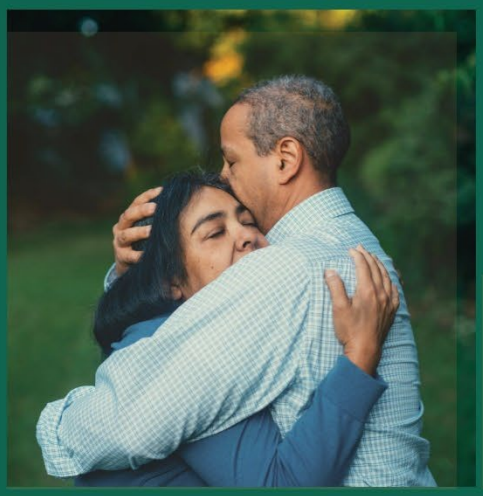
# Community Health Needs Assessment

2024



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

Dartmouth Health

Mt. Ascutney Hospital and Health Center

# Mt. Ascutney Hospital and Health Center

# Community Health Needs Assessment

# 2024

### Community Input on Health Issues and Priorities,

### Selected Service Area Demographics and Health Status Indicators

**Your input is valuable!**

Please share your comments and questions about our Community Health Needs Assessment and our Community Benefits Action Plan by contacting:

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(802) 674-7437

The 2024 Community Health Needs Assessment Partnership includes Mt. Ascutney Hospital and Health Center, Valley Regional Healthcare, New London Hospital, Dartmouth Health, Alice Peck Day Memorial Hospital, Cheshire Medical Center, Visiting Nurse and Hospice for Vermont and New Hampshire with technical support from the New Hampshire Community Health Institute/JSI.

Dartmouth Health
New London Hospital
Dartmouth Health
Visiting Nurse and Hospice for Vermont and New Hampshire
Dartmouth Health
Alice Peck Day Memorial Hospital
Dartmouth Health
Mt. Ascutney Hospital and Health Center
Dartmouth Health
Cheshire Medical Center
Valley Regional Healthcare

# Mt. Ascutney Hospital and Health Center

# 2024 Community Health Needs Assessment

## Executive Summary

During the period October 2023 through September 2024, an assessment of Community Health Needs was completed by Mt. Ascutney Hospital and Health Center in partnership with Dartmouth Health, Valley Regional Hospital, Alice Peck Day Memorial Hospital, New London Hospital, Cheshire Medical Center, Visiting Nurse and Hospice for Vermont 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 Mt. Ascutney Hospital and partner organizations.

For the purpose of the assessment, the geographic area of interest was 13 municipalities comprising the Mt. Ascutney Hospital and Health Center service area with a total resident population of 45,568 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 four community discussion groups convened across the region; and assembly of available population demographics and health status indicators including social drivers of health characteristics of the Mt. Ascutney service area.

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, and 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 25% 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 12% of adults in Windsor County report not having a primary care provider.<br>The Greater Sullivan Public Health region has the third highest percentage out of 13 NH regions for primary medical care visits with travel times greater than 30 minutes, one way (31%). | Issues related to health care provider availability including turnover, choice, wait time and responsiveness was the topic area with the most comments – about one third of 319 different 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 (27%). Among people who had difficulty accessing mental health care, top reasons cited were "Wait time too long" (66%), 'Not accepting new patients' (57%) and 'Service not available' (56%). From survey responses, 44% of community residents and 67% of community leaders think ability to get mental health services has gotten worse in the last few years. | The rate of Self Harm-related Emergency Department visits is significantly higher for residents of Sullivan County (219 visits per 100,000 population) compared to the state overall (183 visits per 100k).<br>In Windsor County, mortality rates from suicide (23.9 per 100,000 population) and opioid overdose (44.7 per 100k) are each 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, need for increased awareness and culturally competent providers. |
| **Cost of health care services including medications, affordability of health insurance** | About 65% of community resident and 58% community leader survey respondents indicated that the cost of health care and health insurance has 'gotten worse' over the last few years. Less than 5% thought this issue has 'gotten better'.<br>'Can't afford out of pocket expenses' was a top 3 barrier identified by community leaders and service providers preventing people from accessing the health care services they need. | The estimated proportion of people with no health insurance (6%) is higher than the overall percent uninsured in VT (4%) and similar to the percent in NH (6%).<br>About 6% of Windsor County residents reported delaying or avoiding health care because of cost. This proportion was substantially higher (15%) in the Greater Sullivan Public Health Region. | Community discussion participants identified health care costs and financial barriers to care as a significant issue. It was also the second most frequently mentioned topic area in the open-ended question about 'one thing you would change to improve health'<br>Obstacles include high cost of private pay insurance, misalignment of coverage and the types of insurance providers accept, and unreasonably high deductibles. |

| 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 (38% of community resident survey respondents).<br>Top reasons cited for access difficulty were 'Wait time too long' (50%), 'Not accepting new patients' (49%), and 'Cost too much' (44%). | More than 1 in 3 area residents report not having visited a dentist or dental clinic in the past year.<br>Sullivan County experiences significantly more hospital emergency department visits for non-traumatic dental conditions (1022 visits per 100,000 population) than in NH overall (636 per 100k). | 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 13% of community survey respondents indicated difficulty getting 'help caring for aging family members' with 'Service not available' cited as the top reason.<br>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 24% are 65+ compared to about 20% in VT and 19% in NH overall.<br>About 29% of the 65+ population in the VRH service area report having serious activity limitations resulting from one or more disability.<br>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. |
| **Social drivers of health and well-being such as affordable access to housing, healthy foods and affordable child care** | About 83% of community resident survey respondents said housing affordability has 'gotten worse' over the last few years.<br>After 'Help with Housing Needs', Child care was the next most frequent social / human service that respondents had difficulty getting (14%). 'Cost too much' was the top reason cited for access difficulty (74%).<br>Affordable Housing was by far the top issue selected by community leader respondents (85%) as a priority for improvement to support a healthy community. | Nearly 1 in 10 area residents experienced food insecurity in the past year.<br>More than 1 in 4 owner occupied housing units and over half of renters in the service area have housing costs >30% of household income.<br>A wide range in community wealth also characterizes the service area where median household income in the wealthiest communities is more than twice as high as 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. |

| 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** |
| **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.<br>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' (71%), 'Difficulty navigating the health care system' (57%) and 'Long wait times or limited office hours' (46%). | 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.<br>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. |

