Hitchcock Medical Center.

Area	Primary Care FTE per 100k Population	Psychiatrist FTE per 100k Population
White River Junction Health District	70.0	
Upper Valley Public Health Region	111.7	17.2
Vermont	69.6	
New Hampshire	42.6	5.0

Data Source: VDH, 2018; NHDHHS, Office of Rural Health and Primary Care, 2021

d. Adults with a Personal Health Care Provider

This indicator reports the percentage of adults aged 18 and older who self-report that they have at least one person who they think of as a personal doctor or health care provider. A lower percentage on this indicator may highlight insufficient access or availability of medical providers, a lack of awareness or health knowledge or other barriers preventing formation of a relationship with a particular medical care provider.

Area	Percent of adults who report having a personal doctor or health care provider
White River Junction Health District	86%
Upper Valley Public Health Region	82%
Vermont	86%
New Hampshire	88%

Data Sources: Behavioral Risk Factor Surveillance System, VDH 2017-2018, NHDHHS 2017.
Regional rates are not significantly different from overall state rates.

e. Preventable Hospital Stays

A high rate of inpatient stays for diagnoses potentially treatable in outpatient settings such as diabetes, hypertension, asthma or chronic obstructive pulmonary disease may indicate limited access, availability or quality of primary and outpatient specialty care in a community. This measure is reported below for Medicare enrollees.

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Windsor County	**32.6**
Grafton County	**33.4**
Vermont	33.2
New Hampshire	38.4

Data Source: Centers for Medicare & Medicaid Services, 2018; accessed through County Health Rankings
Regional rates are not significantly different from overall state rates.

f. Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have visited a dentist, dental hygienist or dental clinic within the past year. The percentage of adults in the Upper Valley Public Health Region who report not having seen a dentist is somewhat higher than for NH overall while the percentage in the White River Junction Health District is somewhat lower compared to Vermont overall although the observed differences are not statistically significant.

Area	Percent of adults who visited a dentist or dental clinic in the past year
White River Junction Health District	**66%**
Upper Valley Public Health Region	**82%**
Vermont	73%
New Hampshire	72%

Data Source: Behavioral Risk Factor Surveillance System, VDH 2016-2018; NHDHHS 2016.
Regional rates are not significantly different from overall state rates.

3. Health Promotion and Disease Prevention

Adopting healthy lifestyle practices and behaviors, such as not smoking and limiting alcohol intake, can prevent or control the effects of disease and injury. For example, regular physical activity not only builds fitness, but helps to maintain balance, promotes relaxation, and reduces the risk of disease. Similarly, eating a healthy diet rich in fruits, vegetables and whole grains can reduce risk for diseases like heart disease, certain cancers, diabetes, and osteoporosis. This section includes indicators of environmental conditions and individual behaviors influencing personal health and wellness. Some indicators of clinical prevention practices, such as screening for cancer and heart disease, are included in a later section that also describes population health outcomes in those areas.

a. Food Insecurity

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food contributing to reduced quality, variety, or desirability of diet, disrupted eating patterns and reduced food intake. Approximately 10% of Grafton County households experienced food insecurity in 2019.

Area	Experienced food insecurity, past year
Windsor County	**10%**
Grafton County	**10%**
Vermont	11%
New Hampshire	9%

Data Source: USDA data, 2019 accessed through Feeding America, Mapping the Meal Gap.

b. Physical Activity (Adults)

Physical activity reduces the risk for multiple chronic diseases and conditions including heart disease, colon cancer, stroke, type 2 diabetes, obesity, and osteoporosis. This indicator reports the percentage of adults aged 18 and older who self-report regular leisure time physical activity meeting recommendations describing moderate or vigorous physical activity. About 3 of every 5 adults in Grafton County can be considered physically active on a regular basis.

Area	% of Adults meeting physical activity recommendations
White River Junction Health District	**61%**
Grafton County	**59%**
Vermont	60%
New Hampshire	54%

Data Source: Behavioral Risk Factor Surveillance System, VDH 2017; NHDHHS 2017.
Regional rates are not significantly different from overall state rates.

c. Pneumonia, Influenza and COVID-19 Vaccinations (Adults)

The indicators on the next page include the percentage of adults who self-report that they received an influenza vaccine in the past year (at the time of the survey) or have ever received a pneumococcal vaccine (age 65+). In addition to measuring the population proportion receiving preventive vaccines, these measures can also highlight access to preventive care issues or opportunities for health education including addressing concerns for vaccine safety and efficacy. This latter consideration has received significant attention in recent months due to the efforts to achieve broad distribution and administration of COVID-19 vaccines. The table on the next page includes the most recently available statistic for the proportion of area residents aged 12 years and up who are fully vaccinated.

Area	Influenza Vaccination in the past year	Pneumococcal Vaccination Ever; 65 years or older	COVID-19, Fully Vaccinated; % of Population age 5+
White River Junction Health District	61.6%*	77.4%	
Upper Valley Public Health Region	43.9%**	84.5%	
Windsor County			76%
Grafton County			76%
Vermont	59.6%*	80.6%	80%
New Hampshire	44.0%**	82.1%	71%

*65 years or older; **18 years or older

Data Sources: Behavioral Risk Factor Surveillance System, VDH 2016-2017, NHDHHS 2017. COVID-19 vaccine data as of January 4, 2022; VDH for VT, CDC for NH. Regional estimates are not significantly different from the overall statewide estimates.

d. Substance Misuse

Substance misuse, involving alcohol, illicit drugs, misuse of prescription drugs, or combinations of all of these behaviors, is associated with a complex range of negative consequences for health and wellbeing of individuals, families and communities. In addition to contributing to both acute and chronic disease and injury, substance misuse is associated with destructive social conditions, including family dysfunction, lower prosperity, domestic violence and crime.

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking more than two drinks per day on average for men or more than one drink per day on average for women), or binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Area	Excessive Drinking in Past 30 days, Percent of Adults
Windsor County	**23%**
Grafton County	**22%**
Vermont	20%
New Hampshire	20%

Data Source: Behavioral Risk Factor Surveillance System accessed via County Health Rankings, 2018.
Regional estimates are not significantly different from the overall state estimates.

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth. On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers. Regional statistics for binge drinking among high school aged youth are similar to the overall state rates although female high school age students in the region were somewhat more likely than males to report binge drinking behavior.

Area	Engaged in Binge Drinking in Past 30 days, Percent of High School Youth		
	Male	Female	Total
Windsor County	13%	15%	14%
Upper Valley Public Health Region	13.5%	15.2%	14.5%
Vermont	15%	16%	15%
New Hampshire	13.8%	14.8%	14.4%

Data Source: VT and NH Youth Risk Behavior Surveys, local and statewide samples, 2019

The misuse of prescription drugs, particularly prescription pain relievers, poses significant risk to individual health and can be a contributing factor leading to misuse of other drugs and a cause of unintentional overdose and mortality. About 5% of high school youth in the Upper Valley Public Health Region reported having ever used a prescription pain relief drug that was not prescribed to them on the 2019 Youth Risk Behavior Survey.

Area	Ever used prescription drugs 'not prescribed to you', Percent of High School Youth		
	Male	Female	Total
Windsor County*	6%	7%	7%
Upper Valley Public Health Region	5.0%	5.0%	5.1%
Vermont*	9%	9%	9%
New Hampshire	10.9%	8.9%	10.0%

Data Source: VT and NH Youth Risk Behavior Surveys, local and statewide samples, 2019
*Vermont statistics specific to prescription pain relievers.

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. Smoking during pregnancy also confers significant short and long term risks to the health of an unborn child. The percentage of adults in the service area estimated to be current smokers (14% in Grafton County; 17% in Windsor County) is similar to the statewide adult smoking proportions for New Hampshire and Vermont. During the period 2015 to 2018, the rate of births where smoking was indicated during pregnancy was about 10 per 100 births in the Upper Valley Public Health Region.

Area	Percent of Adults who are Current Smokers	Smoked during pregnancy, rate per 100 births^
Windsor County	17%	**13.9**
Grafton County	14%	
Upper Valley Public Health Region		**10.1**
Vermont	15%	13.2
New Hampshire	17%	11.0

Data Sources: VDH, 2017-2018; NHDHHS, 2018.

