Community Health Needs Assessment

Fiscal Year 2025

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

Dartmouth Health

Dartmouth Hitchcock Medical Center

Dartmouth Health

Alice Peck Day Memorial Hospital

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Visiting Nurse and Hospice for Vermont and New Hampshire

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The 2025 Community Health Needs Assessment Partnership includes Dartmouth Health, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, New London Hospital, Cheshire Medical Center, Valley Regional Healthcare, Visiting Nurse and Hospice for Vermont and New Hampshire with technical support from the New Hampshire Community Health Institute/JSI.

Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire

Fiscal Year 2025 Community Health Needs Assessment

Executive Summary

During the period October 2023 through December 2024, an assessment of Community Health Needs was completed by Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire in partnership with Mt. Ascutney Hospital and Health Center, New London Hospital, Cheshire Medical Center, and Valley Regional Hospital with technical support from the New Hampshire Community Health Institute/JSI. The aims of the assessment are 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
- Guide community benefit activities of Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital and partner organizations.

For the purpose of the assessment, the geographic area of interest was 19 municipalities of the Upper Valley region of New Hampshire and Vermont comprising the primary service area of Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital. The total resident population of the primary service area is estimated to be 72,736 people. Methods employed in the assessment included: surveys of community residents made available through social media, email distribution, website links and through paper surveys and collection boxes widely distributed in multiple locations and channels across the region; a direct email survey of community leaders and service providers representing multiple community sectors; a set of eleven community discussion groups convened across the region; and assembly of available population demographics and health status indicators including drivers of health characteristics of the hospital service area communities.

Community engagement and information gathering 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, or social or physical isolation. The quantitative and qualitative information gathered through the different sources and methods was then synthesized to understand different perspectives, identify common themes and inform priorities for improvement.

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 primary care and medical sub-specialty services	Primary Health Care was the most frequently mentioned service type people had difficulty accessing (42%). About 26% of community survey respondents also reported difficulty accessing medical sub-specialty care. 'Not accepting new patients' and 'Wait time too long' were top reasons cited for access difficulty for both primary care and sub-specialties. About 54% of community resident and 58% of community leader survey respondents think ability to get primary care services has gotten worse in the last few years.	About 12% of adults in Windsor County report not having a primary care provider. The ratio of population to Primary Care Physicians is substantially lower (better) in Grafton County compared to the rest of NH. The other 3 counties with municipalities in the DHMC-APD service area – Windsor, Orange, Sullivan – all have ratios higher than the ratios for the corresponding states overall.	Issues related to health care provider availability including turnover, choice, wait time and responsiveness was the topic area with the most comments – over 300 comments or about 28% of all comments - on an open-ended question asking 'one thing you would change to improve health in your community'.
Availability of mental health services	Mental Health Care was the third most frequently mentioned service type people had difficulty accessing (35%). Among people who had difficulty accessing mental health care, top reasons cited were "Wait time too long" (68%), 'Not accepting new patients' (62%) and 'Service not available' (53%). From survey responses, 53% of community residents and 65% of community leaders think ability to get mental health services has gotten worse in the last few years.	The rate of Suicide or Self Harm-related hospitalizations among females in the Upper Valley Public Health Region is significantly higher than overall NH rate In Windsor County, mortality rates from opioid overdose (44.7 per 100k) is notably higher, although not statistically different, than VT state rates.	Mental health care was identified as a continuing and top priority for community health improvement in community discussion groups including concerns for insufficient local capacity - particularly for children and youth - need for increased awareness and culturally competent providers.

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**
Cost of health care services including medications, affordability of health insurance	About 63% of community resident and 57% community leader survey respondents indicated that the cost of health care and health insurance has 'gotten worse' over the last few years. Only 3% thought this issue has 'gotten better'. 'Can't afford out of pocket expenses' was a top 2 barrier identified by community leaders and service providers (61%) preventing people from accessing the health care services they need.	The estimated proportion of people with no health insurance (4%) is similar to the overall percent uninsured in VT (4%) and lower than the estimated percent in NH (6%). About 6% of service area residents reported delaying or avoiding health care because of cost.	Community discussion participants identified health care costs and financial barriers to care as a significant issue. It was also the third most frequently mentioned topic area in the open-ended question about 'one thing you would change to improve health' Obstacles include high cost of private pay insurance, misalignment of coverage and the types of insurance providers accept, and unreasonably high deductibles.
Social drivers of health and well-being such as affordable access to housing, healthy foods and affordable child care	About 88% of community resident survey respondents said housing affordability has 'gotten worse' over the last few years. After 'Help with Housing Needs', and child care were the most frequent social / human service that respondents had difficulty getting . 'Cost too much' was the top reason cited for access difficulty. Affordable Housing was by far the top issue selected by community leader respondents (79%) as a priority for improvement to support a healthy community.	Nearly 1 in 10 area residents experienced food insecurity in the past year. About 1 in 4 owner occupied housing units and half of renters in the service area have housing costs >30% of household income. A wide range in community wealth also characterizes the service area where median household income in the wealthiest communities is nearly three times higher than communities with the lowest median household incomes.	The high and rising costs of 'basic needs' was a common theme in discussion groups including accessing and maintaining stable, healthy housing; limited availability of quality low-income housing options; affording healthy foods; being able to pay for prescription medication, and costs of child care. Issues related to affordable housing was the second most common type of comment, after provider availability, on the 'one thing you would change to improve health' question.

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**
Availability and affordability of dental care services for adults	'Dental Care for Adults' was the second most frequently selected service people had difficulty accessing (39% of community resident survey respondents). Top reasons cited for access difficulty were 'Wait time too long' (58%), 'Not accepting new patients' (52%), and 'Cost too much' (46%).	More than 1 in 3 area residents report not having visited a dentist or dental clinic in the past year. The Upper Valley Public Health Region has experienced significantly less hospital emergency department visits for non-traumatic dental conditions in recent years, which is notable in comparison to other more rural areas of NH where the rate of ED visits for non-traumatic dental conditions is nearly 60% higher than non-rural regions of the state.	Affordability and availability of dental care was raised as an issue in discussion groups and open-ended survey comments including the need to travel long distances outside the local service area to access dental services.
Services for older adults including opportunities for social interaction and supports for aging in place	About 12% of community survey respondents indicated difficulty getting 'help caring for aging family members' and 14% had difficulty accessing 'help with rides to services. 'Service not available' was cited as the top reason for access difficulty. More than half (55%) of community leaders identified 'isolated populations such as homebound or very rural' as a population not being adequately served by local resources.	The service area population has a relatively high proportion of seniors. Overall, about 22% are ages 65+ with a continuing aging trend similar to VT (21% age 65+ and NH (20%) overall. About 29% of the 65+ population in the VRH service area report having serious activity limitations resulting from one or more disability. Nearly 1 in 3 area residents age 65+ report having experienced a fall in the past 12 months.	Ability to age in place was a topic raised in discussion groups and written comments with concerns expressed about shortages of qualified workers to provide home care, issues of cost, lack of options for transportation to medical appointments and related concerns around social isolation and over-reliance on technology for information and communication.
Health and human service workforce shortages and challenges navigating the health care system	'Not accepting new patients' or 'Wait time too long' were the top 2 reasons cited for access difficulty by community survey respondents for primary care, adult dental care, mental health care, and subspecialty medical care. Top barriers identified by community leaders and service providers preventing people from accessing the health care services they need included 'Service not available; not enough local capacity' (72%), 'Difficulty navigating the health care system' (59%) and 'Long wait times or limited office hours' (44%).	Difficulty navigating the health care system and the related issue of workforce shortages manifests in measures of population health such as delayed care and inpatient stays for diagnoses potentially treatable in outpatient settings such as diabetes, hypertension or asthma.	This theme emerged in both discussion groups and survey comments. Health and human service providers are described as understaffed and stretched too thin for the level of need in the region. Frustration was expressed about connecting with provider staff, difficulties navigating the process of finding and connecting with local specialists, and other complexities of the health care system.

Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire

2025 Community Health Needs Assessment

TABLE OF CONTENTS

A. COMMUNITY OVERVIEW WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total resident population of the Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital primary service area is estimated as 72,736 people (United States Census Bureau, American Community Survey, 5 year estimates, 2023). The service area population increased by about 3,100 people or 4.5% over the three years since the last Community Health Needs Assessment. Table 1 displays the service area population distribution by municipality, as well as the median age, the proportion of residents who are under 18 years of age and the proportion who are 65 and older.

Compared to Vermont or New Hampshire overall, the service area population has a similar proportion of older adults - about 22% are 65+ compared to about 19% in New Hampshire and 21% in Vermont – and the median age of service area residents is also similar at about 42 years of age. A substantial range is observed within the region for the older adult statistic from 14% of residents in Norwich aged 65+ to 39% of Dorchester residents. A similar, inverse range is observed for the percentage of residents who are under 18 years of age from about 11% in Dorchester to 26% in Norwich.

| TABLE 1. Service Area Population by Municipality |

(continued on the next page)

Municipality (in alphabetical order)	2023 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Canaan	3,801	5%	46	15%	23%
Dorchester	431	1%	56	11%	39%
Enfield	4,488	6%	54	13%	29%
Fairlee	1,042	1%	53	12%	32%
Grafton	1,248	2%	44	21%	21%
Grantham	3,434	5%	51	21%	24%
Hanover	11,702	16%	27	14%	18%
Hartford	10,713	15%	44	19%	23%
Hartland	3,462	5%	55	16%	26%
Lebanon	14,759	20%	39	14%	21%
Lyme	1,672	2%	51	19%	26%
Norwich	3,628	5%	40	26%	14%
Orange	301	0%	45	18%	19%
Orford	1,289	2%	48	14%	24%

Municipality (in alphabetical order)	2023 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Piermont	928	1%	47	23%	20%
Plainfield	2,493	3%	41	21%	22%
Sharon	1,518	2%	45	23%	24%
Thetford	2,802	4%	46	17%	21%
Woodstock	3,025	4%	55	17%	29%
DHMC-APD Service Area	**72,736**	**100%**	**42**	**17%**	**22%**
New Hampshire	1,387,834		43	19%	19%
Vermont	645,254		43	18%	21%

Table 2 displays additional demographic information for the towns of the primary hospital service area. In general, the region has higher median household income ($101,876) compared to New Hampshire ($95,628) or Vermont ($78,024) overall. The percent of people living in poverty (about 8%) is also similar to the New Hampshire statewide statistic (7%) and slightly lower than in Vermont overall (8%). Within the region there is a substantial range on this and other related measures. For example, the town with the highest median household income (Hanover, $163,654) has median household income nearly three times higher than the lowest income community (Dorchester, $58,750). Similarly, a substantial range is observed for the percent of people living below the federal poverty level (FPL) with an estimate of 0% in Grantham compared to about 17% of residents in Dorchester. The map following Table 2 displays the distribution of median household income across towns in the service area.

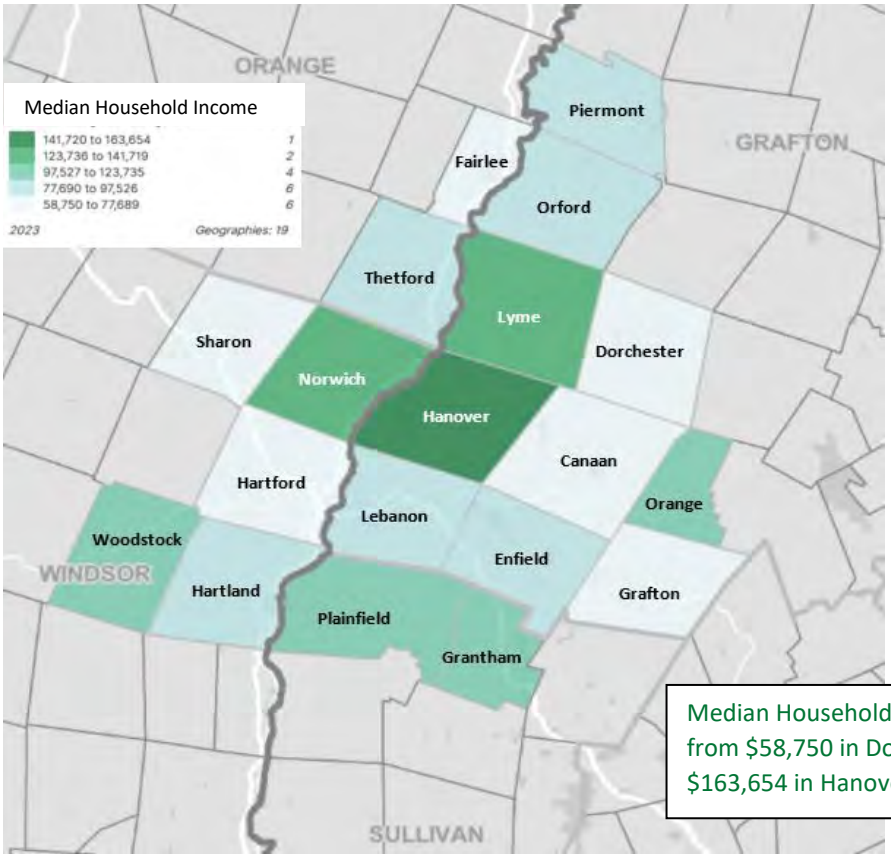
| TABLE 2. Selected Demographic and Economic Indicators |

(continued on the next page)

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Hanover	$163,654	7%	11%	7%
Lyme	$141,719	2%	20%	13%
Norwich	$140,139	3%	21%	9%
Woodstock	$123,735	8%	20%	10%
Plainfield	$118,618	5%	18%	13%
Orange	$117,000	7%	60%	10%
Grantham	$113,510	0%	24%	7%
DHMC-APD Service Area	**$101,876**	**8%**	**26%**	**12%**

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Hartland	$97,526	8%	34%	13%
Enfield	$96,695	13%	27%	13%
New Hampshire	$95,628	7%	27%	13%
Piermont	$93,393	5%	41%	15%
Lebanon	$92,288	9%	31%	13%
Thetford	$87,330	7%	23%	11%
Orford	$85,938	8%	31%	7%
Vermont	$78,024	10%	32%	14%
Canaan	$77,689	13%	28%	19%
Hartford	$73,879	11%	30%	16%
Sharon	$72,750	5%	31%	11%
Grafton	$72,188	8%	51%	17%
Fairlee	$65,962	11%	65%	10%
Dorchester	$58,750	17%	11%	26%

Figure 1 – Median Household Income by Town, DHMC-APD Service Area



Median Household Income ranges from $58,750 in Dorchester to $163,654 in Hanover.

As displayed by Table 3, about 88%% of the population of the Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital service area identifies as 'White', about 4% identifies as 'Asian, and 5% identify as '2 or more races' according to the U.S. Census Bureau. About 2.5% of the service area population identify as Hispanic ethnicity (any race). In general, the service area population is similar to New Hampshire and Vermont overall with regard to diversity of race and ethnicity.

| TABLE 3. Race and Ethnicity Characteristics |

Area	Race							Ethnicity
	White	2 or more races	Asian	Black / African American	American Indian / Alaska Native	Native Hawaiian / Pacific Islander	Other Race	Hispanic or Latino
DHMC-APD service area	88.4%	5.0%	4.2%	1.2%	0.2%	<0.1%	1.0%	2.5%
New Hampshire	88.9%	5.5%	2.6%	1.5%	0.1%	<0.1%	1.3%	4.5%
Vermont	91.4%	4.8%	1.7%	1.2%	0.2%	<0.1%	0.7%	2.5%

Drivers of Health: The 2025 Community Health Needs Assessment is based on the understanding that the conditions of the communities where we are born, live, age, work, and play are as important to achieving good health as receiving regular health care services, proper nutrition, and adequate physical activity. These conditions can be described as drivers of health that can directly or indirectly affect risks and outcomes related to health and wellness. Drivers of health can include characteristics such as: household wealth; availability of quality health care; access to affordable, healthy food; educational attainment; safe, quality housing; employment status and opportunities; transportation and public infrastructure; and other social, economic, and environmental factors.

The term "drivers" reflects a shift from perhaps more familiar terminology of Social Determinants of Health since "determinants" can imply health outcomes that are pre-determined. Instead, our focus is on how these factors can actively influence health outcomes while emphasizing the potential for interventions that can positively affect health and well-being. The collective efforts of

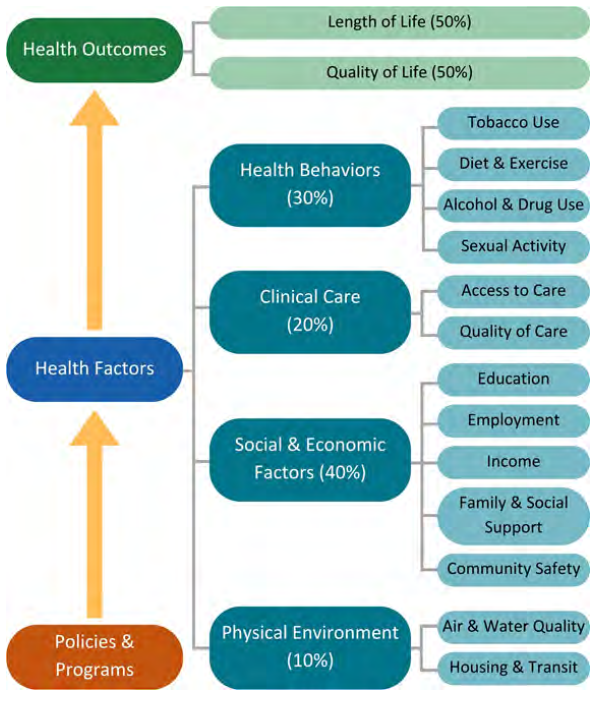


Figure 2: County Health Rankings Model

community organizations, policymakers, and individuals can have profound effects on the health and happiness of community members.

The County Health Rankings Model (Figure 2), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute[1], provides a framework for population health that emphasizes the many drivers of health which, if improved, can help make communities healthier places to live.

The factors fall into four domains—health behaviors, clinical care, social and economic factors, and physical environment—which together encompass a broad set of modifiable factors influencing individual and community health. The 2025 Community Health Needs Assessment was developed with these considerations in mind, as well as considerations for findings of previous needs assessments and collaborative efforts for community health improvement that are ongoing across the region.

[1] The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org

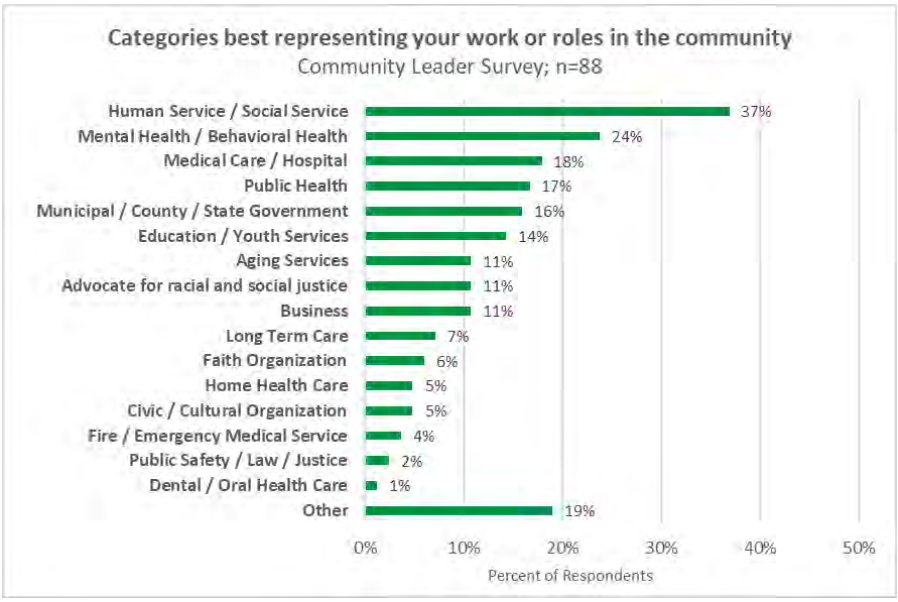
B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and September 2024, the Community Health Needs Assessment committee fielded two surveys; one with targeted distribution to community leaders and service providers, and one broadly disseminated to residents across the region. The survey instruments were designed to have some questions in common to facilitate comparisons and contrasts in the analysis.

The community leader survey was distributed via a unique email link to 350 individuals in positions of leadership in agencies, municipalities, business, civic and volunteer organizations serving the combined service areas of the partner organizations ranging from the Greater Windsor and Claremont area, to the New London and Newport area, and to the Upper Valley communities of New Hampshire and Vermont around Lebanon and White River Junction. The survey distribution list was developed by the planning committee. With the understanding that some organizational leaders may be more familiar with some areas of the wider region than others, the survey instrument asked respondents to identify "the areas you primarily serve or are most familiar with". Of the 350 partners invited to participate in the Community Leader Survey, 206 completed surveys (59% response). Of the 206 respondents to the Community Leader survey, 88 (43%) indicated being familiar with the "Greater Lebanon, NH / Hartford, VT area". The results included in this assessment report from the community leader survey are specific to that group of 88 respondents. Figure 3 displays the range of community sectors represented by these individuals.

(Note: Respondents could identify as representatives of more than one sector).

| Figure 3 |



The community resident survey was distributed electronically through email and social media communication channels, on the Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital websites, 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 libraries, clinics, and community meeting spaces. The survey was available in both English and Spanish language.