## Mt. Ascutney Hospital and Health Center

## 2024 Community Health Needs Assessment

## TABLE OF CONTENTS

**EXECUTIVE SUMMARY**

A. Community Overview with Selected Service Area Demographics 6
B. Community Input on Health Issues and Priorities 10
    1. Progress on Community Health Priorities and Concerns 12
    2. Characteristics of a Healthy Community 17
    3. Barriers to Services 19
    4. Services and Resources to Support a Healthy Community 26
    5. Interest in Specific Community Health Programs or Services 27
C. Community Health Discussion Themes and Priorities 31
    1. Overview 31
    2. Health Concerns and Priorities – Main Themes 32
    3. Perceived Improvements 39
    4. Loneliness and Social Isolation 41
D. Community Health Status Indicators 43
    1. Demographics and Social Drivers of Health 44
    2. Access to Care 50
    3. Health Promotion and Disease Prevention Practices 57
    4. Selected Health Outcomes 69
E. Summary 83

## A. Community Overview with Selected Service Area Demographics

The total resident population of the Mt. Ascutney Hospital and Health Center primary service area in 2022 was 45,568 people according to the United States Census Bureau (American Community Survey). The estimated service area population increased by 3.6% or about 1,600 people over the last 3 years. 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 proportionally more seniors - about 24% are 65+ compared to about 20% in each state overall – and the median age of service area residents is 4 years older than either state. A substantial range is observed for this statistic within the region from 18% of residents in Barnard aged 65+ to 30% of Pomfret and Windsor residents. A similar range is observed for the percentage of residents who are under 18 years of age from about 12% in Bridgewater to 25% in Barnard.

**| TABLE 1. Service Area Population by Municipality |**

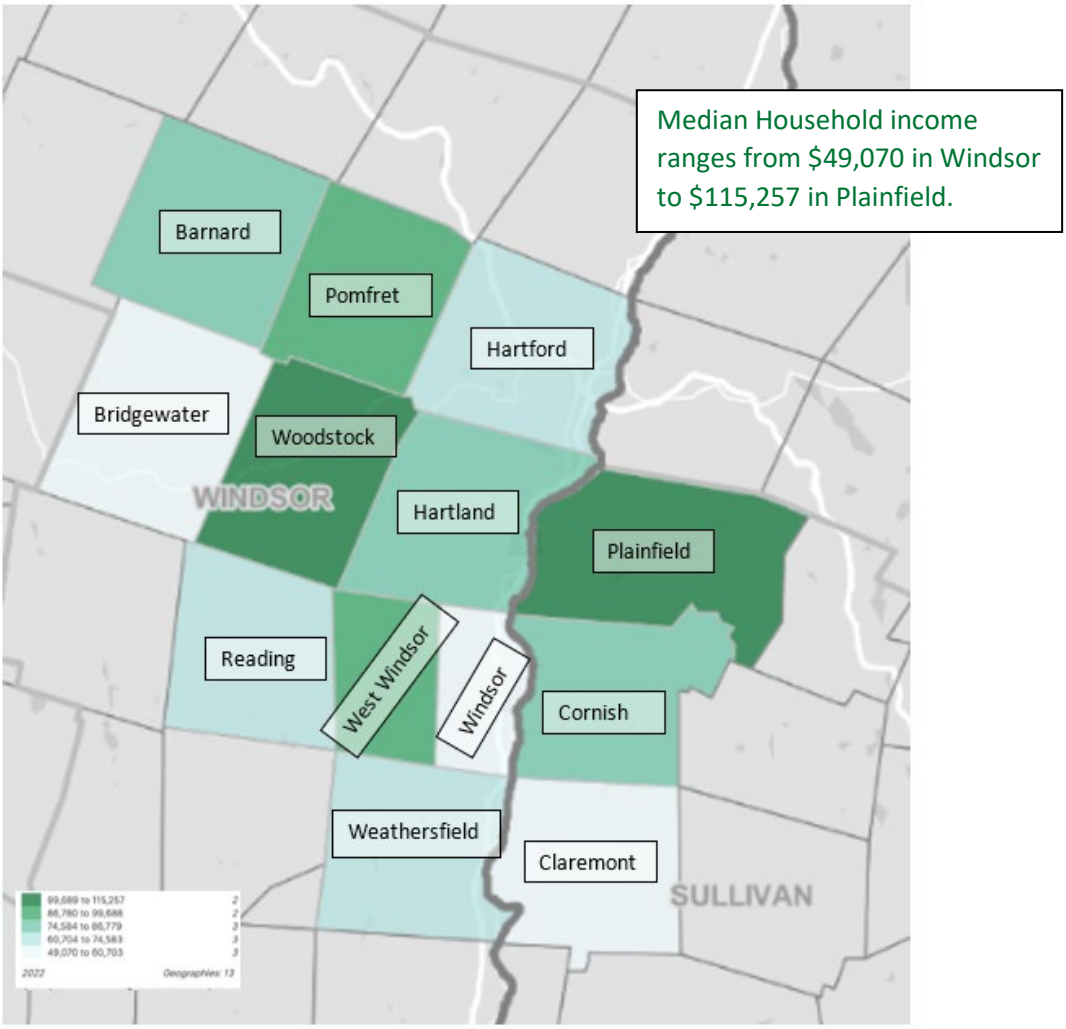
| Municipality (in alphabetical order) | 2022 Population Estimate | % of Service Area Population | Median age | % Under 18 years of age | % 65+ years of age |
|---|---|---|---|---|---|
| Barnard | 1,141 | 3% | 44 | 25% | 18% |
| Bridgewater | 926 | 2% | 58 | 12% | 23% |
| Claremont | 13,018 | 29% | 44 | 20% | 20% |
| Cornish | 1,914 | 4% | 54 | 15% | 29% |
| Hartford | 10,687 | 23% | 44 | 18% | 22% |
| Hartland | 3,452 | 8% | 51 | 21% | 24% |
| Plainfield | 2,478 | 5% | 40 | 22% | 21% |
| Pomfret | 854 | 2% | 57 | 14% | 30% |
| Reading | 628 | 1% | 49 | 17% | 26% |
| Weathersfield | 2,844 | 6% | 52 | 16% | 28% |
| West Windsor | 1,058 | 2% | 55 | 18% | 25% |
| Windsor | 3,548 | 8% | 44 | 19% | 30% |
| Woodstock | 3,020 | 7% | 56 | 18% | 29% |
| **Total MAHHC Service Area** | **45,568** | **100%** | **47** | **19%** | **24%** |
| Vermont | 643,816 | | 43 | 18% | 20% |
| New Hampshire | 1,379,610 | --- | 43 | 19% | 19% |

Table 2 displays additional demographic information for the towns of the Mt. Ascutney Hospital and Health Center primary service area. In general, the region has lower household income compared to New Hampshire overall - about $19,000 less - and is similar to Vermont statewide median household income. The percent of people living in poverty (about 10%) is also similar to the Vermont statewide statistic. The region also has a higher percentage of households with children headed by a single parent. Within the region there are substantial ranges on these measures. For example, the town with the highest median household income (Plainfield, $115,257) has median household income over twice as high as the lowest income community (Windsor, $49,070). Similarly, a substantial range is observed for the percent of people living below the federal poverty level (FPL) with an estimate of 3% in Barnard and West Windsor compared to about 16% of residents in Claremont. The map on the next page displays the distribution of median household income across towns in the service area.