^Data Sources: Vital Records Birth Certificate Data, Vermont, 2019, NH 2015-2018.

Regional estimates are not significantly different from the overall state estimates.

f. Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rate in the Upper Valley Public Health Region is lower than the rate in New Hampshire overall according to the most recently available data.

Area	Teen Birth Rate per 1,000 Women Age Under 20
Windsor County	**6.0**
Upper Valley Public Health Region	**4.9***
Vermont	7.6
New Hampshire	11.4

Data Sources: Vital Records Birth Certificate Data, Vermont, 2019, NH 2012-2016.

Regional rate is significantly different and lower than the overall NH rate.

g. Child Safety

Measures of child safety or child abuse and neglect in a community include the rate of substantiated child maltreatment victims, as well as the rate of children in temporary, out of home placement. In Vermont, there was a 22% decrease in reports made to the Vermont Department of Children & Families Child Protection Line in 2020. As stated by Vermont DCF in the 2020 annual report on Child Protection in Vermont, this decrease *"is almost certainly an anomaly due to the COVID-19 pandemic. Stay-at-home orders and school closures kept children away from the watchful eyes of mandated reporters — especially educators who typically make about a third of all child abuse and neglect reports in Vermont".* In the communities served by the Hartford District Office, there were 37 substantiated investigations for child abuse or neglect in 2020 compared to 81 substantiated investigations in 2019. As displayed by the table below, the rates of child maltreatment and out-of-home placements in Grafton County during 2016 were somewhat higher than the overall NH rates.

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Children in out-of-home placements, rate per 1,000 children under age 18
Grafton County	**3.9**	**3.7**
New Hampshire	3.5	4.6

Data source: Annie E. Casey Foundation, Kids Count Data Center, 2016

4. Health Outcomes

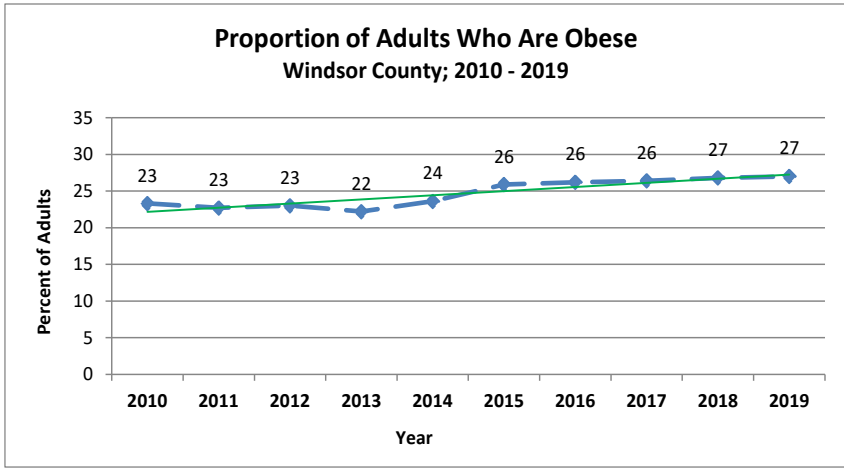
Traditional measures of population health status focus on rates of illness or disease (morbidity) and death (mortality) from specific causes. Advances in public health and medicine over the last century have reduced infectious disease and complications of childbirth as major contributors to or causes of death and disease. Chronic diseases, such as heart disease, cancer, respiratory disease and diabetes, along with injury and violence, are now the primary burdens on the health and wellbeing of individuals, families and communities. In addition to considering the absolute magnitude of specific disease burdens in a population, examination of disparities in disease rates can help to identify areas of need and opportunities for intervention.

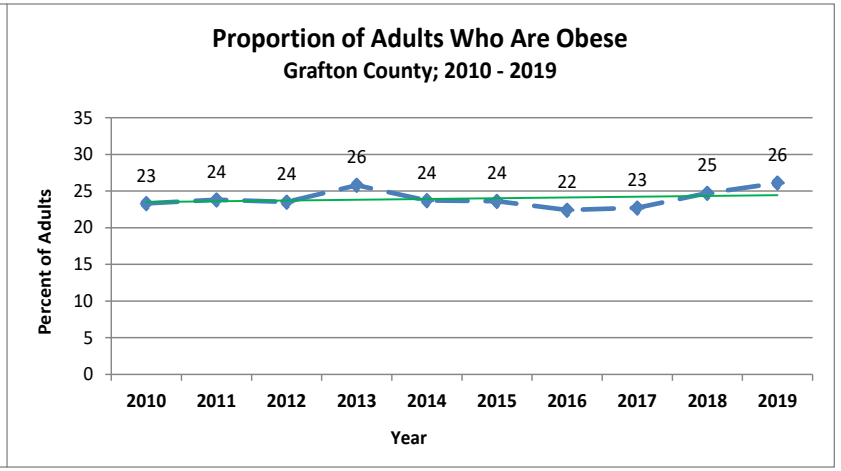
a. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older (BRFSS), as well as high school students (YRBS) who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese). The chart on the next page displays the increasing trend in adult obesity in Windsor County over a ten year period from 2008 to 2017.

Area	Adults Aged 20+ Years, Percent Obese	High School Students, Percent Obese
Windsor County	**27%**	**11.5%**
Upper Valley Public Health Region		**7.9%**
Grafton County	**26.1%**	
Vermont	29%	12.6%
New Hampshire	26.4%	12.8%

Data Sources: Centers for Disease Control and Prevention, National Diabetes Surveillance System 2017; VT and NH Youth Risk Behavior Survey 2017.





Data Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System

b. Heart Disease

Heart disease is the second leading cause of death in Vermont and New Hampshire after all forms of Cancer. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance misuse including tobacco use.

Heart Disease Risk Factors: About 23% of adults in Windsor County and 26% of adults in the Upper Valley Public Health Region self-report that they have been told by a doctor that they have high blood pressure. About 1 in every 4 adults have not had their cholesterol checked in the past 5 years.

Area	Percent of adults who have high blood pressure	Percent of adults who have had a cholesterol check in the past 5 years	Adults told by a health professional that their blood cholesterol was high
Windsor County	**23%**	**76%**	
Upper Valley Public Health Region	**26%**		**27%**
Vermont	25%	83%	
New Hampshire	30%		33%

Data Sources: Behavioral Risk Factor Surveillance System, VDH 2015-2017, NHDHHS 2017
Estimates are not statistically different from the overall state percentage estimates.

Heart Disease-Related Hospitalization: The table below displays age adjusted rates of inpatient hospitalization for hypertension, cardiovascular disease (VT) and heart failure (NH). The inpatient hospitalization rate for hypertension and cardiovascular disease was significantly higher among residents of the White River Junction Hospital Service Area than for Vermont overall.

Area	Hypertension – Inpatient, age adjusted rate per 100,000 population; 18+ years of age	Cardiovascular Disease-Related Hospital Discharges, primary diagnosis; rate per 100,000	Heart Failure – Inpatient, age adjusted rate per 100,000 population; 18+ years of age
White River Jct. HSA	**54.0***	**1,284***	
Upper Valley Public Health Region	**19.3**		**260.8****
Vermont	32.0	1,119	
New Hampshire	30.8		320.5

Data Source: Uniform Healthcare Facility Discharge Dataset, VT 2013-2015, NH 2018

****Rate is statistically different and higher than the overall VT rate**

****Rate is statistically different and lower than the overall NH rate**

Heart Disease and Stroke Mortality: Coronary Heart Disease, a narrowing of the small blood vessels that supply blood and oxygen to the heart, is the largest component of heart disease mortality. Cerebrovascular disease (stroke), which happens when blood flow to a part of the brain stops, is the fifth leading cause of death in New Hampshire and sixth leading cause in Vermont.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Windsor County	**103.1**	**39.4**
Grafton County	**60.7***	**21.1**
Vermont	110.8	28.8
Rest of New Hampshire (not including Upper Valley PHR)	92.8	27.2

Data Source: Vital Records death certificate data, VT 2015-2017; NH 2012-2016

***Rate is statistically different and lower than the overall NH rate**

c. Diabetes

Diabetes is an increasingly prevalent chronic health condition that puts individuals at risk for further health complications, but is also amenable to control through diet and adequate clinical care.

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes - about 7% of adults in the service area.