A total of 1,739 community members completed the Community Resident Survey, representing all 19 towns of the primary hospital service area as well as a number of bordering communities. Table 4 displays the grouping of respondents by community. Among respondents who provided information on their current local residence, about 18% are residents of Lebanon and about 14% are residents of Hartford / White River Junction. Among survey respondents who indicated their primary residential location, about 22% are located beyond the primary hospital service area with the most common locations being Claremont (23 respondents), Windsor (21), Strafford (21), Bradford (17), New London (14), Newport/Croydon (10) and Royalton (10).

| TABLE 4 |

Lebanon	258	18%
Hartford	211	14%
Enfield	136	9%
Hanover	100	7%
Canaan/Orange	81	6%
Lyme	74	5%
Norwich	57	4%
Grantham	46	3%
Thetford	35	2%
Orford	33	2%
Hartland	32	2%
Plainfield	27	2%
Fairlee	19	1%
Woodstock	16	1%
Sharon	10	1%
Grafton	8	1%
Dorchester	5	>1%
Piermont	3	>1%
Other Locations	317	22%

***Percent of respondents who provided information on the location of their residence. About 16% of respondents did not provide this information.**

Compared to regional demographics overall, community survey respondents were proportionally more likely to be female and 65 years of age or more. Approximately 22% of respondents have household income of less than $50,000, while 36% reported household income of $100,000 or more. About 13% of respondents did not provide household income information. Table 5 displays selected characteristics of respondents to the community survey.

| TABLE 5 |

Age < 45 years	Age >= 65 years	Woman	Black, Indigenous and People of Color
27%	39%	77%	6%
Household Income < $50K	**Household Income > $100K**	**Currently Uninsured**	**Currently has Medicaid coverage**
22%	36%	2%	9%

1. Progress on Community Health Priorities and Concerns

Assessments of community health needs are conducted every three years by Dartmouth Health and partner organizations. Over the course of these assessment cycles, a relatively consistent pattern has been observed with regard to the priority issues and concerns identified for health improvement by the community. Among these priorities have been:

- cost of health care services including health insurance and prescription drugs;
- access to behavioral health services including mental health care and substance use treatment;
- availability of health care services including primary care and medical sub-specialties;
- senior services and concerns of aging;
- availability and affordability of dental services; and
- affordability and availability of basic needs including housing, healthy food and child care.

In consideration of this observed consistency over time, the 2025 Community Health Needs Assessment asked respondents to the Community Resident and Community Leader surveys to reflect on a set of statements describing the main priorities and themes identified in the recent past by indicating if there has been improvement or not in those areas. Specifically, the surveys included the following statement and question:

> *"In past surveys like this one, people have said that the health needs listed below are the most important for us to work on. Do you think these needs have gotten worse, are about the same, or have gotten better in the last few years or so?"*

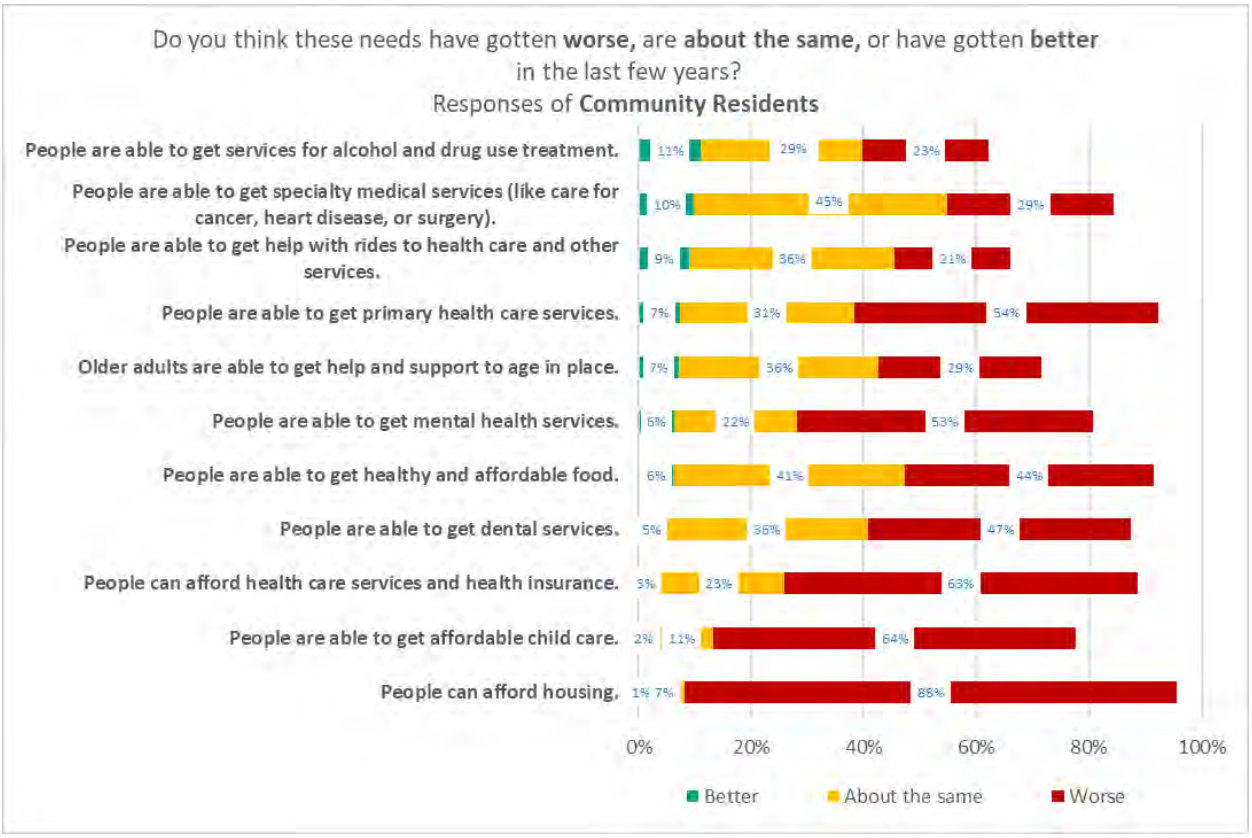
Figure 4 on the next page displays the results for this question set from respondents to the community resident survey. Ability to get services for drug and alcohol treatment was reported to be "Better" by 11% of respondents, which was the highest percentage for any of the areas of need listed. Ability to get specialty medical services was reported as 'better' by about 10% of respondents and ability to get rides to health care and other services was reported better by a similar percentage.

In general, more community residents reported needs getting worse compared to those reporting needs getting better over the last few years in each of the topic areas. A majority of survey respondents indicated that affordability of health care, child care, and housing have gotten worse.

"We need more affordable housing. If you don't have a safe place to stay, especially in the winter, nothing else matters."
- Community Resident Survey Respondent

"All I really know is there is a common theme of it being difficult to secure a Primary Care provider for both adults and children. I've heard this complaint for several years now by others moving into the area."
- Community Resident Survey Respondent

| Figure 4 |



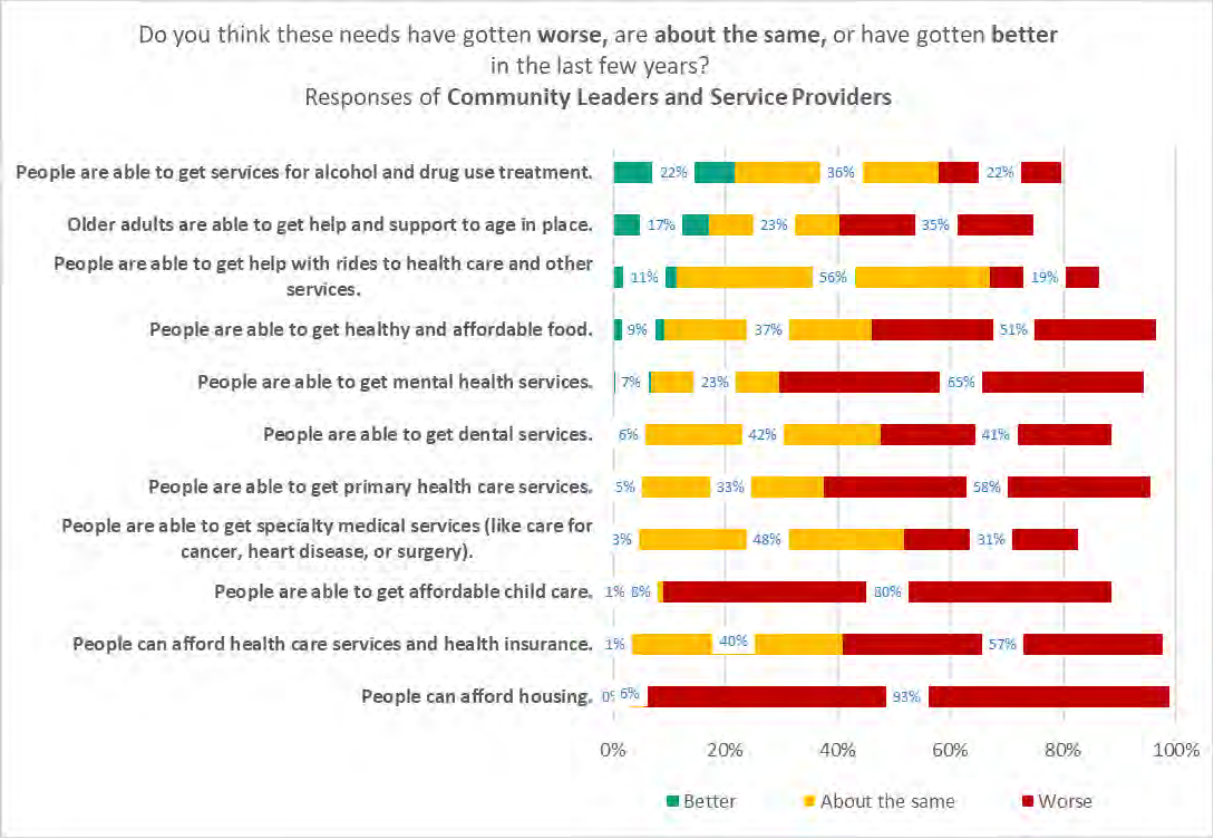
Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the need is Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

Figure 5 displays the results for the same set of questions from respondents to the survey of community leaders and service providers. A similar pattern is observed with community leaders also more likely to indicate needs overall have gotten worse than better.

Nearly all community leader survey respondents indicated the ability to afford housing has gotten worse and a majority of community leader respondents also indicated that affordability of child care and health care services have gotten worse. Similar to the responses on the community resident survey, community leaders were most likely to indicate that ability to get substance use treatment has improved (22%, Better). Ability of older adults to get help and support to age in place was the next most frequently topic selected as having gotten better (17%).

> *"(Need) Significant increase in affordable housing. It impacts everyone, including the ability of health care professionals to live and work here, and the ability of people in our community to be safe and comfortable, and to have resources available for other needs such as nourishing food and health care costs."*
> *- Community Leader, Civic sector*

| Figure 5 |



Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the needs are Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

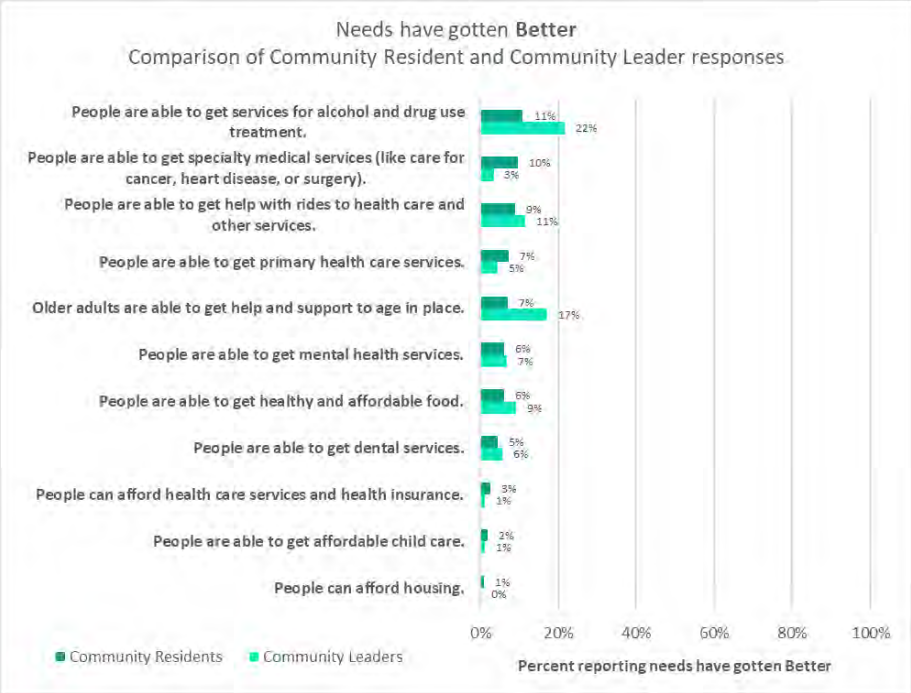
The two charts on the next page display comparisons of community residents and community leaders for the percentage of respondents who report needs have gotten better (Figure 6) and the percentage who report needs have gotten worse (Figure 7). In general, there is a high degree of agreement and consistency between the two response groups: agreement with regard to substantially more respondents reporting needs have gotten worse for each topic than those who report needs are better; and general consistency in the order of topics with the greatest number of respondents indicating a need has gotten worse (e.g., issues of affordability are at the top including housing, child care, and health

"Systemic/societal problems have increased dramatically; basically, many cannot afford basic cost of living and health care suffers."
- Community Leader, Medical Care

"It's all too expensive. We need preventative care, and mental health support that is affordable and easy to access. Not for people in crisis - for people before they reach crisis."
- Community Resident Survey Respondent

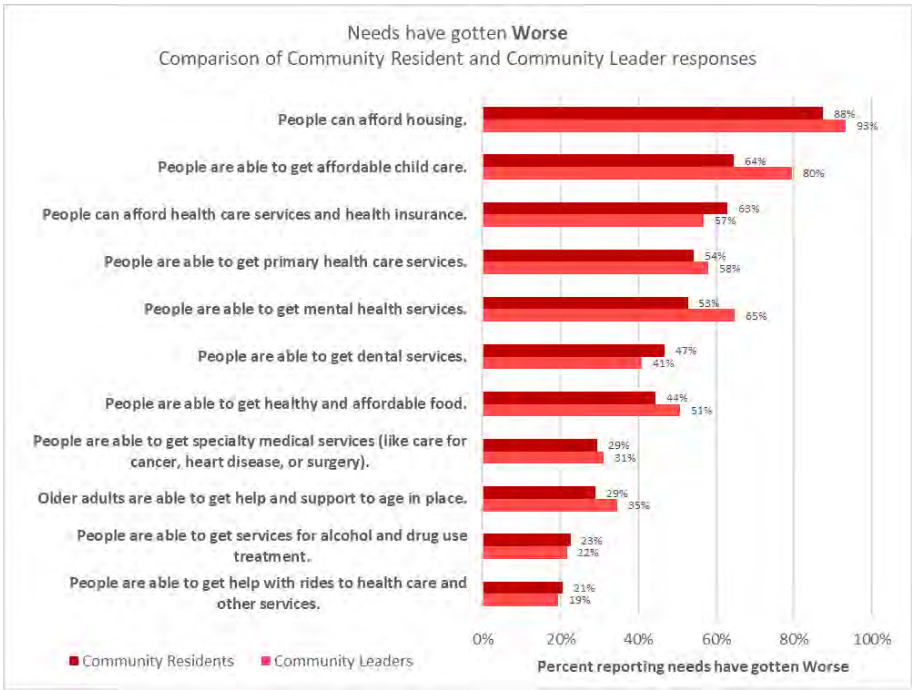
care). Community leaders were somewhat more likely to report that the ability to get substance use treatment has improved, and also ability for older adults to age in place, while community residents were somewhat more likely to indicate that access to sub-specialty medical services has improved.

| Figure 6 |



Note: Statements are shown in order of highest to lowest percentage of community resident respondents indicating the needs are Better.

| Figure 7|

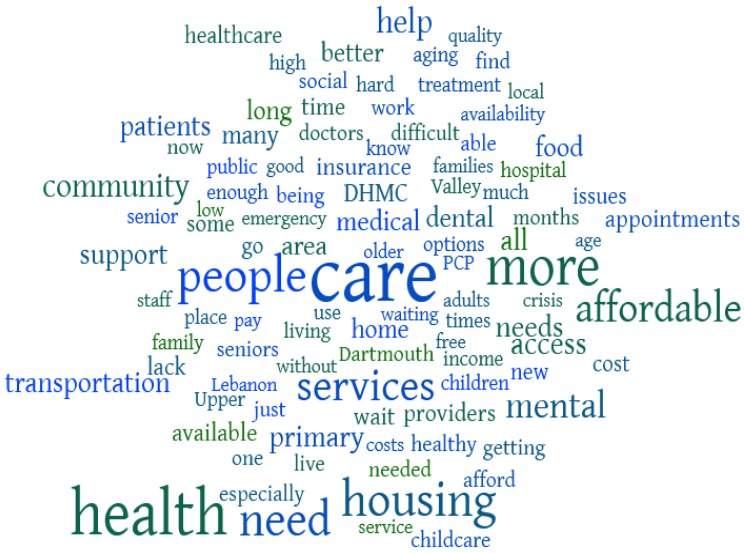


Note: Statements are shown in order of highest to lowest percentage of community resident respondents indicating the needs are Worse.

Also of note, community respondents were more likely to select "Don't Know" for certain topics including help with rides, substance use treatment and mental health services.

Each survey also included an open-ended question following the list of historical priority areas asking*, "Are there other health needs that you think are important for your community to address now?".* A total of 624 comments were received in response to this question. The most common topic areas included:

1. Health care provider availability in general and primary care in particular; wait times, patient-provider communication and service delivery improvements (more than 24% of all comments addressed this area of concern);
2. Senior services and concerns of aging;
3. Housing affordability and availability;
4. Availability of mental health care services;
5. Access to transportation services including rides to medical appointments;
6. Affordability of health care and prescription medications;
7. Opportunities and facilities for social interaction; reducing social isolation;
8. Cost of living and basic needs (in addition to affordable housing);
9. Availability of dental care
10. Addiction treatment and recovery services, illicit drug use concerns;
11. Promoting healthy lifestyles, focus on wellness, nutrition and exercise;
12. Availability of women's health care through life stages, fertility and perinatal care options;
13. Affordable child care, services and supports for children, youth and families.



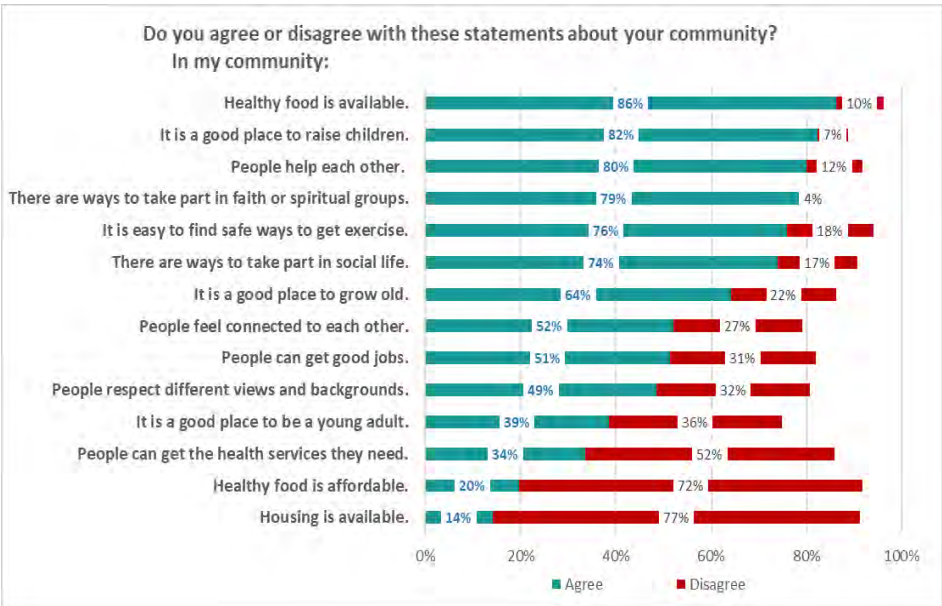
> *"(Need) Adequate primary care providers with less turnover so they get to know their patients over time."*
> *- Community Resident Survey Respondent*

> *"There is a severe lack of support for people who need regular assistance with basic home care needs (laundry, cleaning, etc.) and this often leads to deteriorations in health and then hospitalizations and/or rehabilitation."*
> *- Community Leader, Housing sector*

2. Characteristics of a Healthy Community

The Community Resident survey included a series of fourteen statements that collectively can describe characteristics of a healthy and resilient community. The statements addressed topics such as availability and affordability of basic needs, availability of health services, social opportunities, sense of community connection and perceptions of the community as a good place to live (e.g., a good place to raise children; a good place to grow old). Survey respondents were asked to think of the area they consider to be their community and to then indicate whether they Agree or Disagree with each statement.

| Figure 8 |



Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents who Agree with each statement. Totals do not equal 100% because the response choice of "Don't Know/Not Sure" is not displayed.

Figure 8 displays the results for this set of questions. Community residents overall were most likely to agree that 'in my community':

- Healthy food is available (86% of survey respondents agree with that statement).
- It is a good place to raise children (82% agree).
- People help each other (80% agree).
- There are ways to take part in faith or spiritual groups (79% agree).

Community residents overall were least likely to agree that 'in my community':

- People can get the health services they need (52% disagree)
- Healthy food is affordable (72% disagree).
- Housing is available (77% disagree).