**| TABLE 2. Selected Demographic and Economic Indicators |**

| 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 |
|---|---|---|---|---|
| Plainfield | $115,257 | 6% | 24% | 11% |
| Woodstock | $109,097 | 5% | 18% | 8% |
| West Windsor | $99,688 | 3% | 28% | 10% |
| Pomfret | $94,821 | 7% | 8% | 9% |
| New Hampshire | $90,845 | 7% | 27% | 13% |
| Cornish | $86,779 | 5% | 18% | 11% |
| Barnard | $83,750 | 3% | 15% | 8% |
| Hartland | $79,914 | 9% | 25% | 12% |
| Reading | $74,583 | 8% | 18% | 19% |
| Vermont | $74,014 | 10% | 32% | 14% |
| Weathersfield | $73,278 | 11% | 40% | 11% |
| **MAHHC Service Area** | **$71,303** | **10%** | **34%** | **15%** |
| Hartford | $69,138 | 9% | 21% | 16% |
| Bridgewater | $60,703 | 13% | 11% | 14% |
| Claremont | $53,697 | 16% | 62% | 18% |
| Windsor | $49,070 | 6% | 46% | 22% |

## Figure 1 – Median Household Income by Town, MAHHC Service Area




As displayed by the next table, 92% of the population of the Mt. Ascutney Hospital service area identifies as 'White' and about 2% identify as Hispanic ethnicity. In general, the service area is similar to 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 |
| **MAHHC service area** | 92.4% | 4.3% | 1.2% | 1.1% | 0.1% | <0.1% | 0.8% | 1.6% |
| **Vermont** | 92.3% | 4.0% | 1.7% | 1.2% | 0.2% | <0.1% | 0.6% | 2.1% |
| **New Hampshire** | 90.0% | 4.6% | 2.6% | 1.5% | 0.2% | <0.1% | 1.1% | 4.3% |

**Social Drivers of Health:** Household wealth and poverty are examples of Social Drivers of Health (SDOH; also referred to as Social Determinants of Health). Social Drivers of Health are conditions in the places where people live, learn, work, and play that can directly or indirectly affect risks and outcomes related to health and wellness. Examples of SDOH include: availability of quality healthcare; access to affordable, healthy food; educational performance and attainment; transportation; safe, quality housing; employment status and opportunities; public infrastructure; and other social, economic, and environmental factors. The World Health Organization (WHO) Commission on Social Determinants of Health has stated that progress on SDOH can be the most successful means of enhancing all people's well-being and addressing disparities in health outcomes. Further, numerous studies suggest that SDOH can account for between 30-55% of health outcomes.[1] Social drivers of health can be influenced by social and economic policies, as well as local community health improvement initiatives. As displayed by Table 4, SDOH can be categorized in six categories.

Because of the potential importance of SDOH in affecting community health outcomes and opportunities for improvement, the 2024 Community Health Needs Assessment included aspects of SDOH in the community survey content and community discussion group topics. Results of those assessment activities are shared beginning on the next page.

**| TABLE 4. Social Drivers of Health |**

| Economic Stability | Physical Location & Environment | Development & Education | Community, Safety & Social Context | Food | Health Care System |
|---|---|---|---|---|---|
| • Employment<br>• Income and Wealth<br>• Expenses and Debt<br>• Health insurance<br>• Financial safety net | • Housing affordability, quality<br>• Transportation<br>• Walkability<br>• Safety of built environment<br>• Parks, green space<br>• Recreation, leisure opportunities<br>• Clean air and water | • Literacy<br>• Language<br>• Early childhood development<br>• Strong families<br>• Vocational training<br>• Higher education | • Community engagement<br>• Community support systems, social capital<br>• Stress<br>• Exposure to violence, trauma<br>• Community safety, crime, justice<br>• Discrimination, stigma | • Food security<br>• Access to affordable, healthy food options | • Health professional and Pharmacy availability<br>• Access to culturally appropriate and respectful care<br>• Quality of care |

*Adapted from the Kaiser Family Foundation[2]*

[1] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

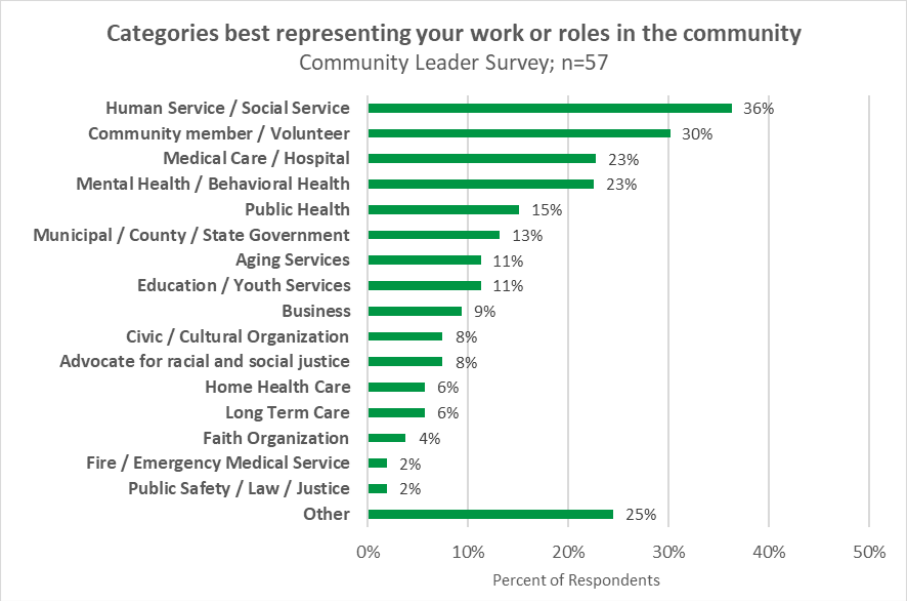
[2] Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, Kaiser Family Foundation Issue Brief, 2018.

## B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and August 2024, the Community Health Needs Assessment committee fielded two surveys; one with targeted distribution to community leaders and one broadly disseminated to residents across the region. The survey instruments were designed to have 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 area to the New London area and to the Upper Valley communities of New Hampshire and Vermont north of 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, 57 (28%) indicated being familiar with the Greater Windsor area. The results included in this assessment report from the community leader survey are specific to that group of 57 respondents. Figure 2 displays the range of community sectors represented by these individuals. (Note: Respondents could identify as representatives of more than one sector).

**| Figure 2 |**




The community resident survey was distributed electronically through email and social media communication channels, on the Mt. Ascutney Hospital website, 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.

A total of 568 community members completed the Community Resident Survey, representing all 13 towns of the Mt. Ascutney Hospital primary service area as well as a number of bordering communities. Table 5 displays the grouping of respondents by community. Among respondents who provided information on their current local residence, about 29% are residents of Windsor and about 11% are residents of Woodstock.