Area	Percent of Adults with Diabetes, age adjusted
Windsor County	**7.2%**
Grafton County	**6.8%**
Vermont	7.6%
New Hampshire	8.7%

Data Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2018
Regional estimates are not statistically different from the overall state estimates

Diabetes-Related Hospitalization: The table below displays age adjusted rates of inpatient hospitalization for diabetes primary diagnosis (VT) and long term complications of diabetes (NH). The hospitalization rate for diabetes as the primary diagnosis was significantly higher among residents of the Springfield Hospital Service Area than for Vermont overall.

Area	Diabetes-Related Hospital Discharges, primary diagnosis; rate per 100,000	Diabetes Long -Term Complications - Inpatient, age adjusted rate per 100,000 population, 18+ years of age
White River Jct. HSA	**129**	
Upper Valley Public Health Region		37.7
Vermont	112	
New Hampshire		55.5

Data Sources: Uniform Healthcare Facility Discharge Dataset, VT 2013-2015, NH 2018
Regional estimates are not statistically different from the overall state estimates

Diabetes-related Mortality: Diabetes is the seventh leading cause of death in Vermont and New Hampshire. The rate of death due to Diabetes Mellitus among residents of the Upper Valley Public Health Region was significantly lower than the overall New Hampshire rate for the 5 year period 2021 – 2016 (most recent statistics available for the region).

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Windsor County	**16.6**
Upper Valley Public Health Region	**9.3***
Vermont	16.8
New Hampshire	17.7

Data Source: For VT, National Center for Health Statistics. Underlying Cause of Death on CDC WONDER, 2018-2019
For NH, Vital Records Death Certificate Data via NH Health Wisdom, 2012-2016
***Rate is statistically different and lower than the overall NH rate**

d. Cancer

Cancer is the leading cause of death in Vermont and New Hampshire. Although not all cancers can be prevented, risk factors for some cancers can be reduced. It is estimated that nearly two-thirds of cancer diagnoses and deaths in the US can be linked to behaviors, including tobacco use, poor nutrition, obesity, and lack of exercise.

Cancer Screening: The table below displays screening rates for colorectal cancer, breast cancer and cervical cancer. The percentage of females ages 21 to 65 receiving a Pap screening test in the past 3 years was significantly higher in 2016 than the reported percentage in overall NH.

Cancer Screening Type	Windsor County	Vermont	Upper Valley Public Health Region	New Hampshire
Adults 50-75 receiving colorectal cancer screening+	**68.7%**	72.0%	**72.5%**	72.7%
Female adults age 50-74 receiving breast cancer screening++	**74.6%**	78.7%	**62.8%**	76.9%
Female adults age 21-65 receiving cervical cancer screening	**90.0%**	86.0%	**75.9%**	85.1%

+For NH, 'Had colonoscopy in past 10 years (ages 50 to 75)'

++ For NH, 'Had mammogram past two years (women 40+)'

Data Sources: Behavioral Risk Factor Surveillance System, VT 2014-2016 except 2021-2014 for cervical cancer screening; NH 2016.

Regional estimates are not statistically different from the overall state estimates

Cancer Incidence and Cancer Mortality: The table below shows cancer incidence rates by site group for the cancer types that account for the majority new cancer cases (incidence). Incidence rates for the most common forms of cancer were similar across the region compared to statewide rates except for a lower incidence in the Upper Valley Public Health Region of prostate cancer among males, lower incidence of lung cancer, and higher incidence of melanoma.

Cancer Incidence per 100,000 people, age adjusted				
	Windsor County	**Vermont**	**Upper Valley Public Health Region**	**New Hampshire** (rest of state not including UVPHR)
Overall cancer incidence (All Invasive Cancers)		454.4*	**441.8^**	481.9
Cancer Incidence by Type				
Tobacco Associated Cancers	**164.4**	167.6		
Obesity Associated Cancers	**154.4**	156.3		
HPV Associated Cancers	**8.6**	10.6		
Breast (female)+	**104.8**	91.8	**140.2**	143.4
Prostate (male)			**85.2^**	109.7
Lung and bronchus++	**193.5**	193.6	**45.4^**	62.6
Colorectal+			**34.0**	36.3
Melanoma of Skin	**41.4**	33.1	**50.8^^**	32.2
Bladder			**22.6**	27.4

*Data Sources: Vermont Cancer Registry, 2011-2015; NH State Cancer Registry, 2014 – 2018; *American Cancer Society 2013-2017*
+For VT, advanced stage diagnosis, Ages 50+
++For VT, advanced stage diagnosis, Ages 55+
***^Rate is statistically different and lower** than the overall NH rate;*
***^^Rate is statistically different and higher** than the overall NH rate; other rates are not significantly different*

Cancer Mortality: The table below shows the overall cancer mortality rate and for the cancer types that account for the majority of cancer deaths. The overall cancer mortality rate and mortality rate from specific cancer types are similar to the state overall. As displayed by the chart at the bottom of the page, the overall cancer mortality rate in the region has been declining at a linear rate of about -2.4% per year since the year 2001.

Cancer Mortality per 100,000 people, age adjusted				
	Windsor County	**Vermont**	**Upper Valley Public Health Region**	**New Hampshire** (rest of state not including UVPHR)
Overall cancer mortality (All Invasive Cancers)	**161.0**	168.6	**125.3***	159.3
Cancer Mortality by Type				
Lung and bronchus		47.7	**27.8***	43.2
Prostate (male)		21.9	**18.4**	19.0
Breast (female)		18.8	**18.2**	19.1
Pancreas		11.2	**10.9**	10.4
Colorectal		14.4	**11.0**	12.5

Data Sources: Vermont Cancer Registry, 2010-2014; NH State Cancer Registry, 2012 - 2016

***Rate is statistically different and lower than the overall NH rate**; other rates are not significantly different*

e. Asthma

Asthma is a chronic lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing. Asthma is an increasingly prevalent condition that can be exacerbated by poor environmental conditions.

Asthma Prevalence: This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma and the percent of children with asthma as reported by a parent or guardian.

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Windsor County	6%	11%
Grafton County	*Not available*	9.5%
Vermont	8%	11%
New Hampshire	8.3%	11.8%

Data Sources: Behavioral Risk Factor Surveillance System, VDH 2016-2017, NHDHHS 2018
Regional statistics are not statistically different from the overall state statistics.

Asthma-Related Hospitalization: The table below displays age adjusted rates of inpatient and emergency department utilization for complications of asthma. The regional rate is significantly higher than for the state overall.

Area	Asthma hospital emergency department visits, All Ages age adjusted rate per 10,000 population
White River Jct. HSA	43.2
Upper Valley Public Health Region	**31.5***
Vermont	40.0
New Hampshire (rest of NH not including UVPHR)	40.0

Data Source: Uniform Healthcare Facility Discharge Datasets, VT 2015, NH 2013 - 2017

Regional rate is significantly different and lower than the corresponding state rate

e. COVID-19

COVID-19 disease is caused by infection by a new strain of coronavirus (SARS-CoV-2) that had not been previously identified in humans before 2019. Coronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Severe Acute Respiratory syndrome (SARS). The virus causing COVID-19 disease is highly contagious and has caused illness and death in nearly all countries of the world (pandemic). Most people with COVID-19 have mild symptoms, but some people can become severely ill.

The first cases of COVID-19 infection in Vermont and New Hampshire were reported in March 2020. Since that time, there have been more than 76,000 identified cases of COVID-19 infection and over 480 deaths among Vermont residents and among New Hampshire residents more than 214,000 cases and over 2,000 deaths. The cumulative rate of COVID-19 cases and COVID-19 associated fatalities in the Upper Valley Public Health Region is the lowest among NH's 13 Public Health Regions.

	Cumulative COVID-19 Cases		Cumulative Deaths with COVID-19 as a Contributing Factor	
. Area	Total Cases	Cases per 100K population	Total Deaths	Deaths per 100K population, age adjusted
Windsor County	6,042	10,929	46	83.2
Upper Valley Public Health Region	4,874	10,864	16	23.6
Vermont	90,668	14,523	497	79.6
New Hampshire	235,898	17,498	2079	154.2

*Data Source: VDH and NHDHHS COVID-19 Dashboards as of January 17, 2022

f. Intentional and Unintentional Injury

Accidents and injury are the third leading cause of death in Vermont and New Hampshire. In recent years, the epidemic of opioid and other substance misuse has been a substantial underlying cause of unintentional and intentional injury and death.