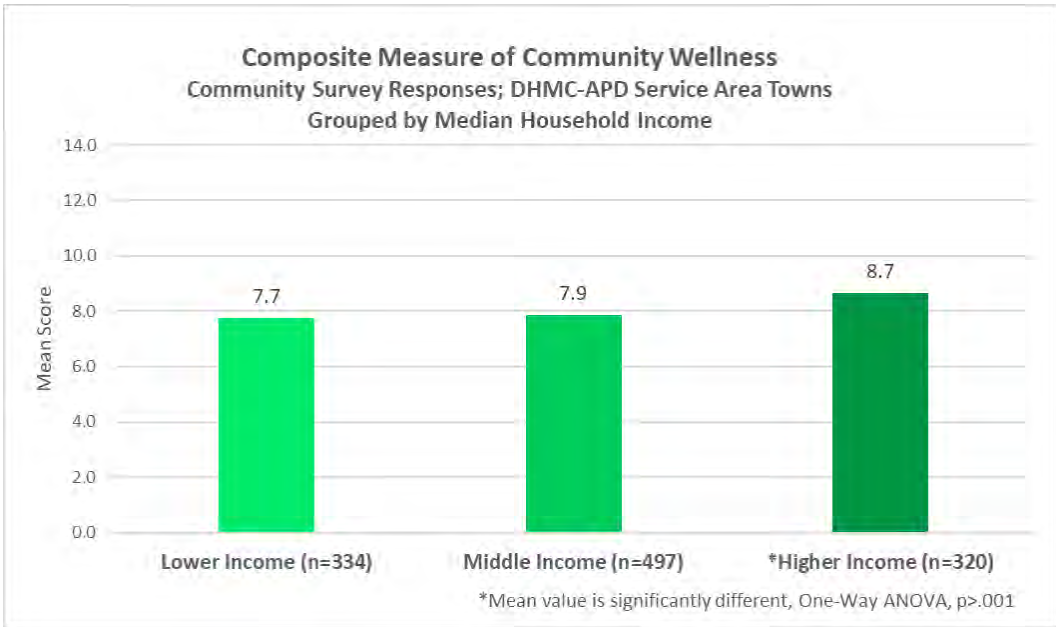
> *"There are so many needs right now. However, I think there is a need for community. We are very disconnected as a society, and being in the Upper Valley can exacerbate this as everything requires travel. We need human connections and caring."*
> *- Community Resident Survey Respondent*

Further analysis of this set of questions was conducted by calculating a composite measure of 'community wellness' for each respondent. Possible scores range from zero to fourteen (14 questions, each question with possible values of 1 or 0) where a score of 14 results when a respondent indicates agreement with each of the 14 statements describing characteristics of a healthy and resilient community. Scores were then aggregated for respondents from 3 sets of communities within the DHMC-APD service area:

1. Communities with median household income below the Vermont statewide median household income ('Lower Income'; Canaan, Hartford, Sharon, Grafton, Fairlee, Dorchester, n=334 survey respondents)
2. Communities with median household above the Vermont state median and below the DH-APD service area median ('Middle Income'; Hartland, Enfield, Piermont, Lebanon, Thetford, Orford, n=497 survey respondents)
3. Communities with median household above ow the DH-APD service area median ('Higher Income'; Hanover, Lyme, Norwich, Woodstock, Plainfield, Grantham, n=320 survey respondents).

Figure 9 displays the mean Composite Measure of Community Wellness calculated from the responses from residents for each of these community groupings. The mean score for the set of towns with higher median household income is significantly different and higher than the mean scores for either of the other town groupings.

| Figure 9 |

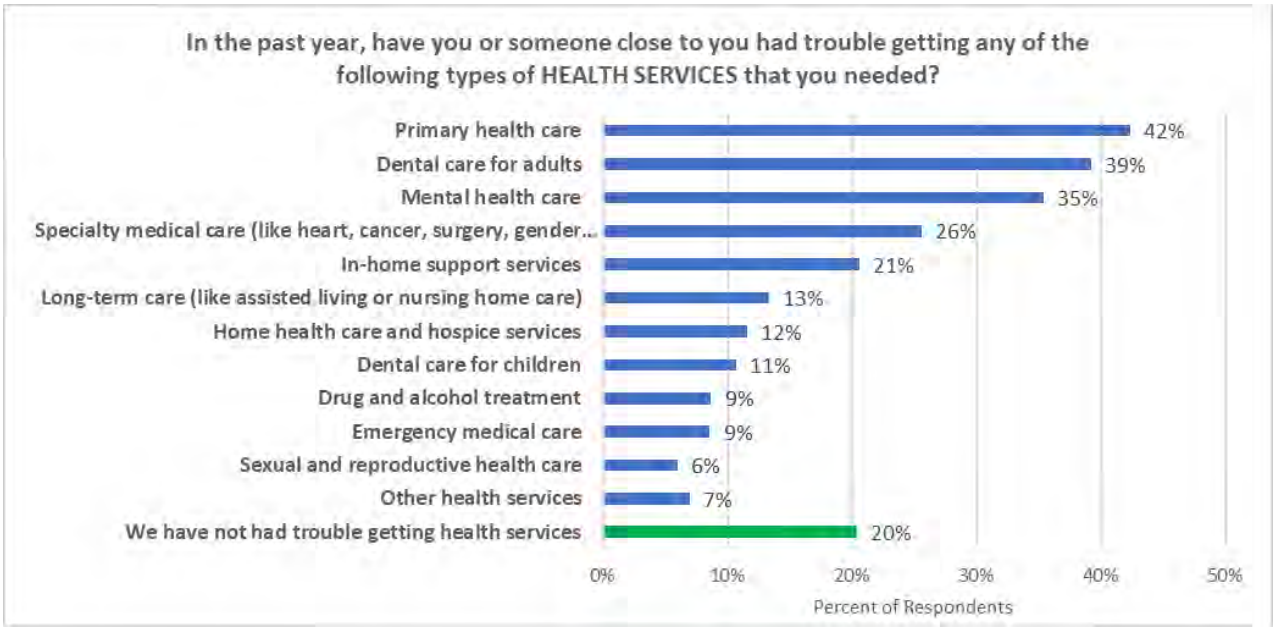


(Note: data from respondents not reporting a residential location or indicating locations outside the DHMC-APD hospital service are not included in this analysis).

3. Barriers to Services

Respondents to the Community Resident survey were presented with a list of potential health services and asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **health services** that you needed?"*. As displayed by the chart below, about 42% of respondents reported having difficulty getting 'Primary health care' 'and 39% had difficulty getting 'Dental care for adults' over the past year. Other more frequently cited services for access difficulty included 'Mental health care' (35%), 'Specialty medical care' (26%), and In-home support services (21%).

| Figure 10 |



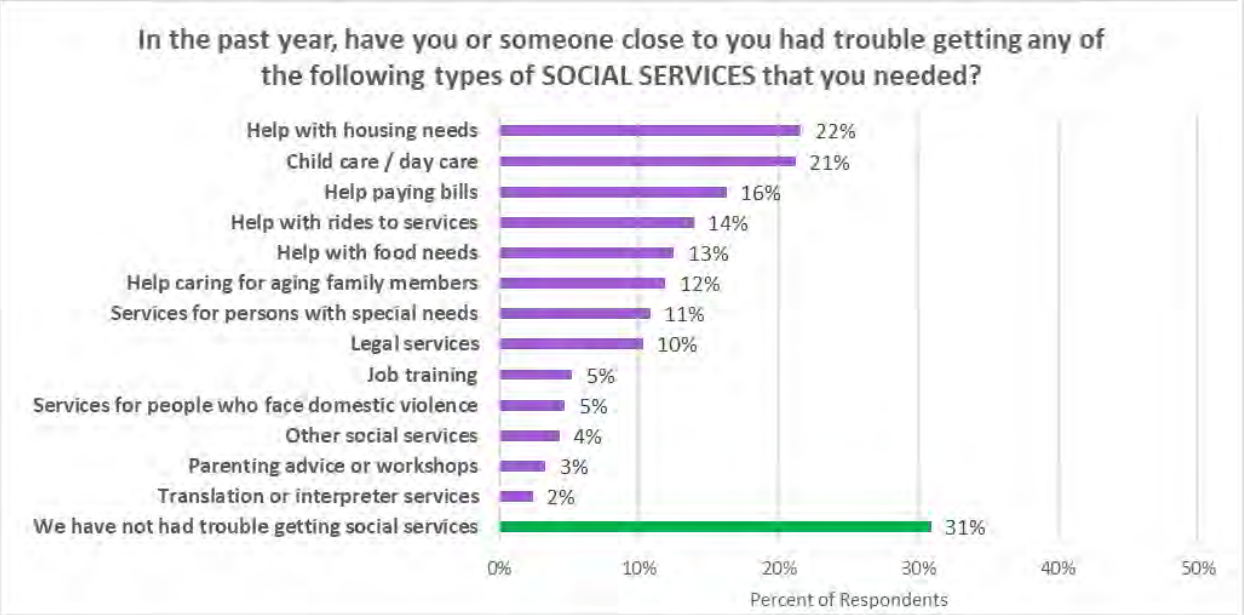
"(Need) Adequate staffing in our healthcare facilities so that patients can be seen in a timely manner, have enough time with their doctors, and the medical staff is not chronically stressed from a healthcare system that is falling apart."
- Community Resident Survey Respondent

"Access to high quality mental health care, in network without 6-12 month wait times and with in-person treatment options should be something available to families."
- Community Resident Survey Respondent

"Make getting health care (all health care including mental, dental, and vision) more affordable. I have insurance and cannot afford to get my medical needs met."
- Community Resident Survey Respondent

On a similar question, the Community Resident survey asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **social services** that you needed?"***.*** As displayed by Figure 11, about 22% of respondents indicated having difficulty getting 'Help with housing needs' and 21% had difficulty getting 'Child care / Day care' over the past year. Other more frequently cited social services for access difficulty included 'Help paying bills' (16%), 'Help with rides to services' (14%) and 'Help with food needs' (13%).

| Figure 11 |



"Having designated people at Dartmouth Health or somewhere that were specifically there to help people navigate health care and social services systems. It is daunting for the average person, let alone an elder without a lot of family support."

- Community Resident Survey Respondent

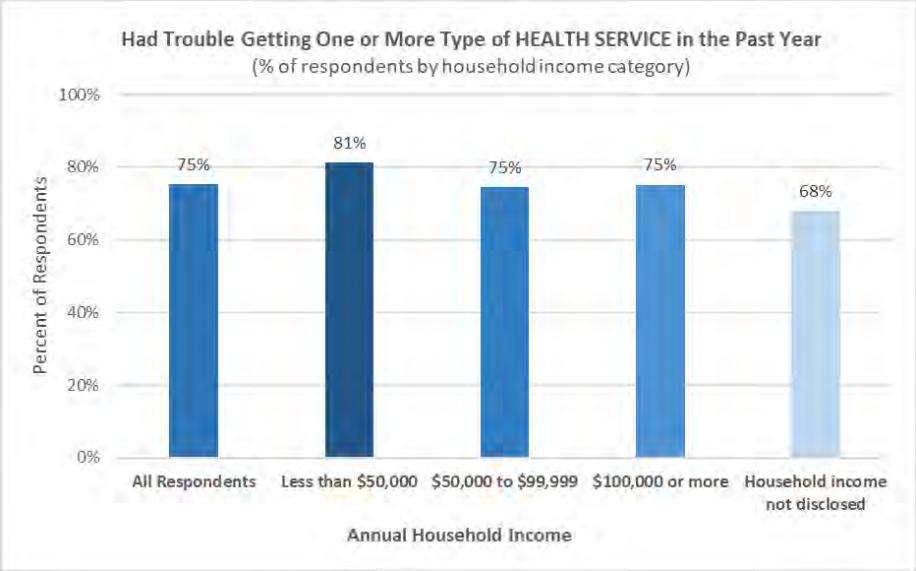
"(Need) Community Health Care and rural access. . . . Mobile social workers to help families that are overwhelmed and don't know how to ask for help. It's not always as easy as people make it out to be.".

- Community Resident Survey Respondent

In general, survey respondents were more likely to report difficulties accessing health services than social services, which may be in part a function of different proportions of the population attempting to access health services or social services within a defined period of time. Overall, about 75% of all survey respondents reported having difficulty accessing at least one type of health service. Figure 12 displays the percentage of survey respondents reporting any access difficulty by

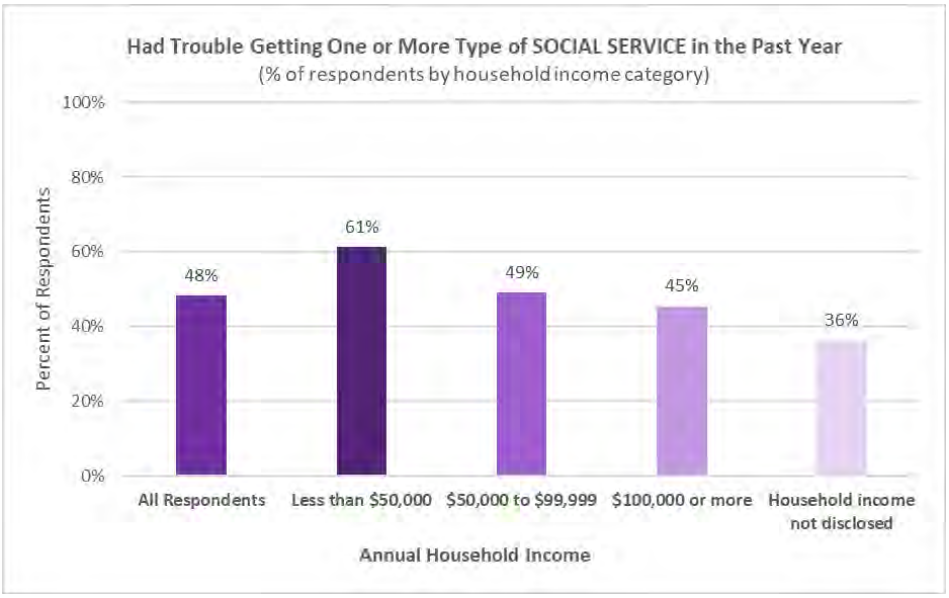
income category. There was little correlation between household income and having difficulty accessing health services. The one observed exception is among survey respondents who declined to report household income. This group was less likely to report difficulty accessing health services.

| Figure 12 |



As displayed by Figure 13, about 48% of survey respondents reported having difficulty accessing at least one type of social service. Respondents with household incomes less than $50,000 were significantly more likely to report difficulty accessing at least one type of social service (61%), while respondents who elected not to disclose household income were the least likely to report having had difficulty accessing social services (p<.001).

| Figure 13 |



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked a follow-up question about the reasons why they had difficulty for each type of service selected. As displayed by Table 6, "Wait time too long" was a common reason cited for difficulty accessing each of the top four types of health care services including 84% of people who indicated difficulty accessing Specialty Medical Care services and 68% of those having difficulty accessing mental health services. The top reason cited for difficulty accessing primary care services was "Not accepting new patients" (75%).

| TABLE 6. Top Reasons Respondents Had Difficulty Accessing Health Care Services by Type of Service |

(Percentages are of those respondents who reported difficulty accessing a particular type of service)

PRIMARY HEALTH CARE (n=688, 42% of respondents)	**DENTAL CARE FOR ADULTS (**n=637, 39% of respondents)	**MENTAL HEALTH CARE** (n=575, 35% of respondents)	**SPECIALTY MEDICAL CARE** (n=415, 26% of respondents)
75% of respondents who indicated difficulty accessing Primary Health Care also selected **"Not accepting new patients"** as a reason	**58%** of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Wait time too long"** as a reason	**68%** of respondents who indicated difficulty accessing Mental Health Care also selected **"Wait time too long"** as a reason	**84%** of respondents who indicated difficulty accessing Specialty Medical Care also selected **"Wait time too long"** as a reason
"Wait time too long" (68%)	**Not accepting new patients (52%)**	**Not accepting new patients (62%)**	**Not accepting new patients (38%)**
Service not available (39%)	**Cost too much (46%)**	**Service not available (53%)**	**Service not available (30%)**
Cost too much (23%)	**No insurance or not enough insurance (44%)**	**Cost too much (43%)**	**Cost too much (28%)**
No insurance or not enough insurance (22%)	**Service not available (38%)**	**No insurance or not enough insurance (38%)**	**No insurance or not enough insurance (21%)**
Not open when I could go (14%)	**Did not know where to go (11%)**	**Did not know where to go (20%)**	**Not open when I could go (13%)**

Other survey options included: No internet access, Language barriers, My race or ethnicity not welcome, My gender or sexual orientation not welcome, My culture or religion not welcome, Other reasons (write-in)

"I find it very nerve wracking that I cannot get a primary care physician. I will try again but it really seems to be a big problem in the Upper Valley
- Community Resident Survey Respondent

"Our region has a huge need for more mental health care practitioners, both clinical psychiatrists and psychologists. And often, patients who reach out to mental health providers have difficulty navigating the system or finding the type of care that is most advantageous to them.
- Community Leader, Advocacy

Survey respondents who reported difficulty accessing social services were similarly asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 7, "Cost too much" was the most common reason cited for difficulty accessing 'Child Care / Day Care' (78%) and also for 'Help with housing needs' (60%). "Service not available" was the most common reason cited for difficulty getting 'Help with paying bills' (43%) and 'Help with rides to services' 67%).

| TABLE 7. Top Reasons Respondents Had Difficulty Accessing Social Services by Type of Service |

(Percentages are of those respondents who reported difficulty accessing a particular type of service)

HELP WITH HOUSING NEEDS (n=344, 22% of respondents)	CHILD CARE / DAY CARE (n=337, 21% of respondents)	HELP PAYING BILLS (n=259, 16% of respondents)	HELP WITH RIDES TO SERVICES (n=221, 14% of respondents)
60% of respondents who indicated difficulty accessing Help with Housing Needs also selected **"Cost too much"** as a reason	**78%** of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason	**43%** of respondents who indicated difficulty accessing Help paying bills also selected **"Service not available"** as a reason	**67%** of respondents who indicated difficulty accessing Help with rides to services also selected **"Service not available"** as a reason
Wait time too long (47%)	**Not accepting new clients (59%)**	**Did not know who to call (36%)**	**Did not know who to call (39%)**
Service not available (42%)	**Wait time too long (58%)**	**Cost too much (33%)**	**Wait time too long (30%)**
Not accepting new clients (24%)	**Service not available (55%)**	**Shame or stigma (18%)**	**Cost too much (30%)**
Did not know who to call (24%)	**Not open when I could go (10%)**	**Not accepting new clients (17%)**	**Not open when I could go (17%)**

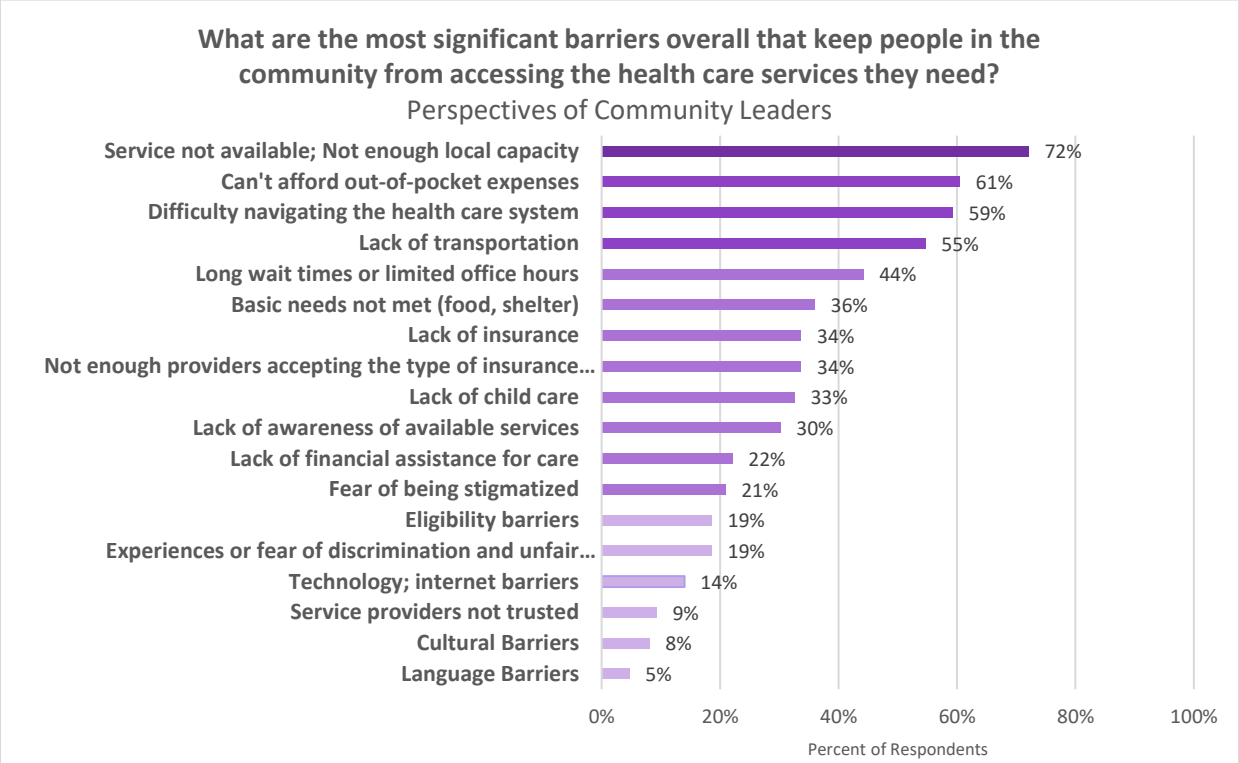
Other survey options included: Had no way to get there, No internet access, Language barriers, My race or ethnicity not welcome, My gender or sexual orientation not welcome, My culture or religion not welcome, Other reasons (write-in)

> *"Lots of time and effort has been put into talking about the kinds of services that are needed to allow older folks to age in place ... programs and infrastructure have been developed and staff have been hired to talk to folks about how to go about availing themselves of services which will allow them to stay in their homes ... but, when the time comes, and real help is needed - that help is not available - at any cost."*
> *- Community Resident Survey Respondent*

In a separate question, Community Survey respondents were asked: *"In the past year, how often have you or someone close to you missed getting health care or social services because of unfair treatment?"*. Unfair treatment' was further specified as "discrimination or stigma based on your race, religion, ethnicity, gender, sexual orientation, age, disability, language, or education". Overall, 3% of respondents indicated that they or someone in their household had "Often" missed getting health care or social services because of unfair treatment, 13% indicated "Sometimes", and 84% indicated "Never" missing health care or social services because of unfair treatment.