Among survey respondents who indicated their primary residential location, about 14% are located beyond the primary hospital service area with the most common locations being Springfield, VT (23 respondents), Charlestown (16) and Bellows Falls (5).

Compared to regional demographics overall, community survey respondents were proportionally more likely to be female and 65 years of age or more. Approximately 28% of respondents have household income of less than $50,000, while 24% reported household income of $100,000 or more. About 15% of respondents did not provide household income information. Table 6 below displays selected characteristics of respondents to the community survey.

**| TABLE 5 |**

| Town | # of respondents | % of total* |
|---|---|---|
| **Windsor** | 139 | 29% |
| **Woodstock** | 55 | 11% |
| **Hartland** | 46 | 9% |
| **Claremont** | 43 | 9% |
| **Weathersfield** | 27 | 6% |
| **Hartford** | 23 | 5% |
| **Reading** | 20 | 4% |
| **Cornish** | 20 | 4% |
| **West Windsor** | 17 | 3% |
| **Plainfield** | 13 | 3% |
| **Pomfret** | 8 | 2% |
| **Bridgewater** | 5 | 1% |
| **Barnard** | 4 | 1% |
| **Other Locations** | 67 | 14% |

*Percent of respondents who provided information on the location of their residence. About 14% of respondents did not provide this information.

**| TABLE 6 |**

| Age < 45 years | Age >= 65 years | Woman | Black, Indigenous and People of Color |
|---|---|---|---|
| 14% | 52% | 72% | 3% |
| **Household Income < $50K** | **Household Income > $100K** | **Currently Uninsured** | **Currently has Medicaid coverage** |
| 28% | 24% | 1% | 9% |

## 1. Progress on Community Health Priorities and Concerns

Assessments of community health needs are conducted every three years by Mt. Ascutney Hospital 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 2024 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 3 on the next page displays the results for this question set from respondents to the community resident survey. Ability to get rides to health care and other services was reported to be "Better" by 24% of respondents, which was the highest percentage for any of the areas of need listed. Ability for older adults to get help and support to age in place was reported as 'better' by about 13% of respondents; and ability to get specialty medical services was reported as 'better' by a similar percent of respondents.

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

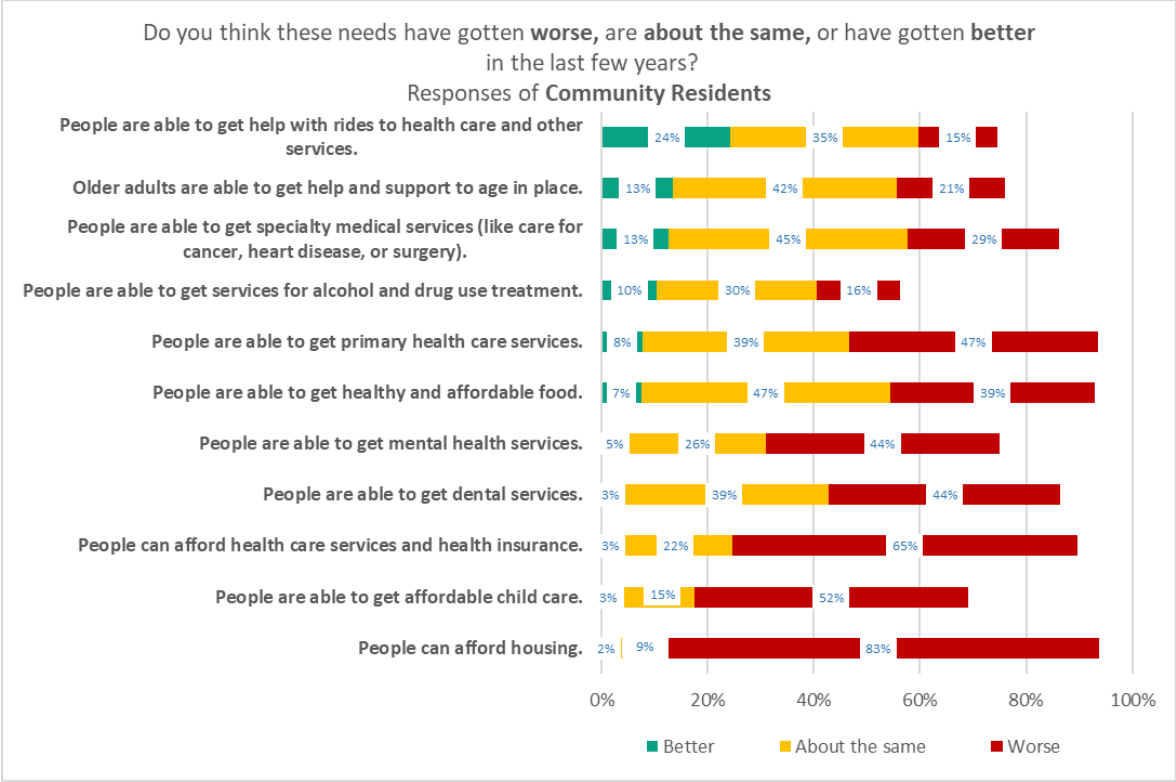
*"Finding affordable housing and childcare are the biggest struggle I see for community members. That should be the top focus."*

*- Community Resident Survey Respondent*

*"The single most important need is affordable health care with providers who are able to give the time needed to each patient so they can really know their patients and not treat them like statistics.*