Substance Use-related Emergency Department Visits, Hospitalization: The table below displays rates of emergency department (ED) visits and inpatient hospitalizations for drug and alcohol related diagnoses including acute alcohol and/or drug poisoning as well as injuries/conditions related to acute drug and/or alcohol use. Not included are visit or inpatient stays involving intentional self-harm (see table on the next page), assault or chronic drug or alcohol related conditions. In 2018, the rate of drug and alcohol-related ED visits by residents of the Upper Valley Public Health Region was significantly lower than for NH overall. In Vermont overall, the rate of nonfatal opioid overdose visits per 10,000 emergency department visits increased by 46% in 2020 compared to the prior year.

Area	Nonfatal drug and opioid overdoses per 10,000 ED visits	Drug and Alcohol Related - ED Visits, age adjusted rate per 100,000 population	Drug and Alcohol Related - Inpatient, age adjusted rate per 100,000 population
Windsor County	Data not available		
Upper Valley Public Health Region		**42.0***	**7.3***
Vermont	70.6		
New Hampshire		140.1	24.2

Data Source: NH Uniform Healthcare Facility Discharge Dataset, NHDHHS Office of Health Statistics and Data Management, 2018
VDH, "Substance Use in Vermont During COVID-19", June 2021

***Regional rate is significantly different and lower than the overall NH rate.**

Drug Overdose Mortality: The number of drug overdose deaths in NH overall has been trending down gradually since 2017 when the rate of over overdose mortality per 100,000 population was 36.4. In contrast, Vermont has experienced one of the highest increases in drug overdose deaths in the country during the COVID-19 pandemic; increasing by 39% in 2020 compared to the prior year. In Windsor County, the rate of Opioid-related overdose fatalities more than tripled in 2020 with 28 fatalities compared to 8 opioid-related deaths in 2019.

. Area	Overdose Deaths per 100,000 people; Opioid-related, 2020	Overdose Deaths per 100,000 people; All drugs, 2020
Windsor County	50.9	
Grafton County		14.4
Vermont	25.2	31.7
New Hampshire		30.3

Data Sources: VDH, "Substance Use in Vermont During COVID-19", June 2021; VDH, "Opioid-Related Fatalities among Vermonters, March 2021; NH Medical Examiner's Office, September 2021

Self Harm-related Emergency Department Visits and Hospitalization: The table below displays rates of emergency department visits and inpatient hospitalizations for injury recorded as intentional including self-intentional poisonings due to drugs, alcohol or other toxic substances. In 2018, the rate of ED visits involving self-inflicted harm in the Upper Valley Public Health Region was not significantly differently than for NH overall.

Area	Self-Inflicted Harm - ED Visit, age adjusted rate per 100,000 population	Self-Inflicted Harm - Inpatient, age adjusted rate per 100,000 population
Windsor County	169.4	
Upper Valley Public Health Region	177.5	51.1
Vermont	201.3	
New Hampshire	195.9	47.3

Data Sources: Uniform Healthcare Facility Discharge Dataset, VT 2014-2016, NH 2018

Regional rates are not significantly different from the overall state rates.

.Suicide: This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care. The rates of suicide deaths in the region are similar to overall state rates.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
Windsor County	18.9
Upper Valley Public Health Region	18.0
Vermont	18.3
New Hampshire	17.3

Data Source: Vital Records death certificate data, VT 2015-2017, NH 2010-2019
Regional statistics are not significantly different from the overall state statistics.

g. Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. During the period 2017 to 2019, 734 deaths in Windsor County occurred before the age of 75. The primary causes of death contributing to premature mortality over this time period were cancer and heart disease.

Area	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Windsor County	6,730
Grafton County	**5,624***
Vermont	6,277
New Hampshire	6,374

Data source: National Center for Health Statistics accessed via County Health Rankings, 2017-2019.
**Regional rate is significantly different from and lower than the overall state rate.*

5. Comparison of Selected Community Health Indicators between 2022 and 2019

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2022) and the previous assessment conducted in 2019, as well as the most recent statewide statistics for each indicator. This comparison is provided for reference purposes and does not indicate that one estimate or rate is significantly different from another for the same measure unless indicated otherwise.

Table 11: Comparison of Selected Community Health Indicators between 2019 and 2022 with State Comparisons

Community Health Indicator	Geographic Area	2019 Community Health Assessment	2022 Community Health Assessment	State Comparison	
				VT	NH
Access to care					
Percentage of adult population (age 18+) without health insurance coverage	DH-APD Service Area	7.1%	**4.9%**	4.0%	5.9%
Have a personal doctor or health care provider, percent of adults	Upper Valley PHR	86%	**82%**	86%	88%
Visited a dentist or dental clinic in the past year, percent of adults	Upper Valley PHR	84%	**82%**	73%	72%
Health Promotion and Disease Prevention					
Current smoking, percent of adults	Grafton County	11% (UV PHR)	**14%**	15%	17.0%
% of Adults meeting physical activity recommendations	WRJ Health District	- - -	**61%**	60%	54%
Excessive drinking, percent of adults	Grafton County	- - -	**22%**	20%	20%
Teen Birth Rate, per 1,000 Women Age 15-19	Upper Valley PHR	10.4	**4.9***	7.6	11.4

Community Health Indicator	Geographic Area	2019 Community Health Assessment	2022 Community Health Assessment	State Comparison	
				VT	NH
Health Outcomes					
Obese, percent of adults	Grafton County	22% (UV PHR)	**26%**	29.0%	26.4%
Ever told had diabetes, percent of adults	Grafton County	8%	**7%**	7.6%	8.7%
Opioid-related deaths per 100,000 population	Windsor County	25.2	**50.9**	25.2	---
Overdose Deaths per 100,000 people; All drugs	Grafton County	9.1	**14.4***	31.7	30.3
Cumulative COVID-19 Deaths per 100,000 people	Windsor County	- - -	**78**	77	149
	Upper Valley PHR		**22**		
Years of potential life lost before age 75 per 100,000 population, age-adjusted	Grafton County	5,138	**5,624***	6,277	6,374

E. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES: RESULTS FROM BLACK, INDIGENOUS AND PEOPLE OF COLOR RESPONDENTS

The following tables and charts present analysis of the 2021 Community Health Needs Assessment Survey results from respondents who selected a category corresponding to Black, Indigenous or People of Color (BIPOC) in response to the question: *"How would you describe your race or ethnicity?"* The analysis also compares BIPOC results (n=286) to results of respondents selecting only "White" for race (n=3,702; survey respondents could select more than one category for race / ethnicity). The table below displays the distribution of respondents by race / ethnicity category with comparison to the population of the combined service area of the Community Health Needs Assessment partner organizations according to the 2020 U.S. Census (48 municipalities of New Hampshire and Vermont, total population 139,259).

Race / Ethnicity	**Community Survey Respondents, % (n)**	**Region: 48 NH and VT Municipalities, % (n)**
Hispanic	2.1% (90)	2.4% (3,393)
Not Hispanic or Latino		
Black or African American alone	0.9% (40)	0.8% (1,112)
American Indian and Alaska Native alone	0.3% (14)	0.2% (341)
Asian alone	1.8% (78)	2.3% (3,229)
Native Hawaiian and Other Pacific Islander alone	0.2% (8)	<0.1% (36)
White alone	85.0% (3,702)	89.0% (124,001)
Middle Eastern or North African	0.2% (8)	
Some Other Race alone		0.4% (605)
Two or more races	1.1% (48)	4.7% (6,542)
Prefer to self-describe	1.9% (81)	
Prefer not to answer	6.6% (287)	
TOTAL	100% (4,356)*	100% (139,259)

*657 additional survey respondents did not respond to the question on race / ethnicity

This table displays selected demographic characteristics of BIPOC and White (White alone) community survey respondents.