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 survey included a list of 18 potential barriers (and a write-in option) from which respondents were asked to select the top 4 barriers to health care access. The top issue identified by this group was 'Service not available; not enough local capacity' (72% of community leaders chose this barrier) followed by 'Can't afford out-of-pocket expenses' (61%), 'Difficulty navigating the health care system (59%), and 'Lack of transportation' (55%).

| Figure 14 |

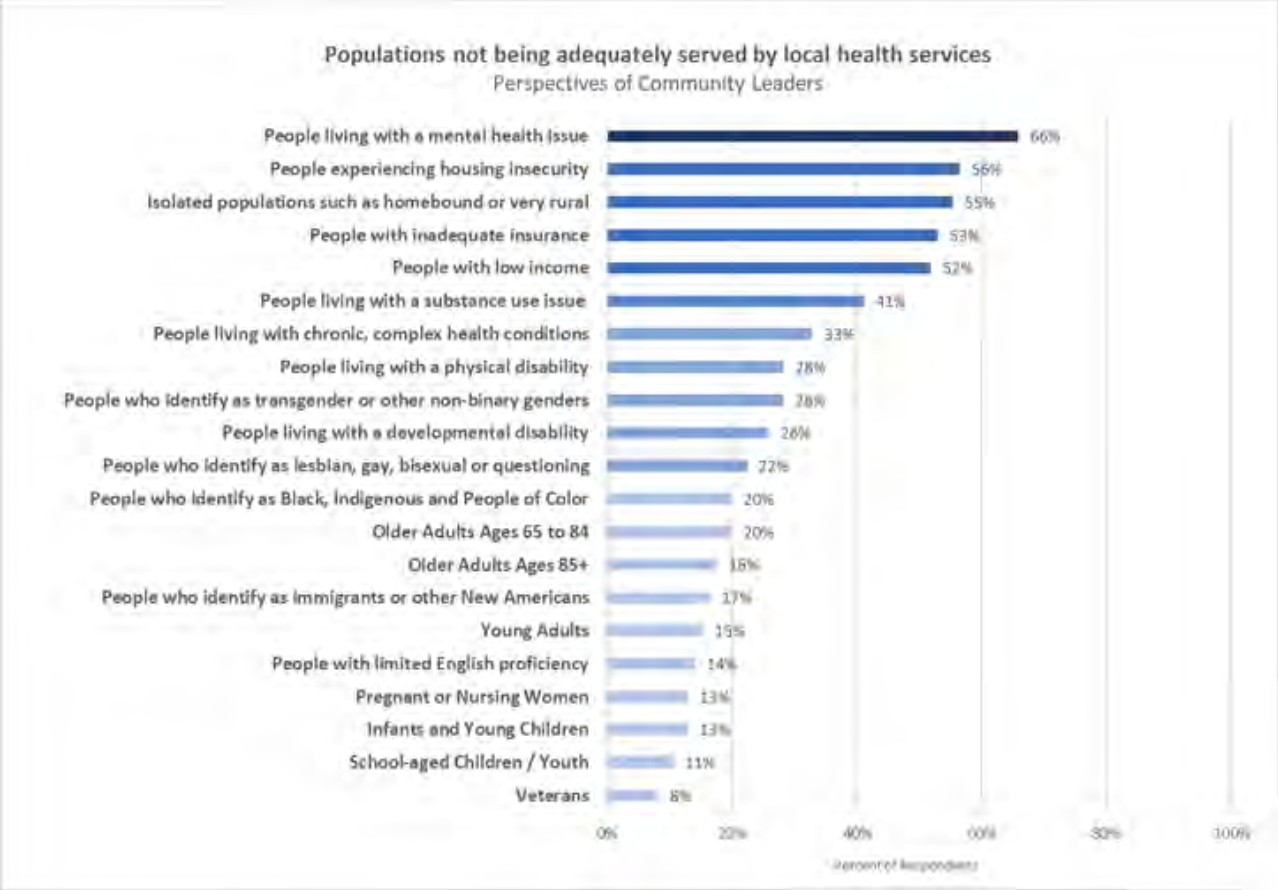


"It seems to be incredibly difficult to access PCPs -- some practices are not accepting new patients and when they are the wait times are incredibly long. Also wait times to access mental health and substance misuse services are very long."
- Community Leader, Social Services sector

Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. Populations most frequently identified by Community Leader survey respondents as underserved (Figure 15) were people living with a mental health issue, people experiencing housing insecurity, isolated populations such as homebound or very rural, people with inadequate health insurance, and people with low income. These results for underserved populations and provider capacity needs are similar to the results of the 2022 Community Health Needs Assessment except for 'isolated populations', which was added as a response choice in 2024.

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?"* A large majority of respondents (84%) responded affirmatively. When asked to comment in an open-ended follow up question, mental health was the most commonly cited service with insufficient capacity or availability (66% of those indicating any specific type of provider or service) followed by about 54% of community leader respondents reporting a need for additional primary care provider capacity. About 27% of respondents commented on the need for more dental care capacity.

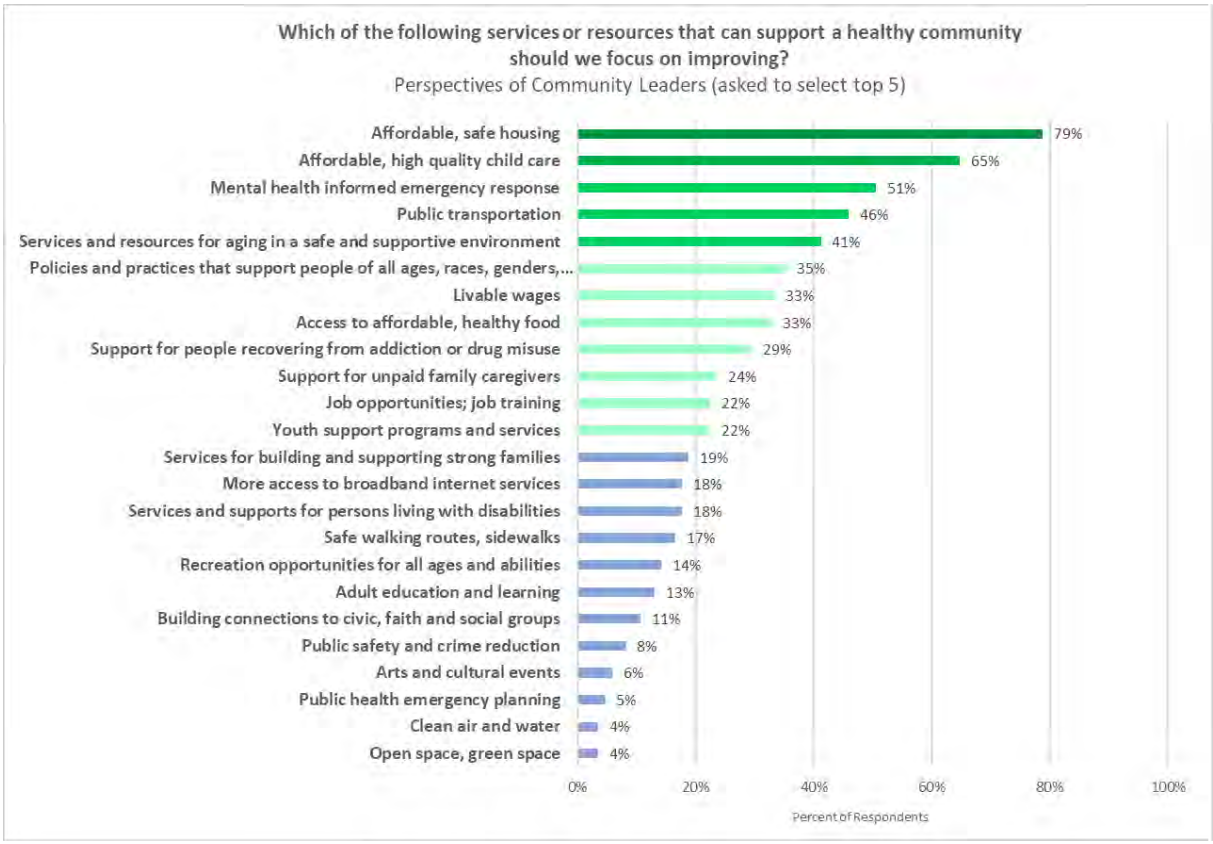
| Figure 15 |



4. 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 24 potential topics (plus an open-ended 'other' option). Sometimes described as drivers 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 6 overall conceptual groups described as follows: 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.

| Figure 16 |



As displayed by Figure 16, 'Affordable, safe housing' was by far the most frequently selected resource; identified by 79% of respondents as an area the community should focus on to support community health improvement. Other top focus areas are Affordable, high quality child care; Mental health

> *"It isn't just affording housing. It is a complete lack of housing; especially if you are low income."*
> *- Community Leader, Education / Youth Services sector*

informed emergency response; Services and resources for aging in a safe and supportive environment, and Public Transportation.

5. 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, *"Would you or your family use any of these services if they were more available in your community?".* The survey instrument included a list of 31 topics organized into 6 overall conceptual groups as follows: Services for Children and Parents; Services for Older Adults; Healthy Living 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. The highest amount of interest was reported for using Recreation and Fitness programs and Biking and Walking Paths (Figure 17). Other services most frequently mentioned were mental health services, public transportation, nutrition programs, programs that address body weight, affordable, dependable child care, stress reduction classes, balance classes / programs to prevent falls, and dental services. These results are similar to the results from the 2022 Community Health Needs Assessment.

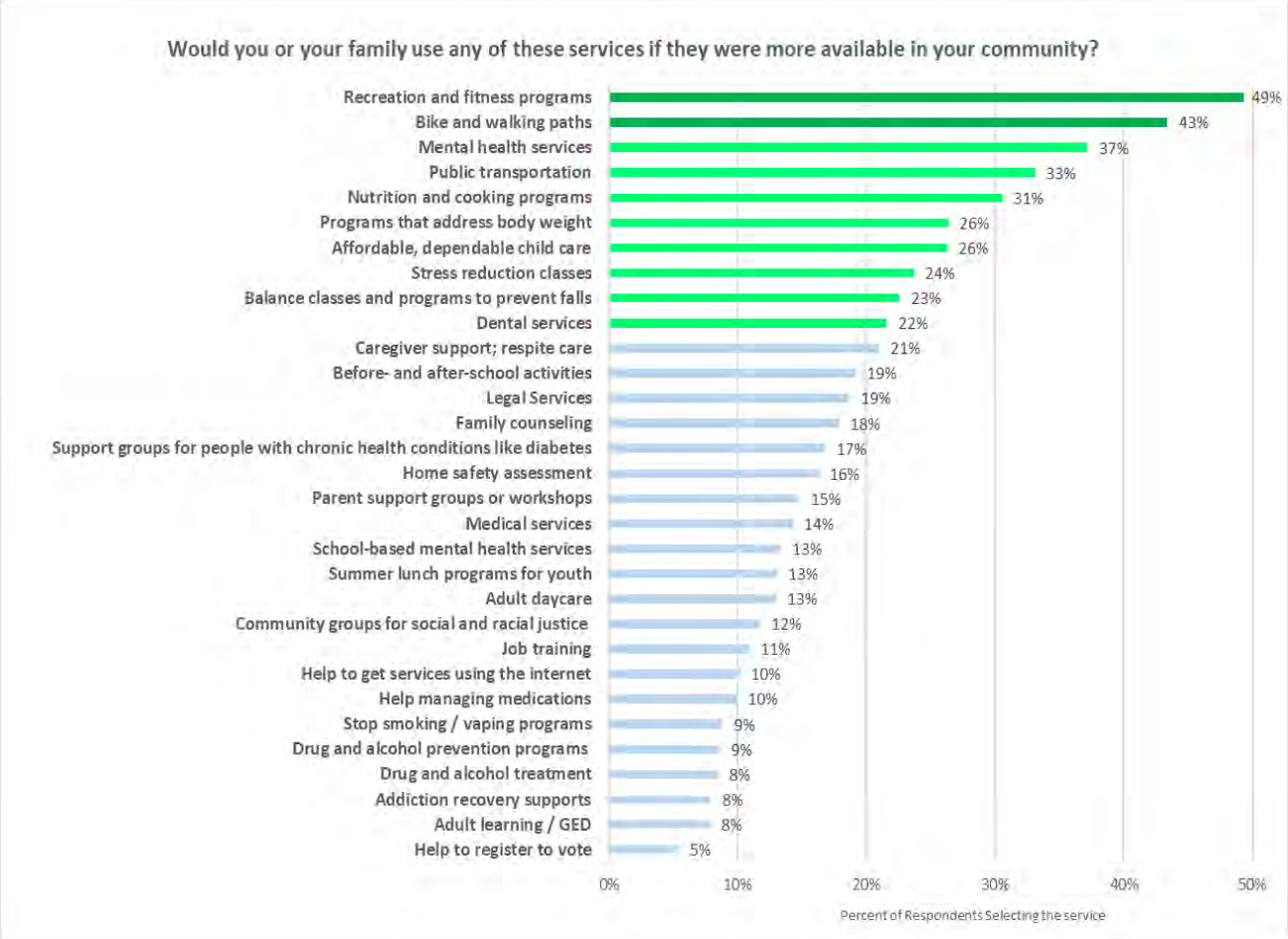


Table 8 displays the top programs or services of interest by age group. 'Recreation and Fitness programs' and 'Biking and Walking Paths' were frequently selected across age groups as resources that people would use if more available. Respondents under age 45 were more likely than older respondents to select 'Mental Health Services', 'Affordable, dependable child care' and 'Before- and after- school activities', while respondents age 65 and older were more likely to choose 'Balance classes and programs to prevent falls' than other potential items on the list of services. In general, respondents age 65 and older chose fewer service or resources from the list of survey options. Table 8 also includes a breakout of responses from people with children (under 18) in their household. These results are similar to the results for the under 45 age group with the addition of 'Family Counseling' selected more frequently than other potential service types of interest.

| TABLE 8. Top services or resources people would use if more available, by Age Group |

Age 18-44 (n=407)		Age 45-64 (n=519)		Age 65+ (n=592)		Households with children (n=401)	
Recreation and fitness programs	65%	Recreation and fitness programs	51%	Recreation and fitness programs	37%	Recreation and fitness programs	58%
Bike and walking paths	59%	Bike and walking paths	44%	Bike and walking paths	33%	Before- and after-school activities	55%
Mental health services	55%	Mental health services	42%	Balance classes and programs to prevent falls	31%	Bike and walking paths	53%
Affordable, dependable child care	53%	Public transportation	36%	Public transportation	28%	Mental health services	50%
Before- and after-school activities	51%	Nutrition and cooking programs	33%	Mental health services	21%	Affordable, dependable child care	47%
Nutrition and cooking programs	44%	Programs that address body weight	32%	Dental services	21%	Nutrition and cooking programs	38%
Public transportation	36%	Stress reduction classes	28%	Nutrition and cooking programs	20%	Family counseling	34%

"Make more community fitness activities available in the evenings a couple days a week. I can't attend yoga or fitness classes because they all meet during working hours or they are at a fitness center that's too expensive.
- Community Resident Survey Respondent

Table 9 displays results for the question on services people would use if more available by the same groups of service area towns described previously for the analysis of a Community Wellness measure. Overall, the services or resources of greatest interest are similar across towns including the same top two services: Bike and walking paths, and Recreation and fitness programs. Mental Health Services was also selected by a similar proportion of respondents in each town grouping. Respondents from lower income communities were somewhat more likely than respondents from other towns to prioritize 'Programs that address body weight' and 'Stress reduction classes'.

| TABLE 9. Top services or resources people would use if more available, by Town Group |

Lower Income Towns (n=334)		Middle Income Towns (n=497)		Higher Income Towns (n=320)	
Recreation and fitness programs	49%	**Recreation and fitness programs**	51%	**Bike and walking paths**	48%
Bike and walking paths	44%	**Bike and walking paths**	39%	**Recreation and fitness programs**	40%
Mental health services	38%	**Mental health services**	35%	**Public transportation**	37%
Nutrition and cooking programs	33%	**Nutrition and cooking programs**	31%	**Mental health services**	31%
Public transportation	31%	**Public transportation**	29%	**Nutrition and cooking programs**	25%
Programs that address body weight	28%	**Affordable, dependable child care**	26%	**Balance classes and programs to prevent falls**	24%
Stress reduction classes	27%	**Before- and after-school activities**	26%	**Affordable, dependable child care**	21%

Lower income communities include Canaan, Hartford, Sharon, Grafton, Fairlee, Dorchester. Middle income communities are Hartland, Enfield, Piermont, Lebanon, Thetford, Orford. Higher income communities are Hanover, Lyme, Norwich, Woodstock, Plainfield, Grantham.

" (Would like) A place where people could be involved in the actual community - like a center - that provides many opportunities to gather for various activities that support health, learning to cook nutritiously, etc. as well as activities for mental health, but also fun activities like crafting, game playing, etc. So many people in rural areas leave for work/school and that creates a void in close knit social gatherings, including for kids that aren't into sports.

- Community Resident Survey Respondent

The 2025 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you think would improve health in your community, what would you change?"* A total of 1,086 survey respondents (62%) provided written responses to this question. Table 10 provides a summary of the responses by topic theme.

| TABLE 10 |
"If you could change one thing that you believe would improve health in your community, what would you change?"

Health care provider availability including primary care and other specialties; workforce shortages; health care delivery system improvements including wait times, patient-provider communication, quality and options	**308 comments (28% of total)**
Affordable housing; workforce housing	**123 (11%)**
Affordability of health care including prescriptions, low cost or subsidized services; health insurance costs; health care payment reform	**117 (11%)**
Caring community, culture; community diversity and acceptance; facilities and opportunities for social interaction; reducing social isolation	**66 (6%)**
Availability, affordability of mental health services; mental health awareness and stigma	**66 (6%)**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**59 (5%)**
Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition	**58 (5%)**
Senior services; concerns of aging; home health care, assisted living; supports for adults with disabilities	**45 (4%)**
Healthy lifestyle education; focus on wellness and prevention; resources for supporting healthy youth and families	**44 (4%)**
Basic needs including livable wages, cost of living, poverty and employment (note: comments specific to affordable food or affordable housing grouped separately above)	**44 (4%)**
Improved transportation services, public transportation; medical transportation	**37 (3%)**
Affordability, availability of dental services	**25 (2%)**
Affordable child care; before and after school programs	**22 (2%)**
Substance misuse prevention including tobacco; substance use treatment; illegal drug availability	**22 (2%)**
Community Safety; physical infrastructure and accessibility	**16 (1%)**
Improved awareness, communication of available services and resources	**12 (1%)**
Other comments; no changes	**22 (2%)**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

Between March and December 2024, the Community Health Needs Assessment Planning Committee worked with community partners to convene discussion groups with residents representing a variety of communities, lived experiences, and perspectives. In total, eleven discussion groups were conducted, seven of which were specifically focused on the DH/APD service area. Four discussion groups were convened in collaboration with CHNA partners and with a broader regional focus across the wider Dartmouth Health system service area.

Discussion groups sought input and representation from a variety of community groups, interests and resources including Upper Valley business leaders; healthcare professionals such as community nurses, behavioral health care managers and service coordinators; substance use treatment and recovery centers; families with young children, teachers and childcare providers; residential and community-based caregivers for adults with disabilities; and affinity and networking groups of BIPOC and LGBTQIA+ community members. The discussion groups sought to obtain more in-depth qualitative input on common health needs and issues; to identify perceived improvements in services, supports, or resources; and to gather suggestions from participants about what healthcare organizations could do better to support health in our communities.

As part of the discussion activities, priority issues from similar community conversations in previous needs assessments were shared. Participants were asked if they thought those issues were still the most important, and if there were new or different issues they considered a higher priority. The priorities informed by previous Community Health Needs Assessments were:

- Cost of health care services, affordability of health insurance
- Availability of primary care and specialty medical services
- Availability of mental health services
- Alcohol and drug use prevention, treatment, and recovery
- Services for older adults including in-home supports for aging in place
- Social and economic factors affecting health (like affordable housing, transportation, food, and child care)

A total of 69 individuals participated in the discussion groups. Table 11 displays some demographic characteristics of the participants.

| TABLE 11. Discussion Group Participant Demographics |

Participants	Total	Woman	Man	Other Gender Identity
	100% (69)	**68% (47)**	**(>5)**	**(≤ 5)**
18 - 34	33% (23)	36% (17)	(≤ 5)	(≤ 5)
35 - 54	44% (30)	40% (19)	52% (11)	–
55 - 64	15% (10)	15% (7)	(≤ 5)	–
65+	(≤ 5)	(≤ 5)	(≤ 5)	–
Unknown	(≤ 5)	(≤ 5)	–	–

The following sections summarize the main health-related themes identified through the discussion groups. Anonymous quotes from discussion group participants are included to illustrate important themes.

1. Health Concerns and Priorities

This section outlines responses to the first three questions asked of discussion group participants:

1. *What do people you know worry about most when it comes to their health and their family's health?*
2. *A few years ago, a similar round of community conversations helped to identify some high priority health issues for our region. Some of these priorities were: (list displayed, reviewed). Do you think these are still the most important health-related issues for our community to address?*
3. *Are there other health issues that should be added to the list or are of a higher priority?*

Discussion group responses reflect diverse concerns about health and well-being, touching on systemic, financial, and personal issues or barriers. A qualitative analysis of key themes and recurring messages resulted in 5 health-related priority topic areas:

1. Healthcare Access and Equity
2. Economic Factors
3. Mental Health & Substance Use
4. Systemic Barriers and Collaboration
5. Specific Service Needs

Overall, responses to these questions indicate significant frustrations with systemic barriers to healthcare, such as accessibility and affordability. Discussion group feedback highlighted a strong sense of urgency to address several foundational drivers of health, particularly housing, childcare, and economic stability. There is also a strong desire for more empathetic, culturally competent, and holistic care models. Health equity, mental health, and a more community-driven integration of services emerged as critical areas for intervention.