*- Community Resident Survey Respondent*

**| Figure 3 |**



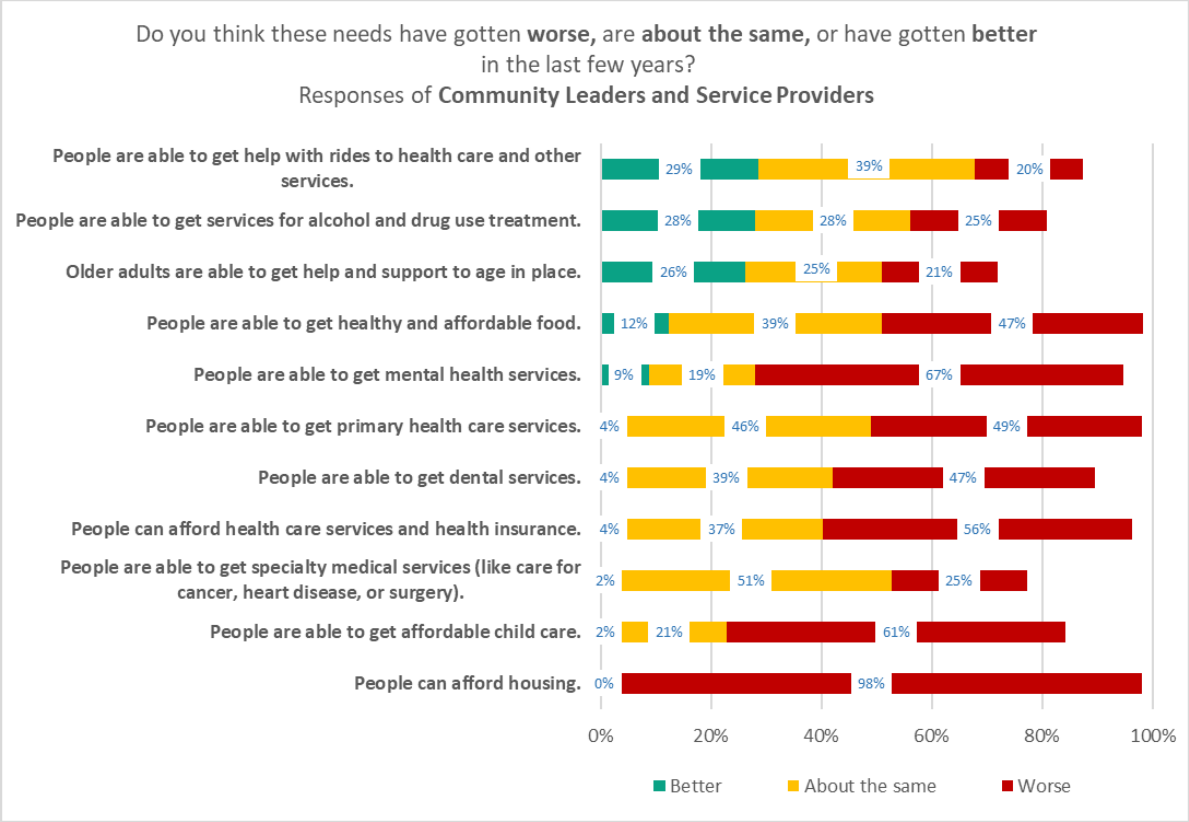

Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the need is Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

Figure 4 on the next page 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. Areas where community leaders were most likely to indicate that needs have gotten better are ability to get rides to health care and other services (29%, said this is Better), ability to get substance use treatment (28%, Better) and ability of older adults to get help and support to age in place (26%, Better).

> *"(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 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 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 5) and the percentage who report needs have gotten worse (Figure 6). 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 care). Community leaders were somewhat more likely to report that the ability to get substance use treatment has improved while community residents were somewhat more likely to indicate that access to sub-specialty medical services has improved.

*"Services are increasingly unaffordable - so even if people can get access to appointments and get there, they can't necessarily afford them."*

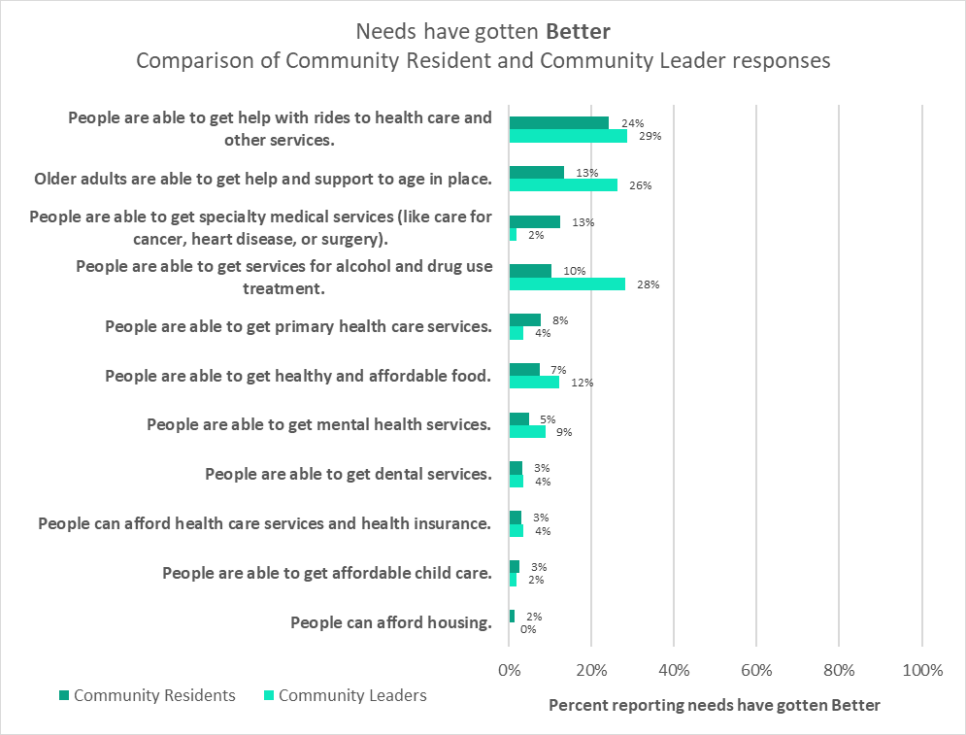
*- Community Leader, Human Service*

*"We need more access to mental health care, especially for youth and young adults. This is a crisis situation.*

*- Community Resident Survey Respondent*

## | Figure 5 |

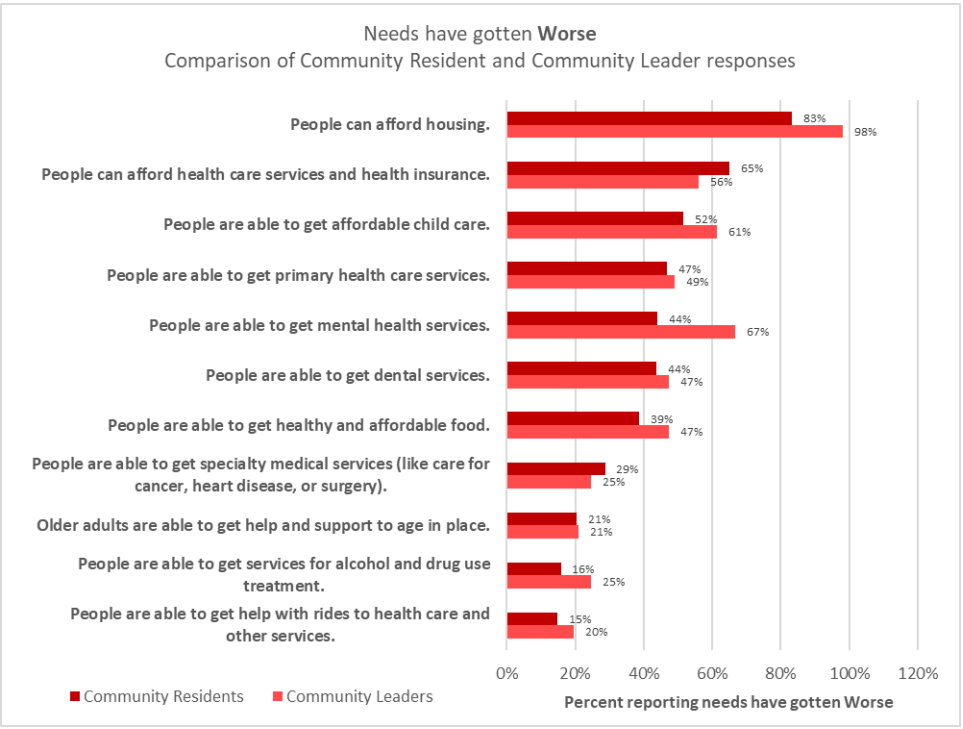
Note: Statements are shown in order of highest to lowest percentage of community resident respondents indicating the needs are Better.