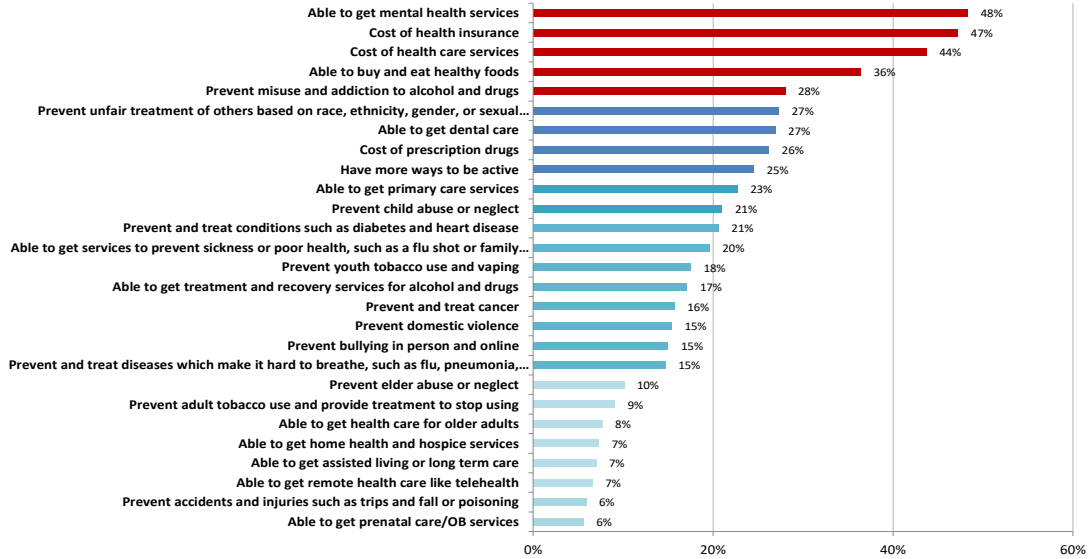
Age of Survey Respondents (years)	**Black, Indigenous, People of Color** (n=286)	**White alone** (n=3,702)
18-24	11.6%	3.3%
25-34	35.6%	11.8%
35-44	16.5%	15.6%
45-54	18.0%	17.8%
55-64	10.2%	20.4%
65-74	5.3%	18.4%
75 years or older	2.5%	12.4%
Prefer not to answer	0.4%	0.3%
Gender Identity	**Black, Indigenous, People of Color** (n=286)	**White alone** (n=3,702)
Female	59.9%	69.6%
Male	37.6%	29.2%
Non-binary / third gender	1.4%	0.3%
Prefer to self-describe	0.0%	0.3%
Prefer not to say	1.1%	0.5%
Household Income	**Black, Indigenous, People of Color** (n=286)	**White alone** (n=3,702)
Less than $25,000	11.4%	7.5%
$25,000 - $49,999	24.2%	16.3%
$50,000 - $74,999	17.1%	17.7%
$75,000 - $99,999	16.0%	16.3%
$100,000 - $199,999	13.9%	23.4%
$200,000 or more	7.8%	6.4%
Prefer not to say	9.6%	12.3%

Median age category in blue shade

BIPOC respondents overall were younger than White respondents and had lower household income.

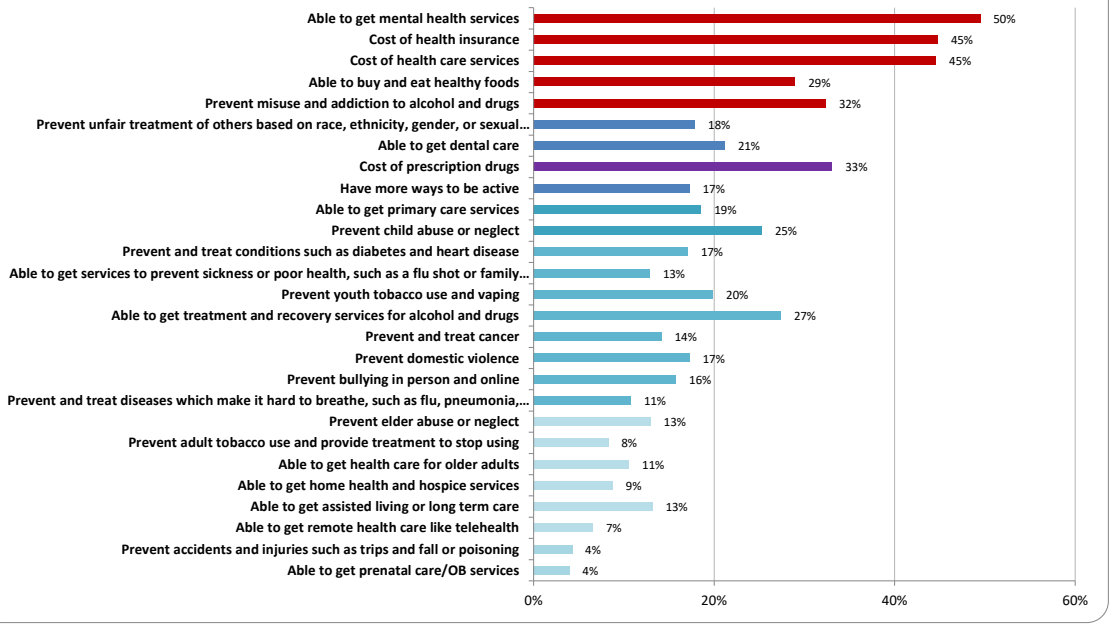
Median income category in blue shade

What do you think are the most pressing health needs or issues in your community today?
(**BIPOC respondents**; respondents were asked to select up to 5 topics)



The top community health issues selected by BIPOC and White respondents were similar. Four (4) of the top 5 and seven (7) of the top 10 most frequently selected issues were the same.

What do you think are the most pressing health needs or issues in your community today?
(**White alone respondents**; respondents were asked to select up to 5 topics)