Areas of Improvement

Accompanying these questions was a prompt to ask participants if they had observed any improvements in the past few years in the previously identified health priorities and concerns. Any improvements noted are included within each section as applicable.

Healthcare Access and Equity

Access to healthcare remains a significant challenge throughout the community, with participants noting long wait times, provider shortages, and restrictive Medicaid policies limiting access to primary care, mental health, and dental services. Inconsistencies in which insurance is accepted by providers has created barriers to accessing necessary care. Modest improvements in access to primary care were noted, with larger emphasis on specialty care access being a persistent issue. Dental care continues to pose a particular challenge, especially for Medicaid recipients.

Areas of Improvement

Primary care offices are seen as more widely advertising openings for new patients.

Expansion of telehealth was noted as a net positive change in access to health care and counseling services through increased flexibility in connecting with patients.

Expansion of Advanced Transit to Saturdays has positively impacted mobility for residents, particularly those in assisted living facilities.

Transportation was noted as a substantial accessibility barrier, hindering access to medical appointments and treatment as well as service options in general.

Marginalized groups, such as people who are uninsured, those with complex healthcare needs, people who identify as LGBTQIA+, and racial or ethnic minorities, feel 'invisible' and under-served or under-represented by the healthcare system. Finding and accessing culturally competent and diverse healthcare providers is a challenge, exacerbating care disparities. Implicit bias and the lack of diversity among healthcare providers is perceived to negatively impact the quality of care for Black, Indigenous, and People of Color (BIPOC). Quality of care was also noted as an issue in these discussions, where perceived stigma and bias in care delivery – especially for minority groups and individuals needing substance use treatment – exacerbate these issues.

"There are a lot of assumptions that are made in the healthcare setting. A large black male with a concussion in the ED is asked if he was a football player. The nurse asked if the patient was drug seeking. Medical staff form these assumptions based on a patient's race"

- Discussion Group Participant

Quality and continuity of care were noted as overarching concerns for all groups. Advocacy for nursing and long-term care services is critical as staffing shortages and funding issues persist in these areas. Additionally, the continuity and quality of care are undermined by high provider turnover, which disrupts relationship-building and continuity. There are also growing concerns about rushed and impersonal care in emergency departments and hospitals.

A theme expressed in several groups was fear that participants shared about being able to access appropriate and representative LGBTQIA+ healthcare services. There were concerns over gender-affirming care access, medication access, lack of access to doctors who are knowledgeable in LGBTQIA+ care, and finding providers who are culturally competent in how to avoid stigmatizing language or interactions with patients. The importance of pronouns and how damaging

misgendering can be – especially for youth in this community – were discussed at length. Increasing the visibility of this kind of care was a priority in order to provide more transparent, equitable access.

> *"LGBTQIA+ counselors that are well trained and won't perpetuate stereotypes and myths are needed more than ever. People are staying with providers who don't understand them or fit them. It boils down to being a trust issue, but they're not leaving to find better care because access is so poor."*
>
> *- Discussion Group Participant.*

Economic Factors

Economic challenges were a significant theme among discussion group participants, with healthcare expenses, including insurance premiums and out-of-pocket costs for essential services like hearing aids and dental care, being prohibitively high. Financial burdens often deter individuals from seeking care, even for urgent health needs, with many participants describing it as a "fear to seek care" based wholly on the burden of cost.

Affordable housing remains a top priority as rising rents, inadequate housing policies, and a lack of options for families and special needs populations exacerbate this crisis.

Access to affordable, nutritious food and physical activity for families in the form of recreational opportunities were noted as being limited, contributing to broader health concerns among caregivers and providers alike.

> *"Even with three jobs I cannot afford the healthcare services here."*
>
> *- Discussion Group Participant.*

Affordable child care and after-school programs are critical needs, but high costs and limited subsidies place these services out of reach for many families. Programs like summer camps are limited, and are often too expensive for families to afford.

Taken in combination, these high (and rising) costs of living have further intensified the financial strain many individuals and families already face, particularly for households losing Medicaid or other pandemic-era supports.

> *"Families have to choose between keeping their career and taking care of their kids because of the cost."*
>
> *- Discussion Group Participant*

Mental Health & Substance Use

Participants reported continuing mental health and substance use crises, as both separate issues and where these two conditions overlap. Concerns included limited access to timely and appropriate services. Long wait times and inadequate Medicaid coverage, especially for children and youth, are reported as having contributed to worsening access to mental health care. Despite a perceived increase in community awareness about these issues, funding and resources are described as inadequate to meet rising demand. Embedded mental health counselors in schools face overwhelming caseloads, leaving many students underserved. Resources for individuals with serious mental illness and those in recovery remain scarce. The lack of integrated services for individuals with dual diagnoses further complicates care. While peer support models (such as the

Next Step peer support center) are seen as valuable, they are not sufficiently widespread to meet the current needs.

Substance use issues, including youth vaping and tobacco use, highlight the urgent need for enhanced education and prevention efforts around tobacco and substance use harms. Additionally, there is a critical shortage of detox and sober living facilities, particularly for families, with affordability and accessibility posing the most significant barriers.

Stigma surrounding mental health and substance use disorders often discourages many from seeking care, worsened by the lack of recovery-friendly healthcare environments that could otherwise provide supportive and compassionate care for those in need.

Areas of Improvement

Perceived progress in drug use prevention programs, community awareness, and available of substance use treatment

Greater understanding and education around substance use disorders and some progress on reducing stigma

Expanded training opportunities for healthcare professionals and service providers, and education about the positive impacts of harm reduction strategies

Expansion of mobile syringe programs for HIV/HCV testing and treatment indicates growing outreach and community impact

The mental health of young people – and limited availability of mental health professionals serving young people – was a common concern among discussion groups. Finding pediatric and adolescent mental health resources was described as challenging, and caregivers who had lived experience said they were most often referred outside the local area for services. Related challenges include:

- 'Extremely long waitlists for intake appointments', before even knowing if a provider is a good fit for a child/teen;
- High costs associated with care and insurance coverage complications;
- Lack of awareness of mental health services that are available for young people

"Mental health services should be at the top of the list. Lots of kids deal with 'grown up issues' and there's a lack of availability to get appointments. Many therapists don't take Medicaid, so it's all private pay and very expensive."

- Discussion Group Participant

Mental health and substance use issues among those in the LGBTQIA+ community – with particular focus on mental and behavioral health concerns – were discussed as well. The ability for young people in this community to access care and support and to understand resources available to them is crucial. Social stigmas and a lack of competent care for LGBTQIA+ are reported as increasing risk of substance use and mental health problems.

"People are staying with providers who don't understand them or fit them. It boils down to being a trust issue – but they're not leaving them to find better care because access is so poor."

- Discussion Group Participant

Systemic Barriers and Collaboration

Systemic barriers and fragmented services hinder community access to essential resources and healthcare services. For example, reliable and affordable transportation options, especially in rural areas or for emergent healthcare needs, were noted consistently throughout all discussion groups as being insufficient. Participants discussed a lack of coordination between services and inconsistencies in resource allocation, with policies such as income thresholds and Medicare restrictions forcing some individuals to forgo necessary treatments. The need for more wraparound and transitional service capacity was emphasized. Holistic, co-located services addressing comprehensive needs were described as largely absent.

Areas of Improvement

Community-based initiatives, such as mobile clinics and outreach by community nurses, have shown positive outcomes by meeting individuals where they are

Participants discussed potential contributors to these systemic issues including gaps in education on nutrition, mental health, substance use prevention, and parenting skills. Community-based solutions and collaboration were highlighted as critical to reduce such barriers. Suggestions included expanded peer support services, community gardens, affordable or free local recreational activities. Initiatives like pop-up dental clinics and sober homes received positive feedback for their ability to improve access. Embedded school clinicians were noted as effective, though too few in number to meet the growing demand.

"We should be creating a culture of better communication between organizations; a culture of 'warm handoffs' for referrals like making sure a patient has the name of a person they can trust. There's no process for closing the loop on referrals. We shouldn't have to rely on the patient to reach out on their own, fill out paperwork on their own, have anxiety of not knowing what to do, how to do it, who to talk to."

- Discussion Group Participant

Participants also identified that conflicting catchment areas can contribute to barriers to comprehensive care. Examples of geographic misalignment included differences in Regional Public Health Network and school district boundaries and the NH and VT border disrupting access to or continuity of care. Differences in state or community funding sources contributes to this misalignment leading to challenges with collaboration across organizations, service responsibility confusion, and efficient resource allocation.

"It could be something as little as the rooms being too tiny – can we not have a room per specialty that's big enough to comfortably accommodate a wheelchair? Can we have better lift systems? Are there scales that are big enough to accommodate a wheelchair?"

- Discussion Group Participant

Specific Service Needs

Several groups identified insufficient support for individuals with disabilities, such as healthcare offices not having sufficient resources or space for individuals in wheelchairs or who need other accommodations. The importance of educating providers on specific health challenges for various disabilities was highlighted, and a related

theme was inability to find providers who are able to competently communicate with a person with disabilities. Understanding and connection with patients with disabilities was noted as being rare.

Maternal care was another area of concern for many participants. Gaps in postpartum and fourth trimester care were specific points of frustration. Participants mentioned the importance of providing education on infant care, and insufficient availability of providers for infant care. Maternal mental health care was also cited as a need.

Several discussion groups brought up recent changes to healthcare legislation, and how these can pose great risks to accessing needed care. This concern was predominantly referring to LGBTQIA+ care and medication access. Participants shared fears about potential delays or denials of medically necessary care. Such legislation and related discourse contribute to inequity experienced among minority groups or communities.

Finally, dental care was mentioned in nearly all discussion groups as a significant need. Participants noted widespread issues with accessing dental care due to provider limitations and long waitlists regardless of insurance coverage including Medicaid.

2. Loneliness and Isolation

This section summarizes recurring themes that emerged from participant responses to the fourth question prompt:

> *Do you think the issue of loneliness is a big concern in our community? If so, what do you think are the root causes? What should we be doing to decrease loneliness in our community?*

Loneliness is widely recognized as a significant health concern, and was defined for the groups as a feeling of lack of connection to other people, and a desire for more, or more satisfying, social relationships.

> *"A lot of our population simply isn't engaged with the community they live in."*
> *- Discussion Group Participant*

Overall, participants felt loneliness in their communities was rooted in transportation issues, social exclusion, economic barriers, and post-pandemic social behaviors. Responses highlighted a need for targeted interventions, such as culturally sensitive healthcare, community-based programs, improved transportation, and supportive social structures to mitigate the impact of loneliness on health. Addressing these concerns requires a holistic approach that considers the diverse needs of different community segments.

Social Isolation and Community Engagement

While several community programs and activities were noted as helpful to fostering community connection, efforts were described as limited in reach. Group dinners, intergenerational activities

and community events can help integrate isolated individuals – such as older adults or young children/teens – and help foster community connection.

Participants noted that young people and children can face loneliness at greater rates due to unsupportive home environments or parental work obligations, emphasizing the need for safe spaces and affordable programs to help foster connections. Existing programs can have economic barriers, such as the cost of entry for events and activities, further excluding low-income families and perpetuating social isolation.

Areas of Improvement

Increase in school programs where students pair with an older adult/ senior in nearby facilities to write letters, visit, have lunch, etc. These intergenerational relationships are mutually beneficial.

Transportation and Accessibility

Transportation challenges significantly contribute to isolation, especially in rural areas where distances are greater and public transit options are minimal. These barriers prevent community members from attending events, accessing healthcare, and participating in social activities, exacerbating feelings of disconnection. Although participants did note some improvements in this area, public transportation remained a main concern, discussed as especially insufficient to meeting the needs of vulnerable populations including older adults and individuals with limited mobility.

"They turn down social activities because of a lack of transportation - they can't get there. There's also a socioeconomic divide in this area, feeding into that loneliness and stigma."
- Discussion Group Participant

Cultural Sensitivity and Socioeconomic Inequality

Cultural and racial isolation were noted as major concerns for minority individuals living in predominantly white communities. Feelings of exclusion and loneliness were discussed as direct results of having a lack of representation where they access care or community services. A need was expressed for increased representation of racially or culturally similar providers and communities to help mitigate these feelings.

"Loneliness is a big issue for me. I go to the hospital or doctor's office and no one looks like me."
- Discussion Group Participant

Additionally, economic inequality plays a significant role in loneliness, with those unable to afford events or activities feeling left out of community life. These systemic issues are compounded by fragmented access to services and a lack of free or low-cost options to promote inclusion and connection.

"Intersectionality can compound already existing obstacles these communities face. Queer experiences can differ tremendously depending on race, income, background, and other factors."
- Discussion Group Participant

Feelings of loneliness among LGBTQIA+ youth were also discussed with community members or their caregivers noting that the smaller population of rural communities can make it harder for people to feel safe and represented. Intersectionality of different social identity combinations can pose additional challenges for social connection and mental health.

Post-Pandemic Challenges

Participants discussed how the pandemic has heightened loneliness, with ongoing fears of social interaction and a greater reliance on technology for connection.

While technology provided a lifeline for many during lockdowns and quarantines, it has also reduced face-to-face engagement and contributed to a generation of young people who are more comfortable with communicating through a screen versus in person. These challenges were noted as most present for older adults and seniors, whose feelings of loneliness may be compounded by not feeling comfortable with technology, health challenges, and limited access to transportation.

> *"I heard a story about people using AI-generated friends, which felt really alarming to me. There's a little bit of fallout from the pandemic… if you were socially anxious to begin with, it was exacerbated. Our relational health needs a lot of attention."*
>
> *- Discussion Group Participant*

Suggestions for health care providers to help address social isolation and loneliness included:

- Utilizing loneliness screenings at doctor's appointments
- Providing resources at the end of appointments that point patients towards existing programs, resources, and community services
- Encouraging patients to talk about their social/emotional/mental health, especially among demographics or groups who may be uncomfortable admitting vulnerability (e.g., veterans, senior men).

3. Suggestions for Improvement

This section includes discussion and responses to the final question:

> *Overall, what do you think health care organizations in this community could be doing better or differently to have a positive impact on the health issues we have talked about?*

Conversations centered around creating a healthcare system that is more inclusive, accessible, and responsive to the diverse needs of community members. Feedback and suggestions underscored the importance of addressing systemic barriers and fostering collaboration to create a more supportive and equitable healthcare environment. A desire for community-centered care was a common thread throughout this aspect of the discussion groups.

Accessibility and Infrastructure

Improving the means in which communities can access healthcare was a common concern, especially in terms of physical infrastructure. Participants highlighted the need for better accommodations, such as larger rooms for wheelchair users and improved lift systems, increased public transportation and the need for more bus stops near medical centers, and the benefits of community-based mobile clinics.

Areas of Improvement

Community nurses and health workers are making a huge difference.

Community-based care where people are being met where they are (both physically and metaphorically) seems to be really successful and growing.

Expanding mobile clinics and integrated care services was seen as a valuable solution for underserved populations, including those in rural areas and individuals with mental health or substance use challenges. School-based health services and mobile outreach programs – combining medical, dental, and/or mental health care – were recommended to improve service delivery and accessibility.

"Mobile clinics are so helpful when they partner with churches, social services, town officers, schools, etc. It's important to meet people where they are in these smaller communities to get them the help they need. People who need help the most have become invisible."

- Discussion Group Participant

Cultural Competence, Equity, and Support for Vulnerable Populations

There was a strong emphasis on enhancing cultural competence in healthcare, including hiring diverse providers and providing trauma-informed care training. Participants noted the importance of fostering trust and addressing implicit biases to ensure equitable treatment. Resources and community-based events aimed at supporting marginalized communities were suggested to help individuals feel supported and helped to integrate.

"Diversity is good for business. You don't need 100,000 BIPOC patients before you hire BIPOC providers."

- Discussion Group Participant

Tailored support for individuals with developmental disabilities and mental health needs was also emphasized, including role-play training for caregivers and dedicated clinicians for specialized care. Suggestions included more

"We need more training around kindness, mental health, and social skills for a population with developmental disabilities. We need to build a common language for DSPs [Direct Support Professionals] to clarify what's not 'the right thing' to say or how to react appropriately."

- Discussion Group Participant

focus on improving housing and transitional support for individuals with significant mental health or substance use challenges.

Coordination and Communication

After emphasizing individual experiences and frustrations with fragmented care and communication gaps, participants offered possible solutions to these types of barriers. These solutions included developing more streamlined systems for referrals, better integration of services and communication among and between healthcare providers and community services, and tools like organization charts to improve transparency. Stronger collaboration between schools and healthcare providers were proposed to address things like limited dental care, access to immunization records, increasing timely access to counselors and therapists, and other shared responsibilities. The need for better communication between providers and their patients in general was a recurring concern.

Participants emphasized the importance of processes like warm handoffs and peer support models to ensure patients felt engaged in their health decisions, have a clear understanding of who is the provider responsible for their care, and are confident in the quality and continuity of care even if or when their provider were to leave.

Specifically referring to prescription medications, participants called for improvements in refill processes and clearer navigation of the healthcare system, such as providing visual aids and increasing effective communication between departments, providers, and pharmacists.

> *"We need better partnership between DHMC providers and other community providers. It's very hard to navigate the healthcare system as it is. And navigating MyDH can be great, but you have to know how to use it."*
>
> *- Discussion Group Participant*

D. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2025 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 Dartmouth Hitchcock Medical Center and Alice Peck Day Memorial Hospital (identified in the following tables as DHMC-APD Service Area).

In some instances, population health data are only available at the county or health district / public health region level. For the 12 New Hampshire municipalities in the DHMC-APD service area, population health information is reported for the Upper Valley Public Health Region if available. That public health region is completely congruent with those 12 municipalities and comprises 65% of the total service area population. Current sub-state data are somewhat less available for Vermont and most information tends to be at the county level. Among the seven Vermont municipalities in the service area, five are in Windsor County and two are in Orange County. In a few instances, data are reported 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.

1. Demographics and Drivers of Health

Drivers of health are the conditions in which individuals are born, age, work, and live and how these factors can influence health, wellness and quality of life. As described earlier in this report, drivers of health include a number of primarily nonmedical factors that can have direct or indirect influence on health outcomes such as economic status, community infrastructure and access to quality housing, food, and education. Similarly, factors such as age, disability, and language can influence the types of health and social services needed by communities in order to thrive.

General Population Characteristics

The prevalence of many health conditions varies by age and different age groups can have different health-related needs and priorities. Awareness of the age distribution within a population can help to anticipate healthcare needs, allocate resources appropriately, and plan for future healthcare demand.

Between 2020 and 2023, the population of the service area grew by by about 3,100 people or 4.5% overall and including estimated population increases of more than 1,000 people in both Hartford and Lebanon. The population of the DHMC-APD Service Area is somewhat older on

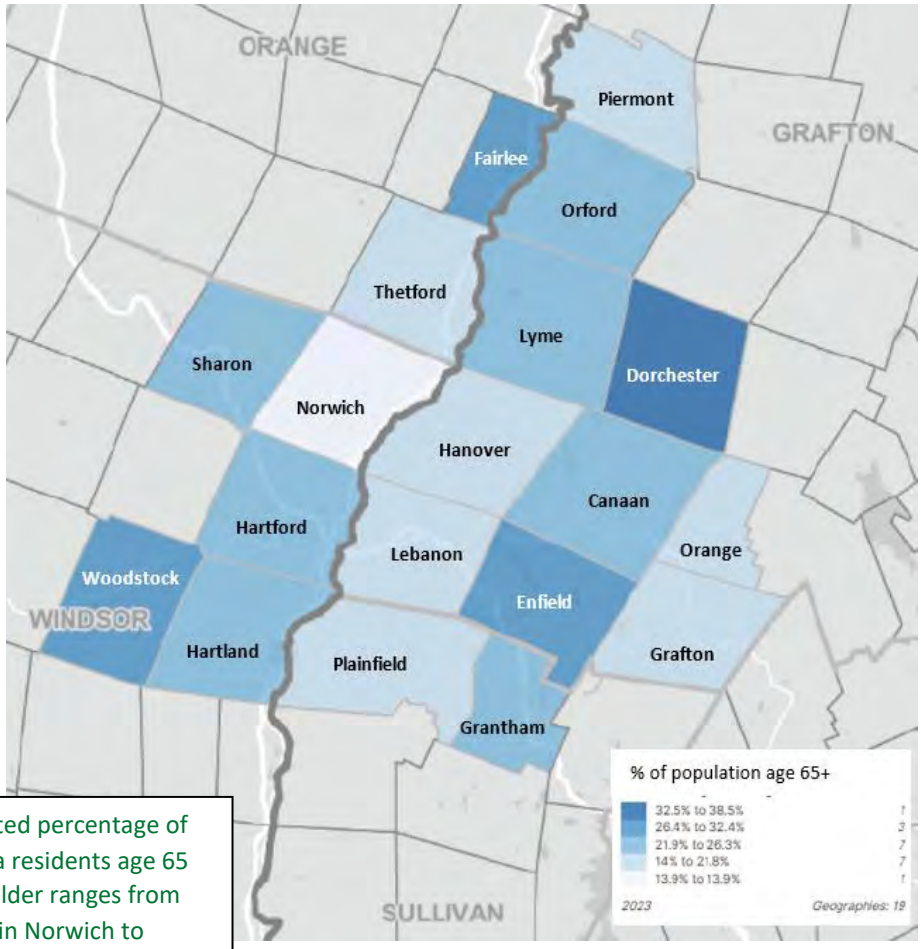
average than in Vermont and New Hampshire overall (Table 12). The service area map (Figure 18) displays the percent of the population 65 years of age and older by town.

| TABLE 12 |

Indicators	DHMC-APD Service Area	Vermont	New Hampshire
Total Population	72,736	645,254	1,387,834
Age under 5 years	4.1%	4.3%	4.6%
Age 5 to 17 years	12.7%	13.8%	14.0%
Age 65 and older	22.2%	20.8%	19.5%
Age 85 and older	2.9%	2.1%	2.0%
Change in population (2020 to 2023)	+4.5%	3.4%	+2.4%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 - 2023

| Figure 18. Percent of Service Area Population 65 years of age and older |



The estimated percentage of service area residents age 65 years and older ranges from about 14% in Norwich to about 39% in Dorchester.