## | Figure 6 |

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 215 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 40% of all comments addressed this area of concern);
2. Cost of living and basic needs including affordable housing;
3. Affordability of health care and prescription medications;
4. Availability of mental health care; addiction treatment and recovery services;
5. Senior services and concerns of aging;
6. Opportunities and facilities for social interaction; reducing social isolation;
7. Promoting healthy lifestyles, focus on wellness, nutrition and exercise;


8. Crime, safety, illicit drug use concerns;
9. Services and supports for children, youth and families;
10. Availability of Dental Care; and
11. Improved access to transportation services.

*"Being able to get in to see a doctor in a timely manner, especially a specialist, has become a nightmare. Also, many doctors are not taking 'new' patients, so it leaves some folks floundering for help that they could/should be receiving.*
*- Community Resident Survey Respondent*

*"I think most types of health providers have long wait lists but addressing the Primary Care need is probably most critical right now."*
*- Community Leader, Medical care 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 7 displays the results for this set of questions. Community residents overall were most likely to agree that 'in my community':

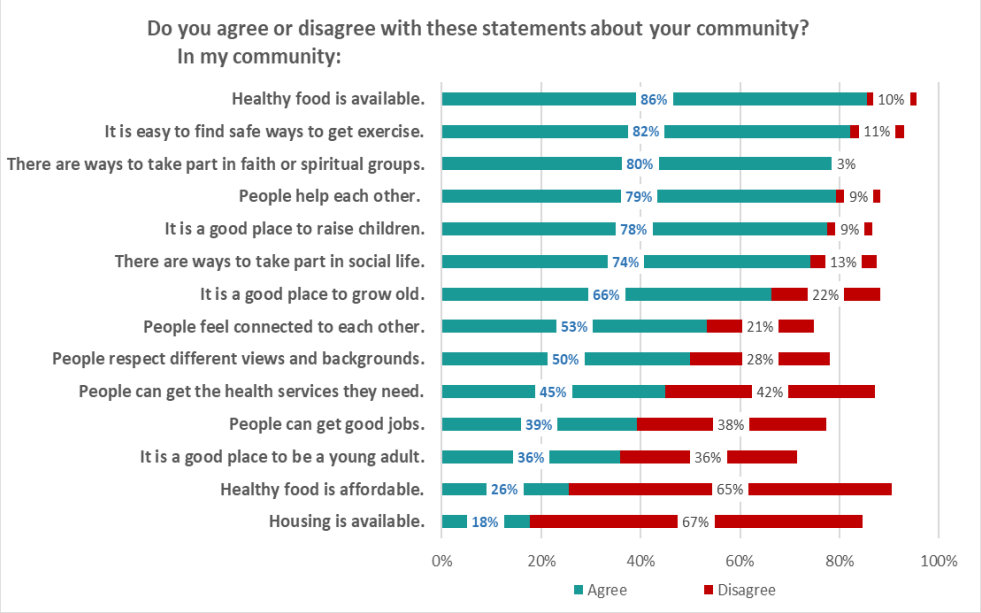
- Healthy food is available. (86% of survey respondents agree)
- It is easy to find safe ways to get exercise. (82%)
- There are ways to take part in faith or spiritual groups. (80%)
- People help each other. (79%)
- It is a good place to raise children. (78%)

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

- It is a good place to be a young adult. (36% agree)
- Healthy food is affordable. (26%)
- Housing is available. (18%)

**| Figure 7 |**

Regarding access to health services, responses were mixed with 45% agreeing with the statement "People can get the health services they need" and 42% disagreeing with the statement (13% responded 'Don't know; Not sure).

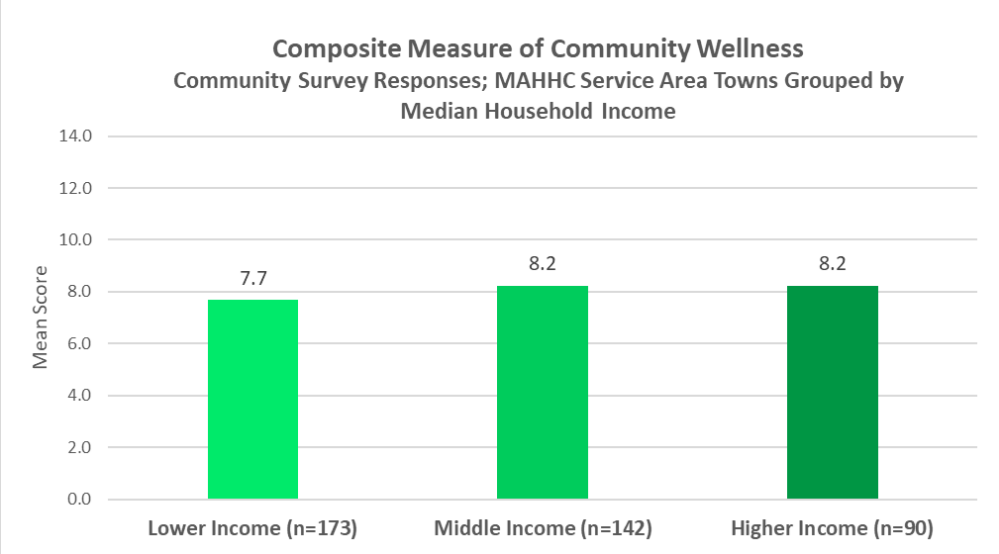



Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents who Agree with each statement. Totals do not equal 100% because the response choice of "Don't Know/Not Sure" is not displayed.

Further analysis of this set of questions was conducted by calculating a composite measure of 'community wellness' for each respondent with possible scores ranging 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 MAHHC service area: (Group 1) communities with median household income below $60,000 per year (Windsor, Claremont; n=173); (Group 2) communities with median household income above $60,000 and below $90,000 (Cornish, Barnard, Hartland, Reading, Weathersfield, Hartford, Bridgewater; n=142); and (Group 3) communities with median household incomes above $90,000 (Plainfield, Woodstock, West Windsor, Pomfret; n=90).

Figure 8 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 lower median household income is slightly lower, but not significantly different than the mean scores for survey responses from the other towns comprising the MAHHC service area. (Note: data from respondents not reporting a residential location or indicating locations outside the MAHHC hospital service are not included in this analysis).