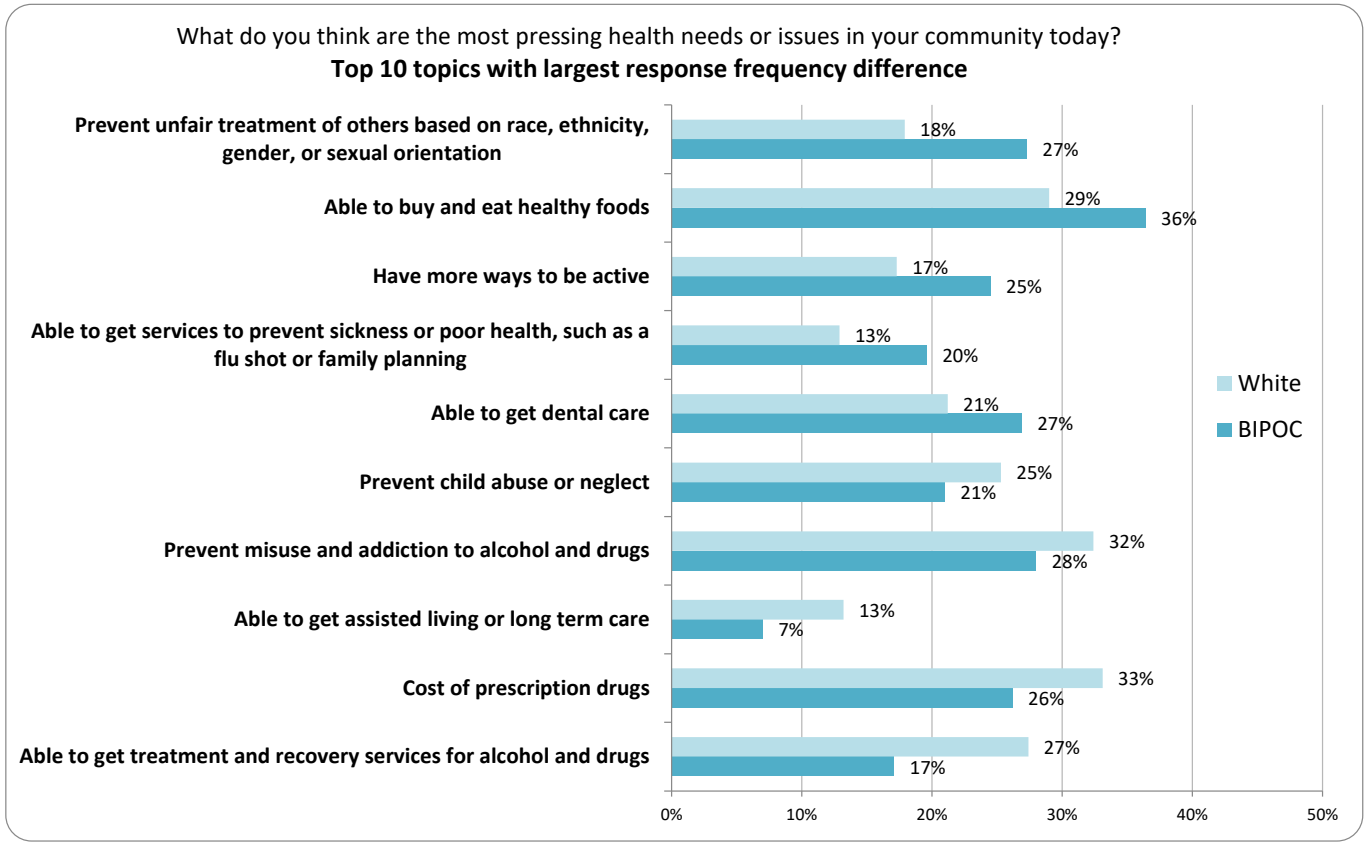


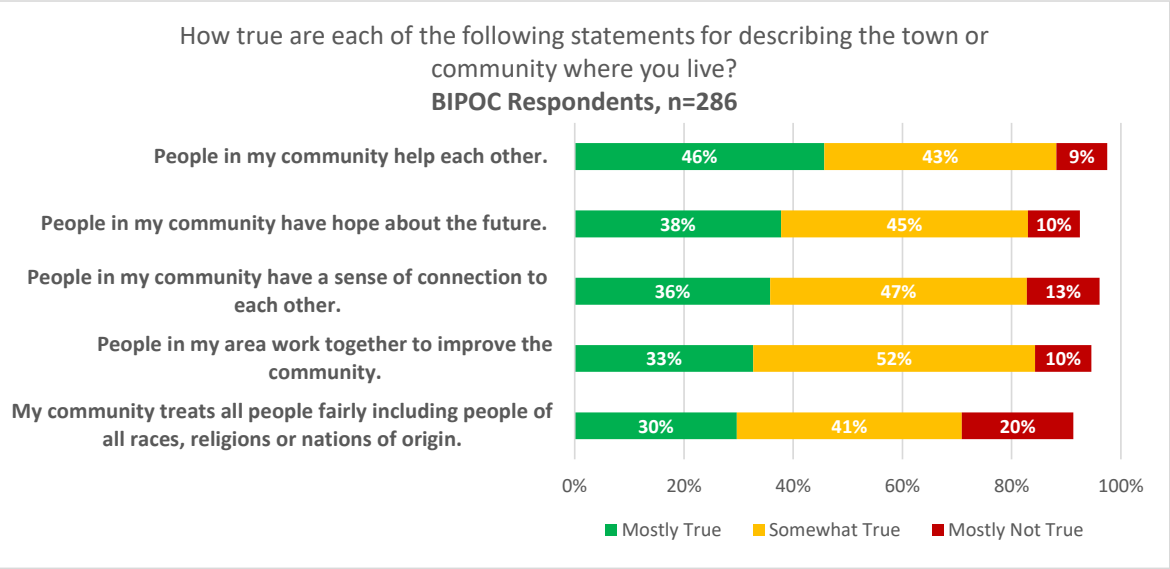
Community health issues on this chart are arrayed in the same order top to bottom as on the BIPOC respondent chart.

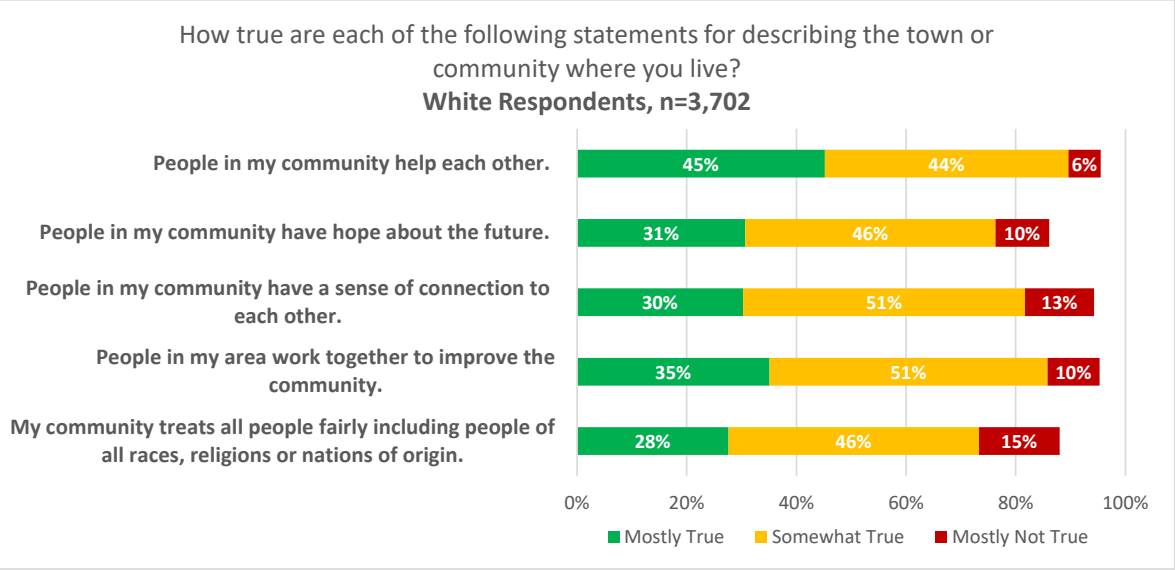
"Able to buy and eat healthy foods" was the issue in the top 5 of most frequently selected topics by BIPOC respondents, but not White respondents (#6).

"Cost of prescription drugs" was the top 5 issue selected by White respondents, but not BIPOC respondents (#8).

This chart displays the community health issues with the largest differences in response frequencies. The largest differences between BIPOC and White respondents were for "*Prevent unfair treatment of others based on race, ethnicity, gender, or sexual orientation"* (selected as a top issue by 27% of BIPOC respondents and 18% of White respondents) and "*Able to get treatment and recovery services for alcohol and drugs*" (selected by 27% of White respondents and 17% of BIPOC respondents).







The Community Health Needs survey asked people to indicate how true certain characteristics of a resilient community were for the community where they live.

The distribution of responses from BIPOC and White respondents were similar overall.