Education

Educational attainment is also considered a key driver of health status, with lower levels of education correlated with both poverty and poor health. As displayed by the next table, the percent of DHMC-APD service area residents ages 25 and older who have earned at least a high school diploma is similar to the percentages across New Hampshire and Vermont overall, while the percent of the service area population with a Bachelor's degree or higher – over half of area residents - is notably greater in comparison to the state percentages.

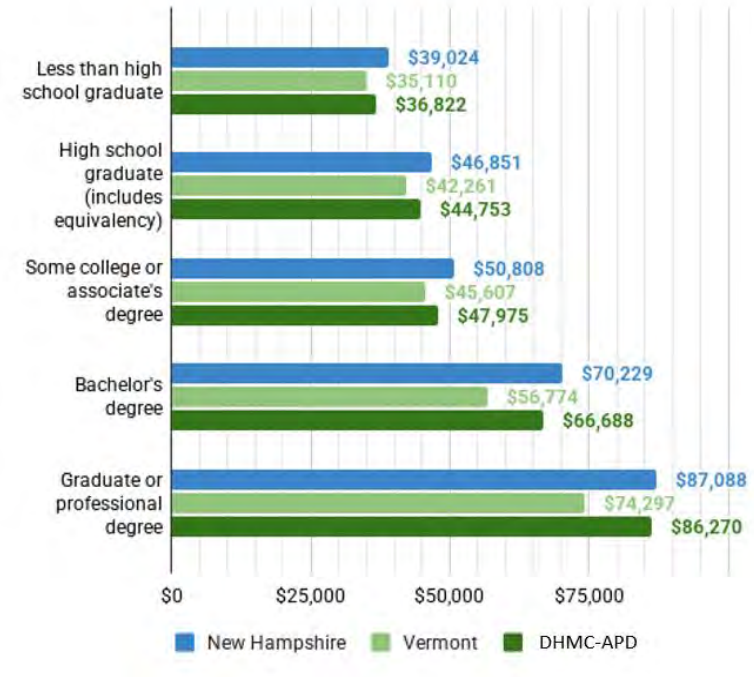
| TABLE 13 |

Percent of Population Aged 25+	DHMC-APD Service Area	Vermont	New Hampshire
High School Diploma (or Equivalent) and Higher	96%	95%	94%
Some College or Associate's Degree	20%	25%	27%
Bachelor's Degree or Higher	55%	43%	40%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

One reason education level is historically associated with better health status is that adults with more education tend to have more opportunities for earning higher income and access to more comprehensive health-related benefits. Figure 19 displays the relationship between education and income, where the amount earned (in 2022 inflation-adjusted dollars) by residents with Bachelor's degrees or higher is consistently greater than those with less educational attainment.

| Figure 19. Median Earnings by Educational Attainment |

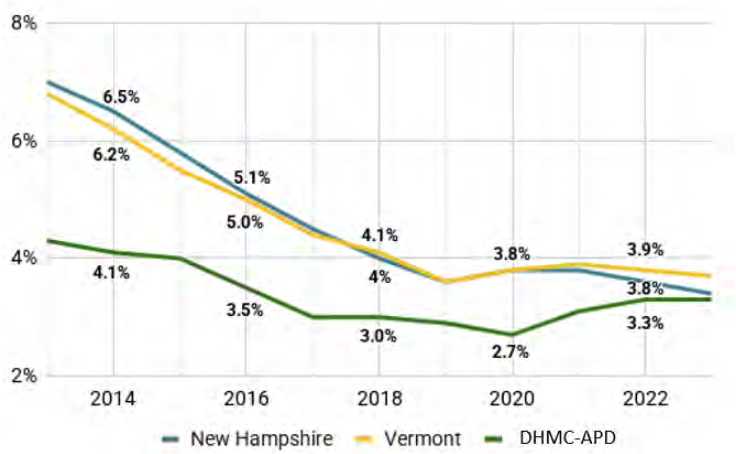


Employment

Stable employment can help ensure financial security including the ability to purchase food, pay for housing and utilities and access healthcare services. Employment can also provide health insurance and other benefits such as paid time off, family medical leave, and wellness benefits. Steady employment can also contribute to mental health by providing opportunities for social interaction, decreased isolation, and sense of purpose.

Over the period 2014 to 2022, NH and VT experienced similar decreases in unemployment rates before leveling off near 4%. Unemployment in the DHMC-APD service area has been consistently lower than state rates, decreasing to around 2% before increasing somewhat during the COVID-19 pandemic.

| Figure 20. Annual Unemployment Rate, 2014 – 2022 |



Income and Poverty

The strong connection between economic prosperity and health is widely recognized. For example, the absence of economic prosperity or poverty can lead to obstacles in obtaining health services, nutritious food, and a healthy physical environment, all of which are fundamental for maintaining good health.

Some information describing household income and poverty status was included in the first overview section of this report. Table 14 displays the percent of people in the hospital service area living in households with income below the Federal Poverty Level (FPL), the percent of children under age 18 in households with income below the FPL, and the percent of adults 65+ years in households with income below the FPL. For context, the Federal Poverty Level for an individual in 2023 was $14,580 and for a family of four was $30,000.

The service area estimate for percent of children in households with income below the poverty level is less than half the Vermont statewide statistic. However, the estimated percent of service area residents age 65 years or more who are living in poverty is higher than the estimate for Vermont or New Hampshire overall.

| TABLE 14 |

Percent of people in households with income below the Federal Poverty Level (FPL)			
Population Group	**DHMC-APD Service Area**	**Vermont**	**New Hampshire**
All people with household income below the FPL	8.1%	10.3%	7.2%
Children (under 18) in households with income below the FPL	5.2%	10.8%	7.8%
Adults 65+ years in households with income below the FPL	9.8%	8.2%	7.4%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

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). Implications can range from limiting access to appropriate healthcare services; difficulty navigating health systems; reduced preventive care due to a difficulty in understanding health-related information, and medication misunderstandings including instructions, dosage, side effects. Language barriers can contribute to feelings of isolation, frustration, and anxiety; especially when unable to effectively express health concerns or understand information provided by healthcare professionals.

The U.S. Census Bureau tracks over 1,300 languages that are further categorized in 42 language groups. The table below reports the most common languages other than English spoken at home in the DHMC-APD service area along with the corresponding percentages throughout NH and VT. An estimated 48 households in the service area (0.2%) are considered limited-English speaking households. A limited English speaking household is defined as one in which no member 14 years old or older either speaks only English or speaks a non-English language and speaks English very well.

| TABLE 15 |

Languages Spoken at Home	DHMC-APD Service Area	Vermont	New Hampshire
English only	90.0%	92.5%	89.5%
French, Haitian, or Cajun	1.5%	2.2%	2.1%
German	1.5%	0.5%	0.6%
Spanish	1.1%	1.7%	3.0%
Chinese	0.8%	0.2%	0.5%
Russian, Polish, other Slavic	0.7%	0.7%	0.6%
Other Languages	4.5%	2.2%	3.7%
Limited English Speaking Households	**0.2%**	**0.6%**	**1.2%**

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

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 can experience financial strain, with less resources available for essential

needs such as food, healthcare, education, transportation and clothing. Other implications of high housing cost burden include housing insecurity and sub-standard living conditions.

Similarly, physical housing conditions can contribute to health hazards. Some examples include inadequate ventilation, which can lead to exposure to mold, pests, or lead-based paint; incomplete kitchen facilities, which can limit nutritional options, increase reliance on heavily processed foods, limit food safety, and reduce hygiene and sanitation; and lacking complete plumbing facilities, which can cause sanitation and hygiene challenges, lead to sewage or waste exposure, increase vector-borne diseases, and limit access to clean water.

Table 16 presents data on the percentage of occupied housing units in the service area that have characteristics of sub-standard housing such as lacking complete plumbing facilities or complete kitchen facilities.

The table also displays the percentage of households with housing costs (with or without a mortgage) or rental costs exceeding 30% of household income. The U.S. Department of Housing and Urban Development defines affordable housing as housing on which the occupant is paying no more than 30 percent of gross income for housing costs including mortgage or rent, utilities, taxes and insurance. About 1 in 4 owner occupied housing units and half of renters in the service area have housing costs exceeding this threshold.

| TABLE 16 |

Percent of Households with High Cost Burden, Substandard Housing or No Internet Access	DHMC-APD Service Area	Vermont	New Hampshire
Housing Costs >30% of Household Income (%)	**24.0%**	24.6%	24.8%
Rental Costs >30% of Household Income (%)	**46.7%**	50.5%	47.6%
Occupied Housing Units Lacking Complete Plumbing Facilities (%)	**0.8%**	0.5%	0.5%
Occupied Housing Units Lacking Complete Kitchen Facilities (%)	**1.1%**	0.8%	0.7%
Without Internet Subscription	**9.3%**	11.6%	8.0%
No Computer in the household	**4.4%**	5.9%	4.4%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

Another attribute of housing that can have implications for the health of families and communities is the age of structures. This could include the type of materials used to build the structure (insulation, paint, plumbing, etc.), inadequate ventilation systems, structural integrity, accessibility and safety.

Vermont and New Hampshire have high percentages of older structures in general, with more than half of occupied housing units within structures that were built before 1980 (50% and 56% respectively). The DHMC-APD service area has a similar percentage with about 55% of housing units built before 1980.

| TABLE 17. Housing Units – Year Structure was Built |

Area	1939 or earlier	1940 to 1959	1960 to 1979*	1980 to 1999	2000 to 2019	2020 or later
DHMC-APD Service Area	22%	10%	23%	31%	16%	1%
Vermont	25%	8%	23%	26%	17%	1%
New Hampshire	19%	8%	23%	29%	18%	1%

Data Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates.

**The use of lead paint and asbestos-containing materials, including pipe and block insulation, was banned in 1978.*

Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. About 5% of households in the service area report having no vehicle available, a percentage similar to New Hampshire and Vermont overall. Towns with the highest estimates for households with no vehicle available are Hanover (10%), Lebanon (8%), Woodstock (7%), Canaan (6%), and Hartford (6%).

| TABLE 18 – Vehicle Availability|

Area	Percent of Households with No Vehicle Available
DHMC-APD service area	5.2%
Vermont	6.8%
New Hampshire	4.5%

Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates.

Disability Status

Disability is defined by the U.S. Census Bureau as a person who has any of the following long-term conditions: (1) deafness serious difficulty hearing; (2) blindness or serious difficulty seeing (3) cognitive difficulty Because of a physical, mental, or emotional problem (4) serious difficulty walking or climbing stairs, (5) difficulty with self-care such as dressing or bathing, or (6) difficulty living independently such as being able to do errands or visit a doctor's office alone.

The percentage of residents in the DHMC-APD service area who report having at least one disability - about 12% - is slightly lower than in Vermont and New Hampshire overall although the percent of older adults age 65+ with a disability – about 29% - is similar.

| TABLE 19 |

	Total Population (Noninstitutionalized) with a Disability		
Age Group (in years)	**DHMC-APD Service Area**	**Vermont**	**New Hampshire**
Age <18 with a disability	**3.1%**	5.5%	4.9%
Age 18-64 with a disability	**8.4%**	12.3%	10.7%
Age 65+ with a disability	**28.6%**	29.2%	28.6%
Total population (%) with a disability	**11.9%**	14.5%	13.0%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

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 relation to population need and demand for services, and related concepts of availability, proximity and appropriateness of services.

Insurance Coverage

Table 20 displays town level estimates of the proportion of residents in the DHMC-APD service area who do not have any form of health insurance coverage, as well as the proportion of residents with Medicare, Medicaid or Veterans Administration coverage. Overall, the percent of the service area population with no insurance (4%) is similar to the percent in Vermont (4%) and lower than in New Hampshire (6%) although there are several service area towns with uninsurance rates of 7% and higher. Also of note is the substantially higher percentage of Medicaid coverage in

Vermont compared to New Hampshire. The service area map on the next page (Figure 20) displays the percent of residents with no health insurance coverage by municipality.

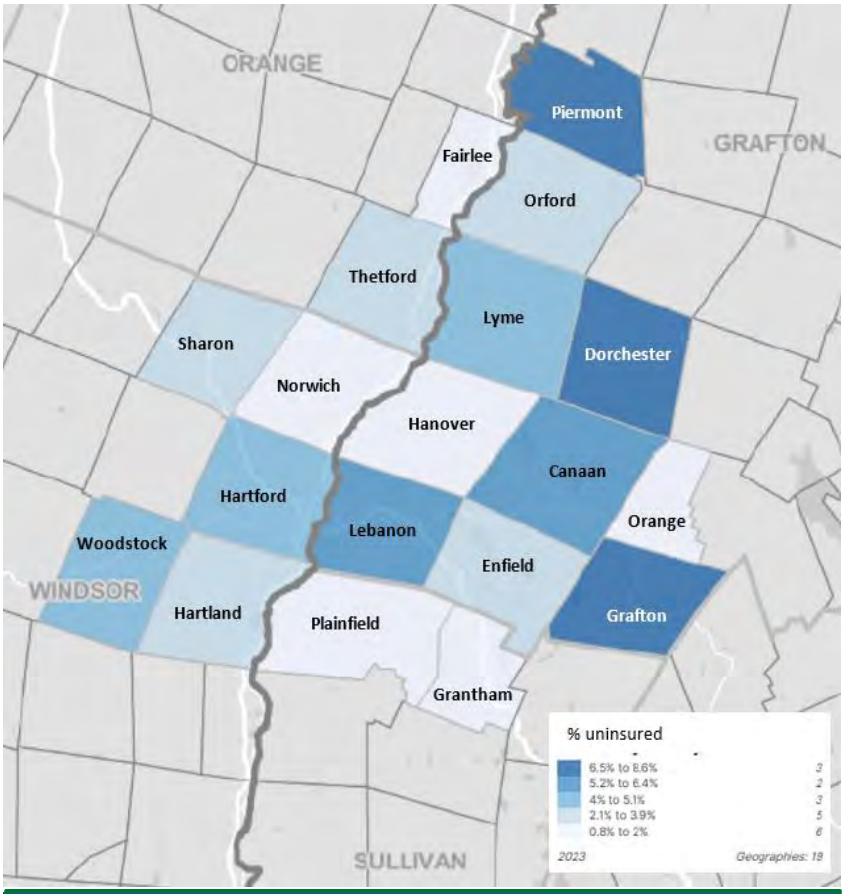
| TABLE 20: Health Insurance Coverage Estimates |

Area (in order of highest to lowest % uninsured)	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Dorchester	9%	43%	23%	2%
Piermont	8%	23%	17%	3%
Grafton	7%	23%	23%	5%
Lebanon	6%	22%	13%	4%
Canaan	6%	27%	25%	3%
New Hampshire	6%	21%	13%	2%
Woodstock	5%	30%	11%	2%
Lyme	5%	27%	6%	3%
Hartford	5%	24%	22%	3%
Vermont	4%	23%	23%	2%
DHMC-APD Service Area	**4%**	**23%**	**13%**	**3%**
Sharon	4%	26%	34%	3%
Orford	4%	24%	6%	3%
Hartland	3%	29%	17%	3%
Enfield	3%	31%	11%	4%
Thetford	3%	21%	17%	2%
Fairlee	2%	36%	19%	2%
Orange	2%	19%	10%	3%
Plainfield	1%	20%	10%	4%
Hanover	1%	16%	2%	1%
Norwich	1%	14%	7%	2%
Grantham	1%	22%	14%	1%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

**Coverage alone or in combination*

| Figure 21 Percent of DHMC-APD Service Area Population Who Are Uninsured |



The estimated percentage of service area residents with no health insurance coverage ranges from 1% in Plainfield, Grantham, Hanover and Norwich to 8% in Piermont and 9% in Dorchester.

Delayed or Avoided Care Due to Cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a healthcare 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. In the Upper Valley

| Table 21 |

Area	Percent of Population Who Could Not See a Doctor because of Cost
Windsor County	6%
Orange County	4%
Upper Valley Public Health Region	6%
Vermont	6%
New Hampshire	11%

Data Sources: Behavioral Risk Factor Surveillance System; VDH 2022, NH Health WRQS, 2019

Public Health Region, about 16% of respondents to the NH Behavioral Risk Factor Survey reported being unable to see a doctor because of cost (2019 data, most recent available).

Provider Capacity

Access to high-quality, cost-effective healthcare is influenced by adequate health care professional availability in balance with population needs. Table 22 displays a measure of availability – population to provider ratio – at the county level for primary care physicians, dentists, and mental health professionals. Sullivan County has the second highest ratio of NH's ten counties for population per mental health provider after Coos County. In general, Grafton County has a lower population to provider ratio for each provider type, due presumably to the location of Dartmouth Hitchcock Medical Center and related practices.

| TABLE 22 |

Area	Ratio of Population to Primary Care Physicians	Ratio of Population to Dentists	Ratio of Population to Mental Health Providers
Grafton County	530:1	1199:1	175:1
Sullivan County	1,404:1	2,585:1	449:1
Orange County	1,231:1	3,316:1	266:1
Windsor County	999:1	1,615:1	170:1
Vermont	899:1	1,377:1	184:1
New Hampshire	1,149:1	1,302:1	263:1

Data Source Area Health Resources Files, US DHHS via County Health Rankings, 2021-2022

The next table displays the percentage of adults who self-reported not having a primary care provider. About 12% of Windsor County residents and 6% of residents in the Upper Valley Public Health region responded on the Behavioral Risk Factor Survey that they do not have a 'personal doctor or health care provider'. (Note: Most recently available New Hampshire data on this measure is from 2019).

| TABLE 23 |

Area	Percent of Population (18+) Without a Primary Care Provider
Upper Valley Public Health Region	6%
Orange County	8%
Windsor County	12%
Vermont	11%
New Hampshire	12%

Data Sources: Behavioral Risk Factor Surveillance System; VDH 2022, NHDHHS, 2019

Travel Time or Distance

The NH State Office of Rural Health (SORH) classifies Public Health Network regions throughout the state as rural or non-rural including the Upper Valley PHN, which is classified as rural. The SORH has reported that health disparities exist between rural and non-rural populations as measured by select primary care-associated health indicators including primary care access.[2] One measure of access to primary care is travel time to health care visits. As displayed by Table 24, about twice as many primary care visits for rural populations require one-way travel time of 30 minutes or more compared to non-rural populations. The Upper Valley Public Health Region is the only rural PHN region that has lower percentage on this measure than non-rural regions of the state.

| TABLE 24 |

Area	Percentage of primary medical care visits with travel times greater than 30 minutes, one way
Upper Valley Public Health Region	13.5%
All Rural New Hampshire	27.5%
All Non-Rural New Hampshire	15.3%

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2019 data

The number of hospitals providing obstetric services has been in decline in rural communities across the country. The loss of hospital-based obstetric services in rural areas is associated with increases in out-of-hospital births and pre-term births, which may contribute to poor maternal and infant outcomes.[3] Compared to other rural and non-rural counties in Vermont and New Hampshire, a larger percentage of the populations of Windsor, Orange and Sullivan county live greater than 15 miles to the nearest hospital providing birthing services.

| TABLE 25 |

Area	Greater than 15 Miles to Nearest Birthing Center, % of total population
Orange County	53%
Windsor County	66%
All Rural Vermont	43%
All Non-Rural Vermont	11%
Grafton County	30%
Sullivan County	95%
All Rural New Hampshire	41%
All Non-Rural New Hampshire	5%

Data Source: New England Rural Health Association, Rural Data Analysis Dashboard, 2023.

[2] Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection, NH State of Rural Health and Primary Care, December 2022.

[3] Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas. Government Accountability Office, GAO-23-105515, Oct 19, 2022.

Preventable Hospital Stays

Preventable Hospital Stays are hospital discharges for diagnoses potentially treatable in outpatient settings, also known as ambulatory care sensitive conditions, such as diabetes, hypertension, asthma and chronic obstructive pulmonary disease. A high rate of inpatient stays for ambulatory care sensitive conditions may indicate limited access, availability, or quality of primary and outpatient specialty care in a community. This measure is reported below for Medicare enrollees. The rates of preventable hospital stays in 2021 across the four counties included in the service were similar to the overall state rates.

| TABLE 26 |

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Grafton County	2,045
Sullivan County	2,350
Orange County	2,059
Windsor County	2,100
Vermont	2,182
New Hampshire	2,478

Data Source: Centers for Medicare & Medicaid Services; accessed through County Health Rankings, 2021 data

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. About one-third of adults in the counties included in the service area report not having had a dental visit in the past year.