**| Figure 8 |**



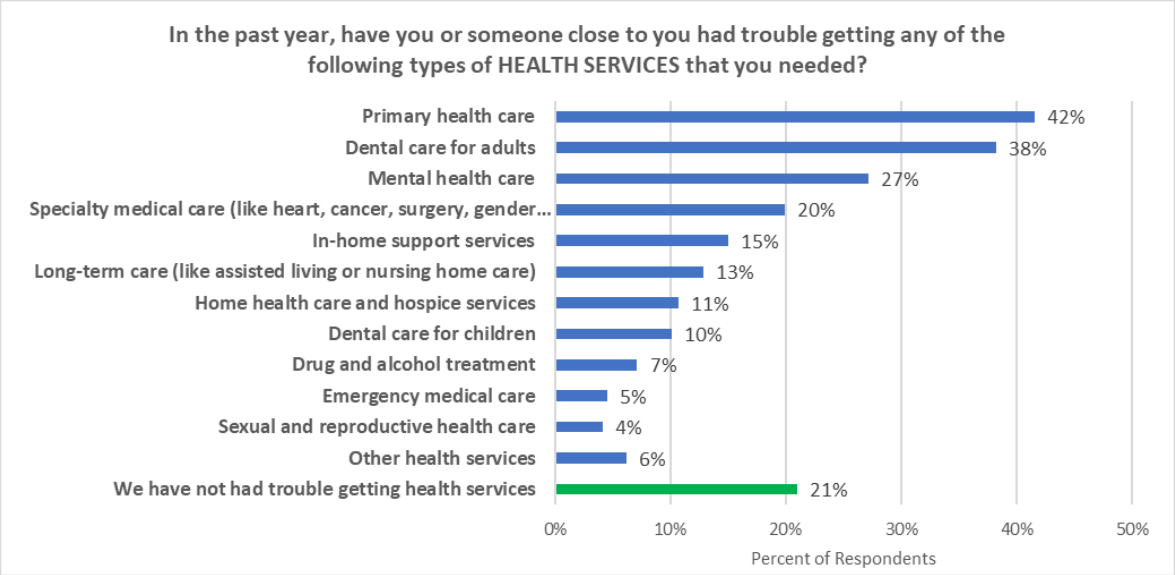

*"Our community needs affordable housing and inflation makes it almost impossible for working families to afford healthy food."*
*.- Community Resident Survey Respondent*

*"With the increase in drug-related crime, it's important for people's physical and emotional health that they feel safe in their homes and in their communities. I don't think that's the case for many, right now.*
*.- Community Resident Survey Respondent*

## 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 38% had difficulty getting 'Dental care for adults' over the past year. Other more frequently cited services for access difficulty included 'Mental health care' (27%) and 'Specialty medical care' (20%).

**| Figure 9 |**

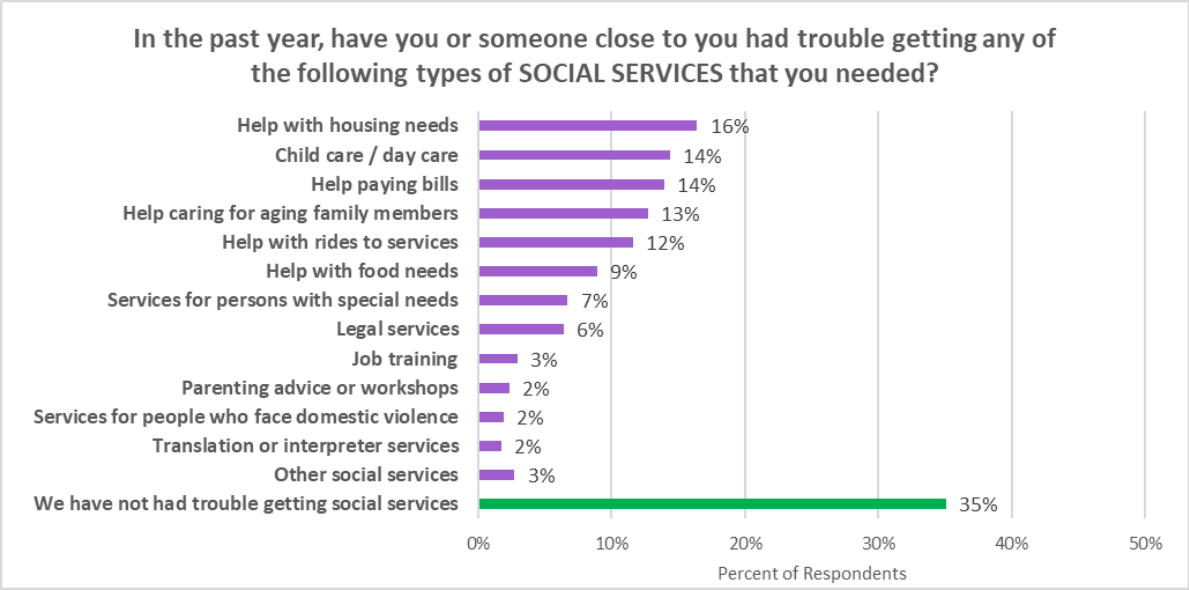



> *"Primary care MDs are as rare as hen's teeth and nobody sticks around. It's a huge problem. Available dentists are also very scarce.*
> *- Community Resident Survey Respondent*

> *"There is a shortage of care providers across all fields, but it's especially noticeable in primary health and mental health."*
> *.- 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 the next chart, about 16% of respondents indicated having difficulty getting 'Help with housing needs' and 14% had difficulty getting 'Child care / Day care' over the past year. Other more frequently cited social services for access difficulty included 'Help paying bills' (14%), 'Help caring for aging family members' (13%) and 'Help with rides to services' (12%).