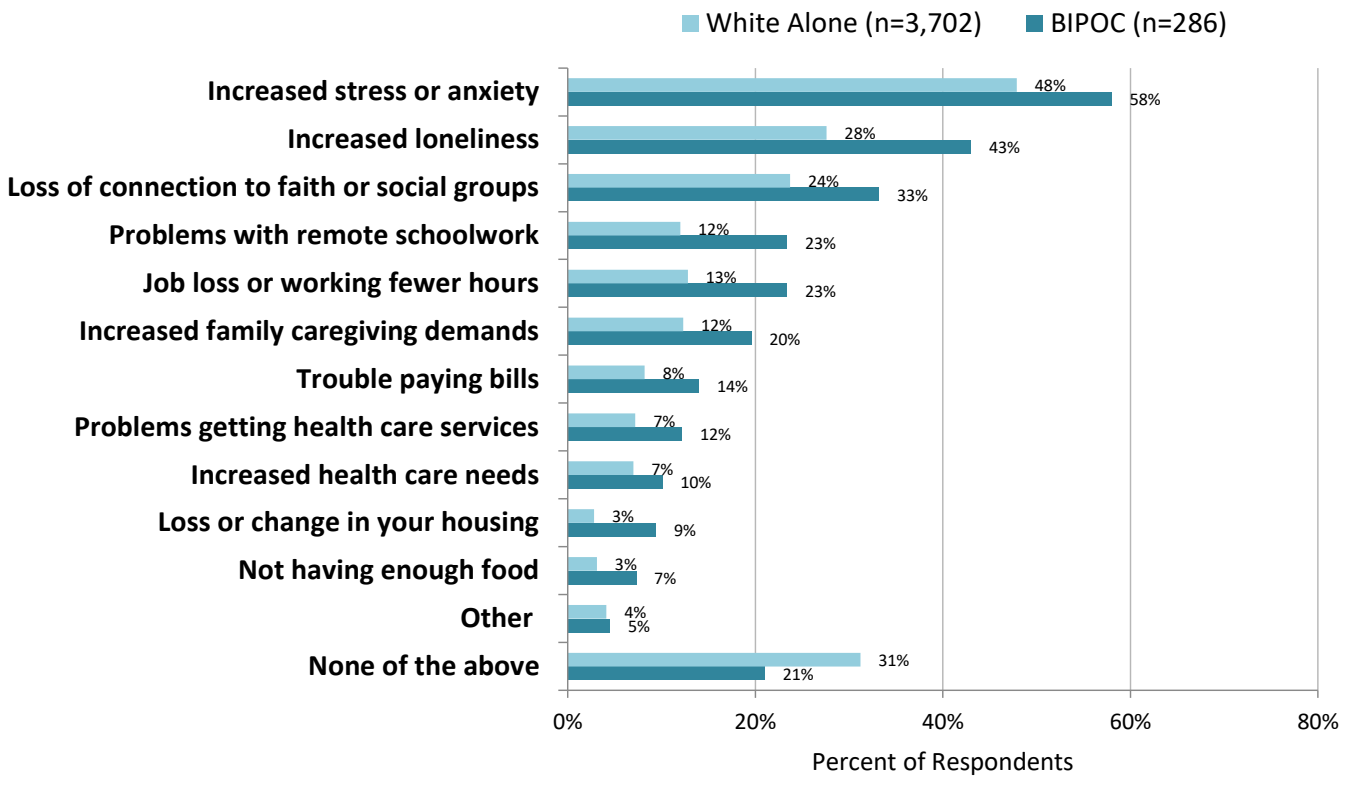
A composite 'Community Resilience Score' was tabulated with possible scores ranging from 0 to 10 where a score of 10 results when a respondent indicates that each of the 5 statements describing a resilient community are 'Mostly True'. The mean Community Resilience score for BIPOC respondents was 5.9; for White respondents the mean score was 5.8.

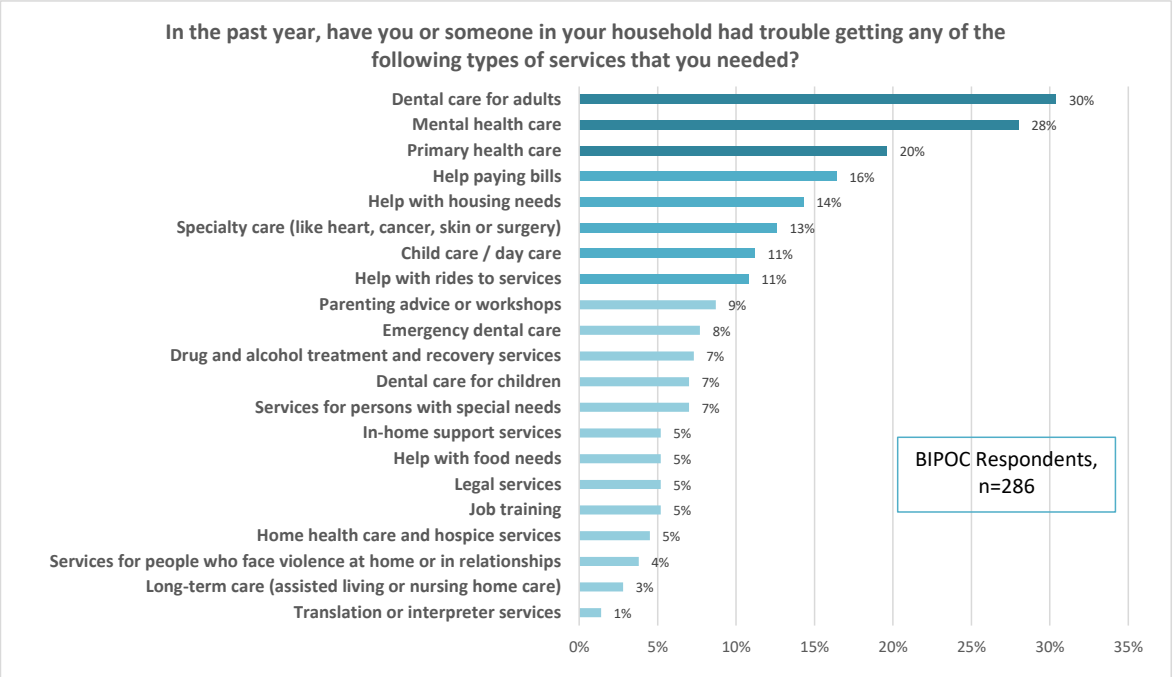
20% of BIPOC respondents and 15% of White respondents indicated it is "Mostly Not True" that "*My community treats all people fairly including people of all races, religions or nations of origin*."

BIPOC respondents were more likely than White respondents to indicate 'having problems' as a result of COVID-19. Overall, 79% of BIPOC respondents indicated at least one problem compared to 69% of White Respondents. Response frequencies were also higher for BIPOC respondents on each individual problem type listed.

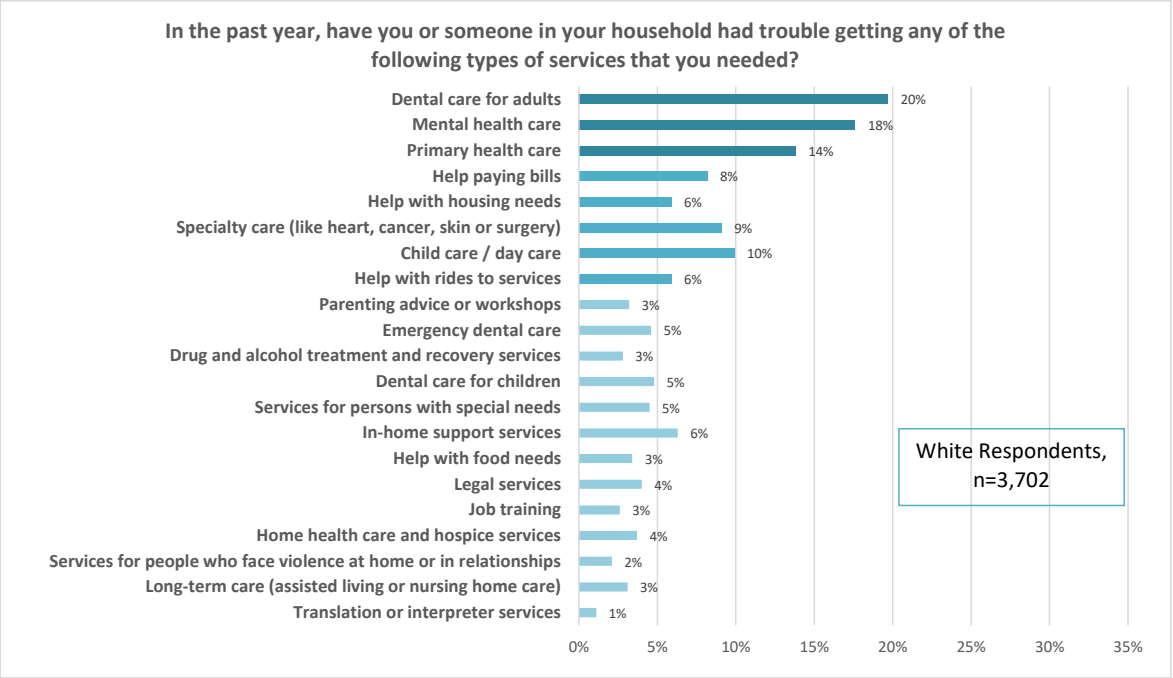
Note: The community survey was administered across the region between March 2021 and September 2021.

As a result of COVID-19, are you or people in your household currently having any of the problems listed below?





BIPOC respondents were also more likely than White respondents to indicate having 'had trouble' getting services in the past year. Overall, 60% of BIPOC respondents and 51% of White respondents indicated that they or someone in their household had trouble getting at least one type of service.



Service types on this chart are arrayed in the same order top to bottom as on the BIPOC respondent chart.