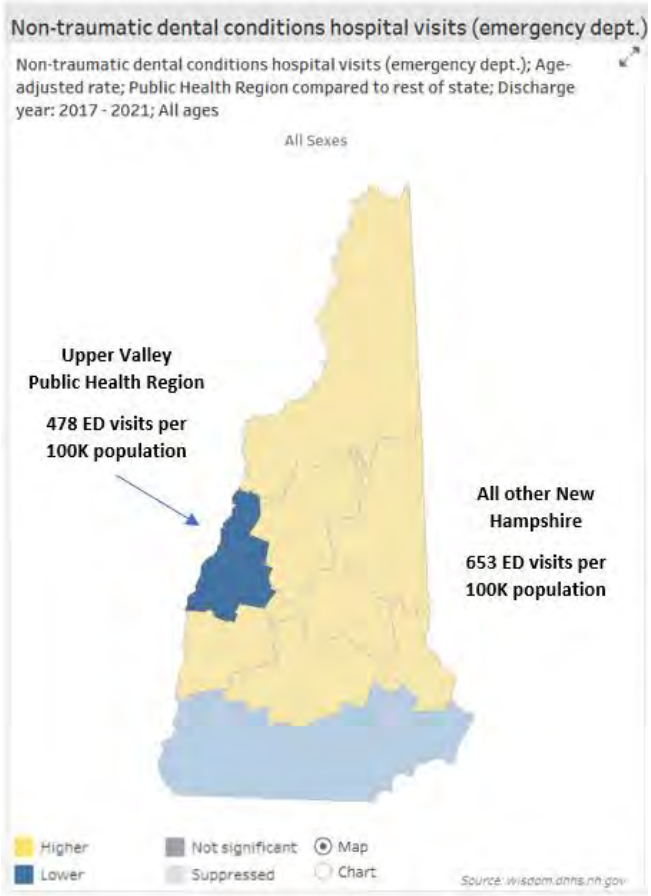
| TABLE 27 |

Area	Percent of adults who visited a dentist or dental clinic in the past year
Grafton County	69%
Sullivan County	64%
Orange County	72%
Windsor County	71%
Vermont	68%
New Hampshire	69%

Data Source: CDC, Population Level Analysis and Community Estimates (PLACES), Behavioral Risk Factor Surveillance System 2022

Emergency department visits for non-traumatic dental conditions provides a measure of unmet oral health needs where timely primary dental care could potentially prevent the need for emergency care. Ambulatory care sensitive dental conditions represent approximately 3% of all emergency department visits in New Hampshire. The Upper Valley Public Health Region experiences significantly fewer hospital emergency department visits for non-traumatic reasons (i.e., not resulting from an acute injury) than across the state overall. The difference is even more notable in comparison to other more rural areas of New Hampshire where the rate of ED visits for non-traumatic dental conditions is nearly 60% higher than non-rural regions of the state.

Figure 21



| TABLE 28 |

Area	Emergency Department visits for non-traumatic dental condition; Age-adjusted rate per 100,000
Upper Valley Public Health Region	**478***
New Hampshire	653

Data Source: NH Hospital Discharge Data, 2017-2021,

***Regional rates are significantly different and higher than the state rate*

3. Health Promotion and Disease Prevention

Healthy lifestyle habits and behaviors can effectively prevent or manage the impact of many diseases and injuries. Regular physical activity, for instance, promotes equilibrium, relaxation, and lowers the risk of developing chronic diseases. Adopting a nutrient-dense diet rich in fruits, vegetables, and whole grains can significantly decrease the likelihood of heart disease, certain cancers, diabetes, and osteoporosis. Adopting healthy behaviors, such as not smoking and limiting alcohol intake, can prevent or control the effects of disease and injury.

This section encompasses both environmental conditions and individual behaviors that influence personal health and well-being. It also highlights indicators of clinical prevention practices, including cancer and heart disease screenings, which will be further discussed in a later section that addresses population health outcomes in those specific areas.

Food Insecurity

Food insecurity is described by the United States Department of Agriculture as the lack of access, at times, to enough food for an active, healthy life. About 11% of households in the service area experienced food insecurity in the past year (2022 data) defined as the percentage of households unable to provide adequate food for one or more household members due to lack of resources.

| TABLE 29 |

Area	Percent of Households Experiencing Food Insecurity
Grafton County	10.7%
Sullivan County	11.7%
Orange County	11.0%
Windsor County	11.0%
Vermont	11.7%
New Hampshire	9.7%

Data Source: Feeding America, Map the Meal Gap, 2022

Table 30 shows the percent of households receiving support through the Supplemental Nutrition Assistance Program (SNAP). About 6% of households in the DHMC-APD service area receive SNAP support. Among these households about 38% have children in the household and about 56%b have at least one household member aged 60 years or older.

| TABLE 30 |

Area	Percent of All Households Receiving SNAP	With Children Under 18 (% of total households receiving SNAP)	With one or more people in the household 60 years and over (% of total households receiving SNAP)
DHMC-APD Service Area	**6%**	**38%**	**56%**
Vermont	10%	33%	45%
New Hampshire	6%	45%	39%

Data Source: Data Source: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates

Physical Activity (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. About 1 in 6 adults in Windsor County self report lack of physical activity ('past month').

| TABLE 31 |

Area	Percent of Adults Participating in Physical Activity Outside of Work, past month
Grafton County	83%
Sullivan County	79%
Orange County	85%
Windsor County	84%
Vermont	84%
New Hampshire	81%

Data Source: CDC, Population Level Analysis and Community Estimates (PLACES), BRFSS 2022; State estimates, BRFSS via County Health Rankings, 2021

Pneumonia and Influenza Vaccinations (Adults)

The table below displays the percentage of adults who self-report that they received an influenza vaccine (either shot or sprayed in their nose) in the past year (at the time of the survey) or have ever received a pneumococcal vaccine. 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.

| TABLE 32 |

Area	+Percent of Medicare enrollees receiving an annual flu vaccine	^Ever Had a Pneumococcal Vaccination, ages 65+
Grafton County	48%	76%
Sullivan County	42%	73%
Orange County	44%	74%
Windsor County	46%	74%
Vermont	49%	73%
New Hampshire	51%	76%

^New England Rural Health Association, Rural Data Dashboard, 2020
+Data Source: Centers for Medicare & Medicaid Services via County Health Rankings, 2021

Substance Misuse

Substance misuse, involving alcohol, illicit drugs and misuse of prescription drugs, or combination of these behaviors, is associated with a complex range of negative health consequences – not just for individuals, but for families and communities. Detrimental effects range from physical health issues, both acute and chronic; mental health disorders such as depression, anxiety, and psychosis; addiction and dependence; destructive social conditions such as family dysfunction, lower prosperity, domestic violence, social isolation, and more; impaired cognitive functioning including memory, attention, and decision-making deficits; financial strain; and much more.

Alcohol

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking 15 or more drinks per week for men or eight drinks or more per week 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 where one occasion means within 2-3 hours), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Table 33 shows the percentage of adults who reported binge and heavy alcohol use. In 2022, Windsor County had a significantly lower estimate of adult binge drinking compared to the overall Vermont estimate. (Cells in gray indicate data are not available or are suppressed due to insufficient sample size).

| TABLE 33 |

Area	Binge Alcohol Use			Heavy Alcohol Use, All Adults
	All Adults	Adult females	Adult males	
Upper Valley Public Health Region	17%			
Orange County	14%			9%
Windsor County	**13%***			8%
Vermont	18%	14%	22%	10%
New Hampshire	17%	13%	21%	8%

Data Source: VDH and NH DHHS, Behavioral Risk Factor Surveillance System, 2022 (VT), 2023 (NH)

**Percent is significantly different and lower than the state statistic*

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth (with marijuana a close second in recent years). On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers.

The percentages of high school aged youth who self- report recent binge drinking is similar to the overall state rate, as is the percentage of high school students who feel it would be 'sort of easy' or 'very easy' to get alcohol. (Note: The NH statistics in the table below are for 'very easy' only.)

| TABLE 34 |

Area	High School Students		
	Currently Drink Alcohol (in past 30 days)	Reported Binge Drinking (in past 30 days)	Think it would be easy to get alcohol^
Upper Valley PHR	21%	12%	30%
Orange County	26%	12%	65%
Windsor County	24%	12%	69%
Vermont	27%	13%	66%
New Hampshire	23%	12%	29%

Data Source: Youth Behavior Risk Survey (YRBS), NH 2023, VT 2023

^Note: NH statistic is percent indicating "very easy" to get alcohol. VT statistic is percent indicating it would be "sort of easy" or "very easy".

Prescription Drugs & Opioids

Vermont and New Hampshire have been significantly affected by the nationwide prescription drug and opioid crisis, experiencing a surge in opioid-related addiction and overdose deaths. This crisis involves the misuse, addiction, and overdose of prescription opioids, as well as illicit opioids like heroin and fentanyl. Several factors have contributed to the crisis, including:

- *Over-prescription of Opioids*: 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.
- *Transition to Heroin and Fentanyl*: As prescription opioids became harder to obtain due to increased awareness of their addictive potential, individuals turned to illicit opioids like heroin. Moreover, the rise of synthetic opioids like fentanyl, which is much more potent than other opioids, has contributed to a spike in overdose deaths.
- *Insufficient Access to Treatment and Suppo*rt: Access to addiction treatment services, including medication-assisted treatment (MAT), counseling, and support programs, has not always been readily available to those who need it. This has made it difficult for individuals struggling with opioid addiction to receive the help they need.
- *Stigma and Misunderstanding*: Opioid addiction is often accompanied by stigma and misconceptions, deterring individuals from seeking help and contributing to an environment where people with addiction issues are not receiving the support they require.

Table 35 shows the percent of young adults in Windsor County who report misuse of any prescription drug in the past year including prescription pain relievers, sedatives, or stimulants. Data displayed for NH are estimates for adults who have ever taken prescription pain relievers and, among those respondents, the percentage who also reported having ever used a prescription pain medication more frequently or in higher doses than directed by their doctor.

| TABLE 35 |

Area	Misuse of any prescription drug in the past year, young adults (ages 18-25)	Ever taken prescription pain relievers, all adults	Ever used pain relievers in higher doses than prescribed, all adults (% of total ever prescribed pain relievers)
Upper Valley Public Health Region		**9%***	
New Hampshire		24%	2%
Orange County	11%		
Windsor County	9%		
Vermont	11%		

Data Sources: VDH, Vermont Young Adult Survey, 2022. NHDHHS, Behavioral Risk Factor Surveillance System, 2019

**Difference is statistically different and lower than the state rate*

According to recent results from the Youth Risk Behavior Survey (YRBS), between 7% and 10% of high school students in the DHMC-APD service area reported having ever taken a prescription drug without a doctor's prescription and in Windsor and Orange counties about 6% reported having done so at least once in the 30 days prior to the survey administration. About 7% of high school students reported having ever used inhalants (Table 37).

| TABLE 36 |

Area	High School Students	
	Ever took prescription drugs without a doctor's prescription	Took a prescription drug without a doctor's prescription, in past 30 days
Upper Valley Public Health Region	7%	2%
Orange County	9%	6%
Windsor County	10%	6%
Vermont	9%	5%
New Hampshire	9%	5%

Data Source: Youth Risk Behavior Survey, NH 2023, VT 2023

| TABLE 37 |

Area	High School Students			
	Used Cocaine in past 30 days	Ever Used Cocaine	Every Used Heroin	Ever Used Inhalants
Upper Valley Public Health Region	2%		1%	5%
Orange County		3%	2%	8%
Windsor County		3%	1%	7%
Vermont		3%	2%	7%
New Hampshire	3%		2%	7%

Data Source: Youth Risk Behavior Survey, NH 2023, VT 2021

Marijuana

Recent results from the 2023 YRBS indicate that about 1 in 5 students self report having used marijuana in the past 30 days prior to survey administration. About 1 in 8 high school age youth report having been offered, sold, or given an illegal drug on school property.

| TABLE 38 |

Area	High School Students		
	Currently use marijuana	Tried marijuana for the first time before age 13 years (NH), before age 11 (VT)	Were offered, sold, or given an illegal drug on school property*
Upper Valley Public Health Region	17%	2%	13%
Orange County	22%	2%	11%
Windsor County	21%	1%	14%
Vermont	22%	2%	12%
New Hampshire	20%	5%	20%

*Data Source: Youth Risk Behavior Survey, NH 2023, VT 2023, *2021*

Cigarette Smoking / Tobacco Use

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 who currently smoke cigarettes in the DHMC-APD service area is similar to the percentage in Vermont and New Hampshire (Table 39). The percentage of Orange and Windsor County high school students who reported smoking cigarettes in the past 30 days is also similar to high school age students across the Vermont overall (about 6%).

| TABLE 39 |

Area	Percent of High School Students Who Currently Smoke Cigarettes	Percent of Adult Population Who Currently Smokes Cigarettes
Upper Valley Public Health Region	5% (female students, male % not reported)	
Grafton County		11%
Sullivan County		11%
Orange County	6%	12%
Windsor County	7%	14%
Vermont	6%	13%
New Hampshire	4%	10%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023, VT 2022; Youth Risk Behavior Survey, NH 2023, VT 2023

As displayed by the Table 50, use of an electronic vapor product among high school age students is substantially more common than cigarette use across the region.

| TABLE 40 |

Area	Percent of High School Students Who Currently Use an Electronic Vapor Product
Upper Valley Public Health Region	11%
Orange County	16%
Windsor County	15%
Vermont	16%
New Hampshire	17%

Youth Risk Behavior Survey, NH 2023, VT 2023

Rural residents have historically had higher rates of smoking during pregnancy than their non-rural counterparts. For example, about 15% of females in the Greater Sullivan County Public Health Region who were pregnant between 2018 and 2022 reported smoking during pregnancy. In contrast, smoking during pregnancy in the Upper Valley region is substantially less prevalent (Table 41).

| TABLE 41 |

Area	Percent of Female Population that Reported Smoking During Pregnancy (all ages)
Upper Valley Public Health Region	5%
Vermont (Sub-state data nor reported)	10%
New Hampshire	6%

Data Sources: NH Vital Records Birth Certificate Data, 2019-2023; Vermont Pregnancy Risk Assessment Monitoring System Phase 8 Report, October 2024 (2022 data)

Smoking during pregnancy has a significant impact on preterm birth and other birth outcomes. The table indicates the percent of preterm births (NH) or low birthweight (VT) associated with smoking during pregnancy.

| TABLE 42 |

Area	Percent of births associated with smoking during pregnancy that were preterm	Percent of births associated with smoking during pregnancy that were low birthweight
Upper Valley Public Health Region	16.0%	
Vermont (Sub-state data nor reported)		15.1%
New Hampshire	13.4%	

Data Source: NH Vital Records Birth Certificate Data, 2019-2023; Vermont Vital Records, 2021

Prenatal Care

Prenatal care is health care and guidance provided to pregnant individuals before the birth of their baby. It plays a crucial role in ensuring the health and well-being of both the pregnant person and the baby. Prenatal care is essential for a variety of reasons, including monitoring fetal development, providing nutritional and exercise guidance, screening for complications, providing emotional and mental health support as well as educational support, and reducing maternal and infant mortality. Regular medical check-ups, screenings, and guidance from healthcare professionals contribute to a healthier pregnancy, a smoother childbirth experience, and better long-term outcomes for both the mother and the baby.

Table 43 shows the percentage of females who have given birth who received no or late prenatal care. Late prenatal care refers to the initiation of prenatal medical care after the second trimester. Over the five year period from 2017 to 2021, the percent of births to females in the Upper Valley Public Health Region who received no or late prenatal care (0.9%) was the lowest percentage among all 13 Public Health Regions in New Hampshire.

| TABLE 43 |

Area	Percent of Female Population that Received No or Late Prenatal Care
Upper Valley Public Health Region	0.9%
Orange County	1.7%
Windsor County	5.4%
Vermont	3.0%
New Hampshire	3.5%

Data Sources: VDH, Vermont Vital Statistics Annual Report, 2022.
NHDHHS, Office of Rural Health and Primary Care, 2017-2021

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

This indicator reports the percentage of newborns considered to have a low birthweight (<2,500g or about 5.5 pounds) born by pregnant women enrolled in the WIC program. For some infants, a low weight at birth can contribute to complications for healthy development.

| TABLE 44 |

Area	Full term low birthweight among WIC enrolled pregnant women	Low and Very Low Birthweight among WIC enrolled pregnant women, all births
Grafton County	7.1%	12.8%
Sullivan County	8.8%	11.8%
White River Jct. Health District		13.4%
Vermont		9.4%
New Hampshire	6.4%	9.3%

Data Sources: NH Pregnancy Nutrition Surveillance System (PNSS), 2022
VDH, Weight Status Among Infants and Children in WIC, 2022 (2017-2018 data).

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 significantly lower than the overall NH state rate.

| TABLE 45|

Area	Teen Birth Rate (per 1,000 female teens)		
	Total (ages 15-19)	Ages 15-17	Ages 18-19
Upper Valley Public Health Region	**2.1***	**0.0***	**3.5***
White River Jct. Health District	10.7	1.2	**7.6**
Vermont	5.8	2.4	9.5
New Hampshire	5.7	1.8	10.7

Data Source: NH Vital Records Birth Certificate Data, 2019 – 2023. VDH, Vermont Maternal and Infant Health Annual Surveillance Report, 2024 (2022 data).

**Rate is significantly different and lower than the state rate.*

Child Safety

Measures of child safety or child abuse and neglect in a community include the rate of child maltreatment victims substantiated by state child protection agencies, as well as the rate of children in temporary, out of home placement. As displayed by the table below, the rates of child maltreatment, both screened-in* and substantiated were higher in Sullivan County than across NH overall in 2020.

| TABLE 46 |

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Screened-in reports of child maltreatment, rate per 1,000 children under age 18
Grafton County	5.5	65.6
Sullivan County	6.5	124.9
Vermont (Sub-state data nor reported)	5.9	33.0
New Hampshire	4.7	63.0

Data source: Annie E. Casey Foundation, Kids Count Data Center, VT, 2022 data, NH 2020 data

*Screened-in refers to the number of children who had an abuse or neglect case opened for review by child protection agencies, whereas substantiated refers to the number of confirmed victims of child maltreatment.

Sullivan County also has a greater rate of children ages 0 to 17 who have entered foster care over the course of one year when compared to NH overall and similar to the Vermont state rate.

| TABLE 47 |

Area	Foster Care Entries, rate per 1,000 children
Grafton County	2.9
Sullivan County	5.7
Vermont (Sub-state data nor reported)	5.0
New Hampshire	2.7

Data source: Annie E. Casey Foundation, Kids Count Data Center, VT, 2021 data, NH 2020 data

Childhood Blood Lead Level Testing

Lead is a toxic metal that can have severe and long-lasting effects on children's health and development. Lead can interfere with the growth and development of certain organs, including the brain and nervous system. Lead exposure can also have significant negative effects on neurological and cognitive development. Even low levels of lead exposure have been associated with learning disabilities, attention deficits, and behavioral problems. Early detection and intervention are essential to minimize the potential for long-term cognitive and developmental impairments. Efforts to reduce lead exposure and prevent elevated blood lead levels include measures such as identifying and remediating lead hazards in the environment, promoting lead-safe practices, improving nutrition to mitigate lead's effects, and advocating for the removal of lead from consumer products and infrastructure.

Vermont and New Hampshire are universal pediatric blood lead level testing states, requiring all children, with parental consent, to have a blood lead level (BLL) test at age one, and a second test at age two. The 'action level' is a blood lead level of 5 micrograms per deciliter (µg/dL) for a child 72 months and younger. When a child has a blood lead level of 5µg/dL or higher, this triggers nurse case management and an environmental investigation. In 2021, the Centers for Disease Control established a screening reference level for blood lead in young children at 3.5 µg/dL.

In 2023, about one in three children in each state under 6 years of age had been tested for elevated BLL. Of the children tested in the Upper Valley Public Health Region, 34 children (4.9%) had BLL of 3.5µg/dL or higher and 1.4% had EBLL of 5µg/dL or higher. These percentages are similar to the overall NH state percentages.

| TABLE 48 |

Area	Percent Tested, Ages 0 to 72 months old	% EBLL 3.5µg/dL or higher	% EBLL 5µg/dL or higher
Upper Valley Public Health Region	32%	4.9%	1.4%
Vermont (Sub-state data nor reported)	30%	4.5%	2.6%
New Hampshire	27%	5.4%	1.8%

Sources: NH DHHS, Division of Public Health Services, Healthy Homes & Lead Poisoning Prevention Program, 2023; VDH, Lead Poisoning Prevention: Report on 2023 Program Outcomes and Activities,

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.

Overweight and Obesity

Being overweight or obese can have a significant impact on an individual's health, and lead to a wide range of physical and psychological complications such as cardiovascular conditions (heart disease, hypertension/high blood pressure, stroke, etc.), diabetes, mental health issues, joint issues, or respiratory problems.

The tables below report the percentage of adults and high school students who self-report characteristics of age, sex, height, and weight that are indicative of obesity. Overweight in adults is defined as Body Mass Index (BMI) between 25.0 and 29.9 kg/m² and obesity is defined as BMI >=30.0 kg/m². For people under the age of 19, obesity is defined as body mass index at or above the 95th percentile on standardized growth charts for age and sex.

About two-thirds of all adults in the region and across the states are considered overweight or obese. Among high school students, a higher percentage of males than females are considered obese in the Upper Valley Public Health Region.

| TABLE 49 |

Area	Percent of adults who are obese	Percent of adults who are overweight
Upper Valley Public Health Region	24%	41%
Windsor County	31%	34%
Orange County	25%	35%
Vermont	27%	35%
New Hampshire	33%	36%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023, VT 2022

| TABLE 50 |

Area	High School Students Considered Obese	Female High School Students	Male High School Students
Upper Valley Public Health Region	10%	8%	12%
Orange County	19%	19%	19%
Windsor County	13%	10%	16%
Vermont	14%	15%	14%
New Hampshire	13%	10%	15%

Data Source: NH DHHS Health Data Portal, 2023 & NH Youth Behavior Risk Survey, 2023, VT YRBS, 2023

***Rate is significantly different and higher than the state rate.*

Heart Disease and Stroke

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

Heart Disease Risk Factors: Awareness of heart disease risk factors includes periodic screening for hypertension and high blood cholesterol. Nearly 1 in 3 adults in the region self-report that they have been told by a doctor that they have high blood pressure and a large majority of adults have been screened for blood cholesterol level within the past 5 years.

| TABLE 51 |

Area	Percent of adults told by a health professional they have high blood pressure	Percent of adults who had their blood cholesterol checked within the past 5 years
Upper Valley Public Health Region	32%	83%
Orange County	34%	81%
Windsor County	34%	80%
Vermont	32%	80%
New Hampshire	33%	90%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023, VT 2022 (HBP), 2021 (Chol)

Table 52 displays the rate of hospitalizations for congestive heart failure – often a consequence and end stage of various heart diseases. Congestive heart failure (CHF) is a leading principal diagnosis for Medicare hospital claims. Approximately 75% of persons with CHF have antecedent hypertension.