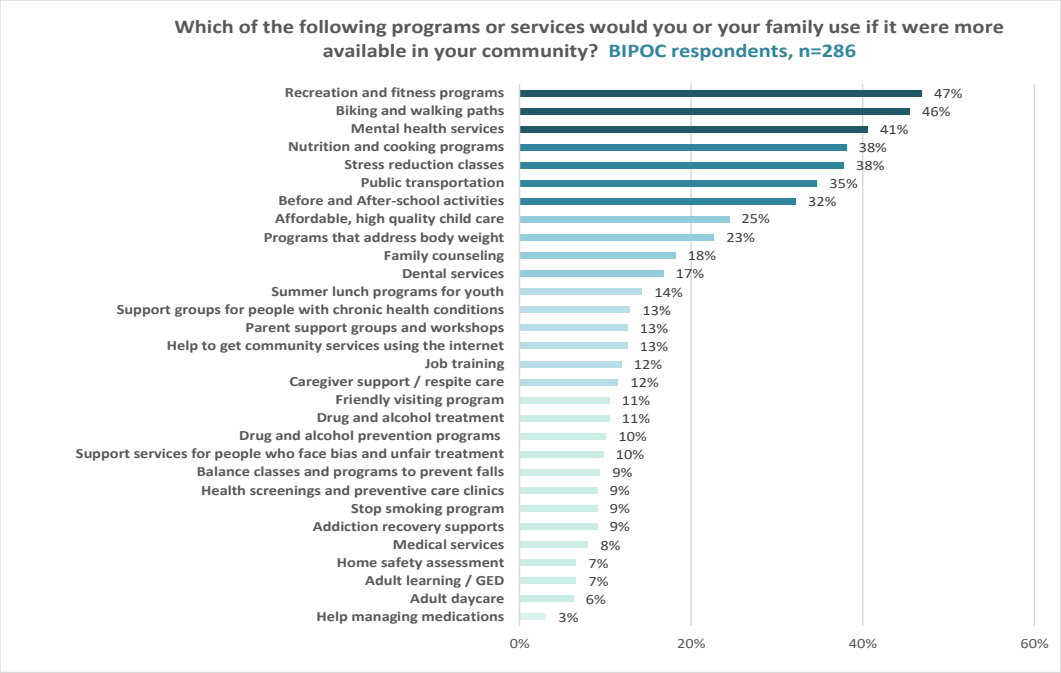
BIPOC respondents were more likely than White respondents to report having *'missed getting health care or social services because of unfair treatment*' in the past year. Overall, 18% of BIPOC respondents and 6% of White respondents indicated missing services because of unfair treatment 'Sometimes' or 'Often'.

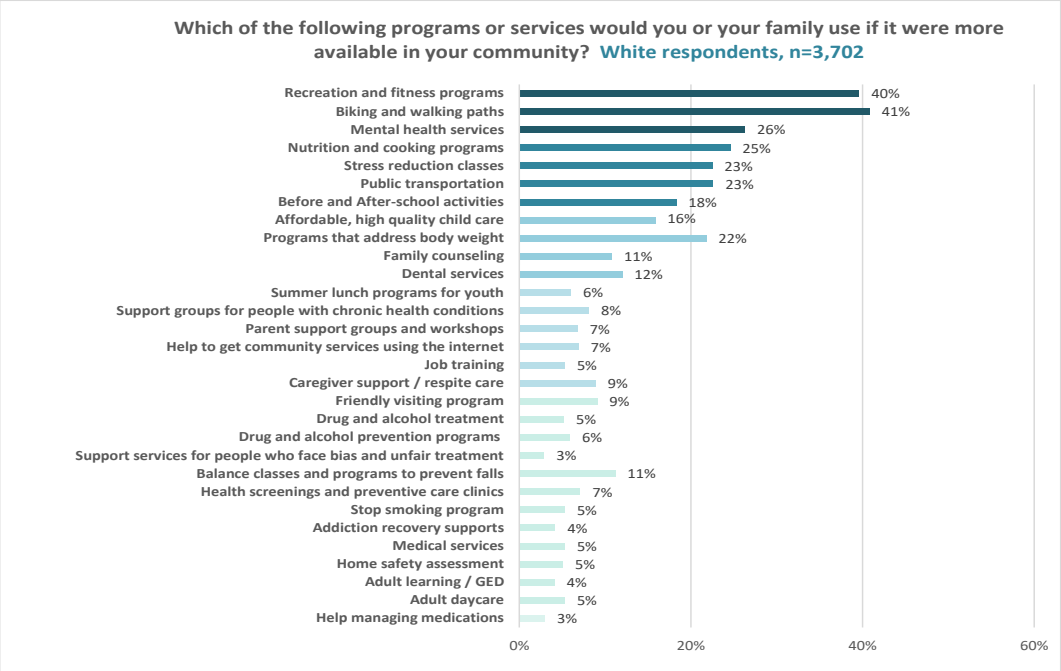
In the past year, how often has anyone in your household missed getting health care or social services because of unfair treatment? Unfair treatment can be due to discrimination or stigma based on your race, ethnic group, gender, sexual orientation, age, disability, language, or education.		
	Black, Indigenous, People of Color (n=286)	**White alone (n=3,702)**
Never	82%	94%
Sometimes	15%	5%
Often	3%	1%

Respondents who selected 'sometimes' or 'often' were asked a follow up question to *"please describe the unfair treatment you have experienced?"* The complete text answers from BIPOC respondents are listed below.

- Being Native American, medical providers assume I don't take care of my health. Assume I am overweight from what I eat or lack of activity.
- Discrimination based on their race (black)
- Disrespect / mistreatment due to gender identity and due to skin color.
- Have accent often feel judged and miss out on services
- Family member has trouble with language
- Not offering qualified interpreter services
- Health care professionals without appropriate cultural competency and providers who are not aware of their own biases - and not open to feedback or conversation when I brought it up
- I was unable to find / access mental health services in my network that didn't extend the feeling of not being understand / judged. No POC therapists
- Judgement and unfair treatment due to being a recovering addict and my child was treated differently and unfairly due to her race.

- My multi-racial teen doesn't seem to be taken seriously & when her Black mother advocates for her I'm often not listened to. The result is we've been trying to get adequate mental health care and accommodation (in school & outside of school) since January 2020. Still waiting. My daughter notices her wealthy white friends receive mental health care + school accommodation significantly quicker.
- Racial discrimination in healthcare, particularly for those with mixed ethnicities
- Since we are Asian, there were some times that sale assistants or clerks refuse to answer questions, which are totally normal and reasonable to ask.
- West central BEHAVIORAL health services discriminated against me because of race and religion
- Your agency employees reporting my family to child services, religion and racial discrimination
- Calls to health care providers have not been returned. Health care providers don't communicate and ghost their patients
- My mother wasn’t given proper assistance when it came to her health and she ended up passing
- Depressed
- Discrimination based on gender and sexual orientation, also weight.
- Due to loss on jobs
- Due to sexual orientation
- There's a struggle to be taken seriously by doctors or pharmacists while overweight. I've also been questioned for my sexuality
- Health providers turn down patients with developmental disabilities because they aren't "experts" in disabilities
- Terrible Orthopedic Surgeon (Springfield)
- I have been waiting since November 2020 to hear back from the office of child support
- I have left appointments in the past due to discriminatory behavior from providers
- IEP evaluation at school
- Just being turned away because of Covid or insurance
- Only because of covid
- Some people don't like Catholics and I have a criminal record and I am half deaf and some people get angry at me when I can't hear them.
- My car needed work and I took it to VIP and they didn't even fix the problem. And they thought I wouldn't notice because I'm a woman. Now I still have barely any breaks.
- Sometimes
- I have to make an extra effort, but it has paid off and I have succeeded in getting all the care requested





The top programs or services respondents would use if more available in the community were similar for BIPOC and White respondents. Nine (9) of the top 10 most frequently selected programs or services were the same.

About 10% of BIPOC respondents and 3% of White respondents selected 'Support services for people who face bias and unfair treatment. The survey provided a comment box for this item. Text responses from BIPOC respondents selecting this service were:

- *All* discrimination
- Anti-racism advocacy
- Need more BIPOC mental health practitioners
- POC support groups
- Promote awareness
- Therapy designed for BIPOC
- Therapy with a racial focus
- TLC
- Your agency causing undue stress and hardship

Service types on this chart are arrayed in the same order top to bottom as on the BIPOC respondent chart.