The rates of hospital inpatient discharges for acute myocardial infarction (commonly called a heart attack) were significantly lower in the Upper Valley Public Health Region compared to the rest of New Hampshire over the period 2017 to 2021.

| TABLE 52 |

Area	Cardiovascular Disease-Related Hospital Discharges (primary diagnosis) rate per 100,000	CHF hospitalizations (inpatient) age-adjusted rate per 100,000	Heart attack hospitalizations (inpatient) age-adjusted per 100,000
Upper Valley Public Health Region		2.6	**130.0***
Vermont (Sub-state data nor reported)	528		
New Hampshire		3.6	141.7

Data Source: NH Hospital Discharge Data Set for NH Residents, 2017 to 2021
Vermont Uniform Hospital Discharge Data Set (VUHDDS), 2023 report (2019 data)
**Rate is significantly different and lower than the state rate.*

Heart Disease and Stroke Mortality: Heart disease is the leading cause of mortality in Vermont and New Hampshire. 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. Heart disease is the second leading cause of mortality in the Upper Valley Public Health Region, occurring at a rate that is significantly lower than the overall NH state rate.

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.

| TABLE 53 |

Area	Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Upper Valley Public Health Region	**115.1***	29.8
Orange County	165.1	30.6
Windsor County	151.7	34.6
Vermont	160.3	29.0
New Hampshire	148.5	30.1

Data Source: NH Hospital Discharge Data Set for NH Residents, 2019 to 2023.
VT data from National Institute on Minority Health and Health Disparities, HDPulse, 2018 to 2022
**Rate is significantly different and lower than the state rate.*

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, physical activity 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. The proportion of people with a diabetes diagnosis increases substantially with age. The estimated prevalence of diabetes among adults in the service area is similar to the Vermont state rate and lower than overall NH rate where nearly 10% of adults report being diagnosed with diabetes.

| TABLE 54 |

Area	Percent of Adults Diagnosed with Diabetes
Upper Valley Public Health Region	7.4%
Orange County	7.3%
Windsor County	7.1%
Vermont	7.0%
New Hampshire	9.8%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023;
VT data from United States Diabetes Surveillance System, CDC, 2021 (county) 2022 (state)

Diabetes-Related Hospitalization: Complications of diabetes such as cardiovascular disease, kidney failure, amputations, and ketoacidosis frequently require hospitalization. The table below shows the age-adjusted rates of inpatient hospitalizations between 2017 and 2021 for diabetes-related conditions. The rate of diabetes-related hospitalizations in the Upper Valley Public Health Region is significantly lower than the overall rate across New Hampshire.

| TABLE 55 |

Area	Diabetes-Related Hospital Discharges; age adjusted rate per 100,000
Upper Valley Public Health Region	**980***
Vermont (Sub-state data nor reported)	1,577
New Hampshire	1,428

Data Sources: NH Uniform Healthcare Facility Discharge Dataset, 2017-2021;
Vermont Uniform Hospital Discharge Data Set (VUHDDS), 2019
**Rate is significantly different and lower than the state rate.*

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus in the service area has been somewhat lower in recent years compared to overall state rates although the observed differences are not statistically significant.

| TABLE 56 |

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Upper Valley Public Health Region	15.6
Orange County	14.9
Windsor County	14.9
Vermont	17.3
New Hampshire	20.0

Data Source: NH Hospital Discharge Data Set for NH Residents, 2019 to 2023. VT data from National Institute on Minority Health and Health Disparities, HDPulse, 2018 to 2022

Cancer

Cancer is the second leading cause of death in Vermont and New Hampshire overall. Although not all cancers can be prevented, risk factors for some cancers can be reduced. It is estimated that about 42% of cancer cases and 45% of cancer deaths in the U.S. are linked to modifiable risk factors.[4] These risk factors and health behaviors include tobacco use and secondhand smoke, body weight, alcohol consumption, a lack of physical activity, and poor nutrition. Cigarette smoking ranks as the highest risk factor, contributing to 19% of all cancer cases in the U.S. and nearly 29% of cancer deaths.

Cancer Screening: Table 57 displays screening rates for several of the most common forms of cancer including colorectal cancer, breast cancer, cervical cancer and prostate cancer.

| TABLE 57 |

Cancer Screening Type	Orange County	Windsor County	Vermont	Upper Valley PHR	New Hampshire
Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2022)	75%	75%	76%	73%	67%
Females ages 50-74 who had a Mammogram in the past 2 years (2022)	72%	69%	76%	71%	81%
Females ages 21-65 who have had a pap test in the past 3 years (2020)+			75%		78%
Males age 40+ who had a PSA test in the past 2 years (2020)+			25%		31%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2022, VT 2022; +CDC, 2020

[4] Proportion and Number of Cancer Cases and Deaths Attributable to Potentially Modifiable Risk Factors in the United States; Farhad Islami et al. CA Can J Clin DOI, Jan;68(1):31-54.

Cancer Incidence: The table below shows cancer incidence rates for the cancer types that account for the majority of new cancer cases (incidence). Compared to NH statewide rates, the lung cancer incidence rate in the Upper Valley Public Health Region is significantly lower while the rate of melanoma is significantly higher.

| TABLE 58 |

Cancer Incidence by Type per 100,000 people, age adjusted rate					
Cancer Type	**Orange County**	**Windsor County**	**Vermont**	**Upper Valley PHR**	**New Hampshire**
Overall cancer incidence (All Invasive Cancers)			454.7	449.3	458.9
Cancer Incidence by Type					
Tobacco-associated	169.5	182.9	179.7		
Obesity-associated	144.3	176.0	165.9		
Alcohol-associated	**103.9***	134.6	127.7		
Ultraviolet-Associated	42.3	38.9	36.6		
Physical Inactivity-Associated	**70.5***	98.6	91.4		
Human papillomavirus-Associated	9.2	10.3	11.8		
Breast (Female)			131.8	146.0	138.9
Prostate (male)			110.2	111.6	116.9
Lung and Bronchus			56.2	**44.9***	59.2
Melanoma of Skin			36.6	**43.7 ****	29.9
Colorectal			33.2	32.7	34.2
Uterus (female)			32.6	26.0	29.6
Bladder			23.0	25.3	26.0
Non-Hodgkin Lymphoma			18.6	20.5	20.0
Thyroid			14.0	14.7	13.2
Kidney and Renal Pelvis			16.2	**11.2***	17.1
Leukemia			12.7	13.4	13.7
Pancreas			12.7	13.1	13.6
Oral Cavity and Pharynx			12.6	12.4	12.6

Data Source: NH State Cancer Registry, 2017-2021; VT State Cancer Registry, 2016-2020

**Rate is significantly different and lower than the state rate*

***Rate is significantly different and higher than the state rate*

Cancer Mortality: The table below shows the overall cancer mortality rate and the cancer mortality rate for types that account for the majority of cancer deaths. The overall mortality rate from all cancers has decreased steadily over the past several decades. For example, the rate of all cancer deaths in NH has decreased from about 195 per 100,000 people in 2001 to a rate of about 141 per 100,000 in 2023.

Compared to NH statewide rates, the cancer mortality rate in the Upper Valley Public Health Region is significantly lower overall and specifically lower for the mortality rate due to lung cancer.

| TABLE 59 |

Cancer Mortality per 100,000 people, age adjusted					
Cancer Type	**Orange County**	**Windsor County**	**Vermont**	**Upper Valley PHR**	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	139.1	140.7	154.8	**125.3***	144.3
Cancer Mortality by Type					
Lung and bronchus			34.0	**21.2***	31.5
Prostate (male)			21.9	15.3	19.3
Breast (female)			17.1	16.1	17.8
Colorectal			13.3	13.1	10.8
Pancreas			11.6	12.6	11.6
Liver and Intrahepatic Bile Duct			6.0	5.9	5.4
Uterus			6.8	4.8	5.0
Ovary			6.1	4.6	6.1
Non-Hodgkin's Lymphoma			5.2	4.6	4.9

Data Source: NH State Cancer Registry, 2019 – 2023; VT State Cancer Registry, 2017-2021; Windsor County data from National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022

**Rate is significantly different and lower than the state rate.*

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. In 2023, about 10% of adults responding to the Behavioral Risk Factor Survey from the Upper Valley Public Health Region reported they currently have asthma.

| TABLE 60 |

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Upper Valley Public Health Region		10%
Orange County		11%
Windsor County	*8%*	12%
Vermont	7%	13%
New Hampshire	10%	12%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2023; VDH, Adult: 2021 and 2022, Child: 2019-2021

Asthma-Related Hospitalizations: The table below displays rates of emergency department visits and inpatient hospitalizations for complications of asthma. The most recently available rates of both emergency department visits and inpatient hospitalizations for asthma-related diagnoses are substantially higher in Windsor County compared to the Vermont state rate, while the rates are lower in the Upper Valley Public Health Region compared to New Hampshire overall.

| TABLE 61 |

Area	Asthma Emergency Department Visits, age adjusted rate per 100,000	Asthma Inpatient Hospitalizations age adjusted rate per 100,000
Upper Valley Public Health Region	**205***	**15***
Orange County	164	**72****
Windsor County	**241****	**146****
Vermont	171	17
New Hampshire	291	28

NH Uniform Healthcare Facility Discharge Dataset, 2017-2021; Vermont Department of Health, VUHDDS 2020

**Rate is significantly different and lower than the state rate.*

***Rate is significantly different and higher than the state rate.*

Intentional and Unintentional Injury

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

Unintentional Injury Deaths: Injuries can happen when a place is unsafe or when people engage in unsafe behaviors. Injuries may be intentional or unintentional. Intentional injuries are usually related to violence caused by oneself or by another. Unintentional injuries are accidental in nature.

The table below reports the total unintentional injury mortality rate, which is the number of deaths that result from accidental injuries per 100,000 people. This measure includes injuries from causes such as motor vehicle accidents, falls, drowning and unintentional drug overdose. The rate of unintentional injury mortality over the period 2019 to 2023 was lower in the Upper Valley Public Health Region than in NH overall. In contrast, the unintentional injury mortality rate in Windsor County was significantly higher than in VT overall (2018-2022).

| TABLE 62 |

Area	Unintentional (accidental) Injury Mortality, all causes Age adjusted rate per 100,000
Upper Valley Public Health Region	**37.7***
Orange County	68.8
Windsor County	**84.6****
Vermont	68.5
New Hampshire	60.2

Data Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom 2019-2023 Vermont data from National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022

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

***Regional rate is significantly different and higher than the state rate*

Older Adult Falls: About one third of adults aged 65 years or older report falling at least once over the past 12 months. Nearly 40% of falls among older adults result in a need for medical treatment or restricted activity. Many conditions contributing to falls can be prevented such as addressing home hazards, balance and strength training exercise, vision correction and appropriate medication management. The next table displays statistics for the percent of residents aged 65 years and older who self-report having experienced a fall in the past 12 months and the rate of fall-related ED visits. The rate of ED visits by older adults for fall-related causes was lower in the Upper Valley Public Health Region than in NH overall over the 5 year period from 2017 to 2021.

| TABLE 63 |

Area	Percent of people age 65+ who report having experienced a fall in the past 12 months	Fall-related ED visits per 100.000 people (NH rate is for age 65 and older; VT rate is all ages)
Upper Valley Public Health Region	32%	**5,248***
Vermont (Sub-state data nor reported)	35%	3,532
New Hampshire	27%	6,881

Data Sources: NH Behavioral Risk Factor Surveillance System, 2023. NH Hospital Discharge Data Set for NH Residents, 2017-2021; VDH, Injury and Violence Report, 2018 (2014 data)

**Rate is significantly different and lower than the state rate.*

Opioid Use-related Emergency Department Visits, Hospitalization: The table below displays rates of hospitalization due to accidental overdose from opioid use. Opioid misuse includes prescription opioid pain relievers, heroin, and synthetic opioids such as fentanyl. The Upper Valley Public Health Region experienced a significantly lower rate of emergency department visits and hospitalizations due to accidental opioid overdose compared to the NH overall during the 5 year period from 2017 to 2021.

| TABLE 66 |

Area	Non-fatal opioid overdose ED visits per 10,000 ED visits	Opioid Overdose ED visits; Age-adjusted rate per 100,000 population	Opioid Overdose Hospitalizations (inpatient) age-adjusted per 100,000 population
Upper Valley Public Health Region		**41.2***	**12.4***
Orange County	10.2		
Windsor County	17.5		
Vermont	16.7		
New Hampshire		135.6	24.0

Data Source: NH Hospital Discharge Data Set for NH Residents, 2017-2021; VDH *Opioid Overdose Dashboard, 2024 data*

**Rate is significantly different and lower than the state rate.*

Drug Overdose Mortality: Over 90% of all accidental and undetermined drug overdose deaths involve opioids. The table below displays the rate of opioid overdose mortality in recent years. Over the 5 year period from 2019 to 2023, the rate of opioid overdose deaths in the Upper Valley Public Health Region was significantly lower than the overall NH rate. In contrast, opioid overdose

mortality in Orange and Windsor counties was more similar to the overall rate in Vermont (2023 data).

The table also displays the rate of alcohol-related overdose deaths in NH over the same time frame (defined as ICD-10 codes: X45, Y15, T51.0, T51.1, T51.9 (alcohol poisoning), X65 (suicide by and exposure to alcohol), and R78.0 (excessive blood level of alcohol) as the underlying cause.

| TABLE 65 |

Area	Opioid Overdose Deaths, age-adjusted per 100,000	Alcohol-related overdose deaths, age-adjusted per 100,000
Upper Valley Public Health Region	**13.5***	3.2
Orange County	33.5	
Windsor County	44.7	
Vermont	35.7	
New Hampshire	28.5	4.7

Data Source: NH Division of Vital Records Death Certificate Data, 2019 to 2023;
VDH Opioid-Related Fatal Overdoses Among Vermont Residents, 2023 Annual Data Brief
**Rate is significantly different and lower than the state rate.*

Self Harm-related Emergency Department Visits and Hospitalization: The next two tables display rates of emergency department (ED) visits for injury recorded as intentional, including self-intentional poisonings due to drugs, alcohol, or other toxic substances. The Vermont information (Table 68) is calculated as a rate per 10,000 ED visits. The NH information (Table 69) is calculated as a rate per 100,000 people. Table 69 also includes rates for inpatient hospitalizations by sex between 2017 and 2021. The rate of ED visits involving self-inflicted harm was significantly lower than the state rate over this period of time in the Upper Valley Public Health Region, while the inpatient hospitalization rate among females was significantly higher. Overall, rates of ED visits and hospitalizations related to self-harm are significantly higher among females than males in the region and across the state.

| TABLE 66 |

Area	Suicide-Related ED Visits, Rate per 10,000 ED Visits
Orange County	170.2
Windsor County	203.1
Vermont	249.9

Data Source: VDH, Annual Suicide Morbidity and Mortality Report, 2024 (2023 data)

| TABLE 67 |

Sex	Area	Suicide or self harm-related hospital visits (ED), age-adjusted rate per 100,000 people	Suicide or self harm-related hospitalizations (inpatient), age-adjusted rate per 100,000 people
Male	Upper Valley PHR	**97.4***	37.3
	New Hampshire	130.6	41.8
Female	Upper Valley PHR	211.3	**87.2****
	New Hampshire	241.2+	62.9+
All Sexes	Upper Valley PHR	**155.1***	62.5
	New Hampshire	184.8	52.2

Data Source: NH Hospital Discharge Data Set (HDDS) for NH Residents, 2017 to 2021;
**Rate is significantly different and lower than the state rate*
***Rate is significantly different and higher than the state rate*
+Female rate is significantly different and higher than male rate.

Suicide Mortality: 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 and other community supports. The suicide mortality rate is significantly higher for males than females in Vermont and New Hampshire.

| TABLE 68 |

Area	Suicide Mortality, age-adjusted rate per 100,000		
	Total	Female	Male++
Upper Valley Public Health Region	11.4	10.5	**12.7***
Orange County	20.1		
Windsor County	12.0		
Vermont	19.3	8.0	30.7
New Hampshire	16.1	6.4	25.9

Data Sources: NH Vital Records Death Certificate Data 2019 to 2023;
VDH, Annual Suicide Morbidity and Mortality Report, 2024 (2023 data);
Regional rate is significantly different and lower than the state rate.
++Rates among males are significantly different and higher than among females.

Infant Mortality

Infant mortality rate - the number of deaths of infants under the age of one year per 1,000 live births - is a significant indicator of the health and wellbeing of a population including maternal health, community nutrition and wellness, accessibility and quality of health care services, health inequalities and access to social support systems. Vermont and New Hampshire have historically had low infant mortality rates relative to the nation.

| TABLE 69 |

Area	Infant Mortality Rate per 1,000 Live Births
Upper Valley Public Health Region	3.3
Vermont (Sub-state data nor reported)	4.7
New Hampshire	3.7

Data Source: NH Vital Records Birth Certificate Data, 2018-2022; VDH, Vermont Vital Statistics Annual Report, 2022.

Leading Causes of Death

Diseases of the heart (e.g., congestive heart failure, coronary heart disease, heart attack) is the leading cause of death Vermont and New Hampshire and the second leading cause of death after cancer in the Upper Valley Public Health Region. in the over the five year period from 2018 to 2022. Accidents and unintentional injury are the third leading cause of death in the region and the state.

| TABLE 70. Leading Causes of Death |
(age-adjusted rate per 100,000)

Cause of Death	Orange County	Windsor County	Vermont	Upper Valley PHR	New Hampshire
Heart diseases	165.1	151.7	160.3	**115.1***	148.5
Malignant neoplasms	139.1	140.7	150.2	**125.3***	143.6
Accidents / Unintentional Injury	68.8	**84.6****	68.5	**37.7***	60.2
Cerebrovascular diseases	30.6	34.6	29.0	29.8	30.1
Alzheimer's disease	28.9	33.2	35.3	24.5	25.7
Chronic lower respiratory disease	33.7	28.3	34.6	**18.4***	36.2
COVID-19	NA	NA	25.2	**8.5***	28.8
Intentional self-harm (suicide)	24.2	23.9	17.8	10.9	15.6
Diabetes mellitus	14.9	14.9	17.3	15.6	20.0
Chronic liver disease	10.4	11.0	10.0	5.5	12.5
Parkinson's disease	NA	NA	10.9	8.3	10.7

Source: NH Vital Records Death Certificate Data, 2019 – 2023; Vermont data from National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022

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

***Regional rate is significantly different and higher than the state rate*

Life Expectancy at Birth

Life expectancy at birth is a commonly used measure of the overall health of people in a particular location or with demographic characteristics in common. The measure estimates an average number of years a person is expected to live and can be influenced by many factors including access to quality health care and public health services, economic development, as well as personal factors such as occupation and biological sex. Over the last century, life expectancy has increased substantially due to widespread improvements in sanitation and access to clean water, adequacy of food and nutrition, advances in prevention of infectious disease, and other advances in medicine and clinical care, particularly with respect to infant and maternal mortality. In the current age, women generally have a higher life expectancy than men.

| TABLE 71. Life Expectancy at Birth (years) and by Sex |

County	Life expectancy	Male	Female
Grafton	80.7	78.0	83.5
Sullivan	79.4	76.8	81.9
Orange County	79.6		
Windsor County	79.0		
New Hampshire	79.5	77.0	82.1
Vermont	79.2	76.1	81.4

Sources: NH Vital Records, death data, 2016 – 2020; National Center for Health Statistics, 2019 - 2021

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. Sullivan County had a higher rate of premature mortality than in New Hampshire overall during the period 2019 to 2021.

| TABLE 72 |

Area	Years of Potential Life Lost before age 75, age-adjusted rate per 100,000
Grafton County	6,291
Sullivan County	**8,048****
Orange County	6,607
Windsor County	7,654
New Hampshire	6,499
Vermont	6,693

Data source: National Center for Health Statistics via County Health Rankings; 2019-2021
***Rate is significantly different and higher than the state rate.*

Summary

The 2025 Community Health Needs Assessment provides a comprehensive overview of the health needs and priorities within the service area. Through analysis of community input from multiple methods and channels, and assembly of demographic data and health indicators, the assessment highlights key health challenges and priorities for health improvement. The report identifies high priority health issues such as health care availability and capacity challenges, cost of care concerns, behavioral health needs, and disparities in access to services. Additionally, the assessment includes information on broad drivers of health including socioeconomic factors that influence community well-being. This assessment will hopefully serve as a useful resource for planning program and service improvements, for guiding targeted interventions, and for strengthening collaborative partnerships to improve overall health and wellness in the communities served by Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire.

"The health and service support community is comprised of exceptionally trained, highly experienced and beautifully caring individuals. They show up hourly to support their neighbors, coworkers, friends, and family members. Recognizing their ongoing efforts regularly, regardless of surveys, reports, costs and efforts at efficiencies and more productivity, would go a long way to better health and wellness in our community."

- Community Leader / Advocacy

"We live in a very supportive community, it's welcoming and kind and a beautiful place to call home."

- Community Leader / Long term care