**| Figure 10 |**

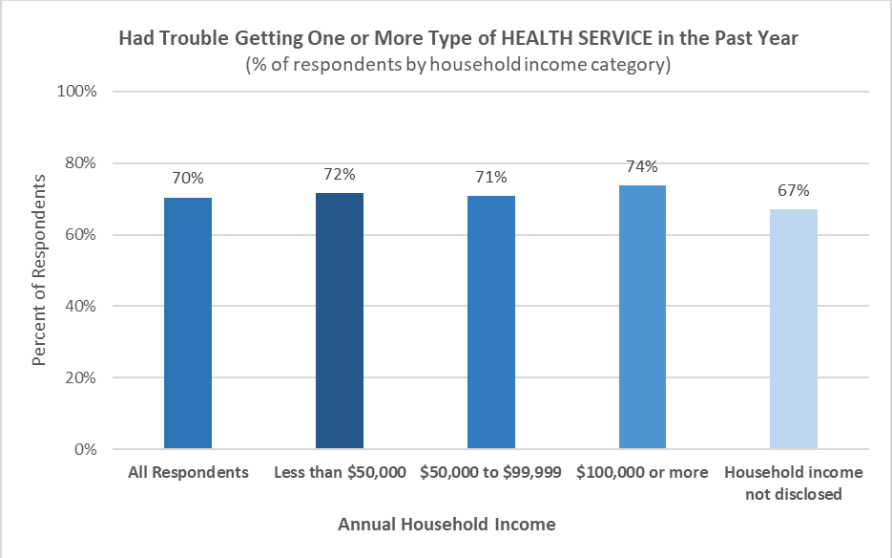



*"Bring back the Community Based Community Care Coordinator. It is a huge loss to have someone that can be a bridge from Community to Health Care regardless if they're a patient or not."*
*.- Community Leader, Aging Services*

*"I think navigating the health care and social services systems can be overwhelming and tricky. A community care coordinator is an essential part of this system."*
*.- 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 70% of all survey respondents reported having difficulty accessing at least one type of health service. Figure 11 displays the percentage of survey respondents reporting any access difficulty by income category. There was essentially no correlation between household income and reported experience of having difficulty accessing health services.

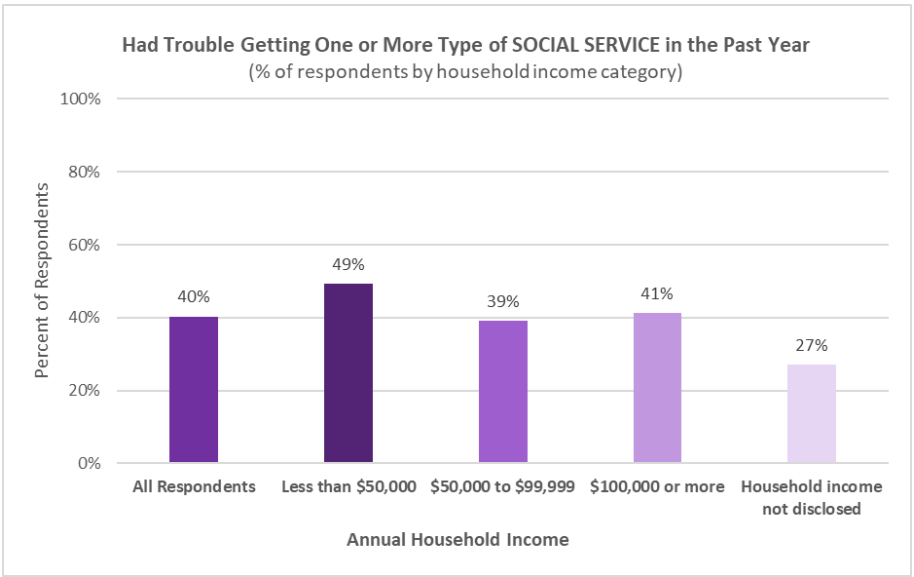
**| Figure 11 |**




As displayed by Figure 12, about 40% of survey respondents reported having difficulty accessing at least one type of social service. About half (49%) with household incomes less than $50,000 reported difficulty accessing at least one type of social service, while respondents who elected not to disclose household income were the least likely to report having had difficulty accessing social services (p<.05).

*"There is inadequate help for the middle class patients we serve. They are under supported in every area and do not qualify for most assistance programs because the income limits are extremely outdated."*
*.- Community Leader / Social services*

**| Figure 12 |**



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 7, "Wait time too long" was a common reason cited for difficulty accessing each of the top four types of health care services including 76% of people who indicated difficulty accessing Specialty Medical Care services and 69% of those having difficulty accessing mental health services. The top reason cited for difficulty accessing primary care services was "Not accepting new patients" (72%).

**| TABLE 7. 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=222, 42% of respondents) | **DENTAL CARE FOR ADULTS (**n=204, 38% of respondents) | **MENTAL HEALTH CARE** (n=145, 27% of respondents) | **SPECIALTY MEDICAL CARE** (n=106, 20% of respondents) |
|---|---|---|---|
| **72%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Not accepting new patients"** as a reason | **50%** of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Wait time too long"** as a reason | **66%** of respondents who indicated difficulty accessing Mental Health Care also selected **"Wait time too long"** as a reason | **76%** of respondents who indicated difficulty accessing Specialty Medical Care also selected **"Wait time too long"** as a reason |
| **"Wait time too long" (70%)** | **Not accepting new patients (49%)** | **Not accepting new patients (57%)** | **Not accepting new patients (47%)** |
| **Service not available (40%)** | **Cost too much (44%)** | **Service not available (56%)** | **Service not available (41%)** |
| **Cost too much (22%)** | **No insurance or not enough insurance (38%)** | **Cost too much (37%)** | **Cost too much (30%)** |
| **No insurance or not enough insurance (20%)** | **Service not available (37%)** | **No insurance or not enough insurance (29%)** | **No insurance or not enough insurance (20%)** |
| **Not open when I could go (9%)** | **Did not know where to go (12%)** | **Did not know where to go (18%)** | **Had no way to get there (12%)** |

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)

*"The amount of turnover of primary care MD's and even PA's at Mt. Ascutney is unbelievable. Also the practice of establishing care is a waste of time. By the time you establish care the person is gone."*

*- Community Resident Survey Respondent*

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 8, "Cost too much" was the most common reason cited for difficulty accessing 'Child Care / Day Care' (74%) and also for 'Help with housing needs' (61%). The most common reason cited for difficulty getting 'Help with paying bills' was "Did not know who to call' (50%), while "Service not available" (54%) was the most common reason for difficulty accessing services to "Help caring for aging family members.

### | TABLE 8. 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=85, 16% of respondents) | CHILD CARE / DAY CARE (n=75, 15% of respondents) | HELP PAYING BILLS (n=72, 14% of respondents) | HELP CARING FOR AGING FAMILY MEMBERS (n=66, 13% of respondents) |
|---|---|---|---|
| **61%** of respondents who indicated difficulty accessing Help with Housing Needs also selected **"Cost too much"** as a reason | **74%** of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason | **50%** of respondents who indicated difficulty accessing Help paying bills also selected **"Did not know who to call"** as a reason | **54%** of respondents who indicated difficulty accessing Help caring for aging family members also selected **"Service not available"** as a reason |
| **Service not available (46%)** | **Service not available (62%)** | **Service not available (39%)** | **Cost too much (51%)** |
| **Wait time too long (45%)** | **Wait time too long (55%)** | **Cost too much (31%)** | **Wait time too long (46%)** |
| **Did not know who to call (31%)** | **Not accepting new clients (51%)** | **Shame or stigma (14%)** | **Did not know who to call (37%)** |
| **Not accepting new clients (19%)** | **Did not know who to call (12%)** | **Not accepting new clients (9%)** | **Not accepting new clients (28%)** |

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)

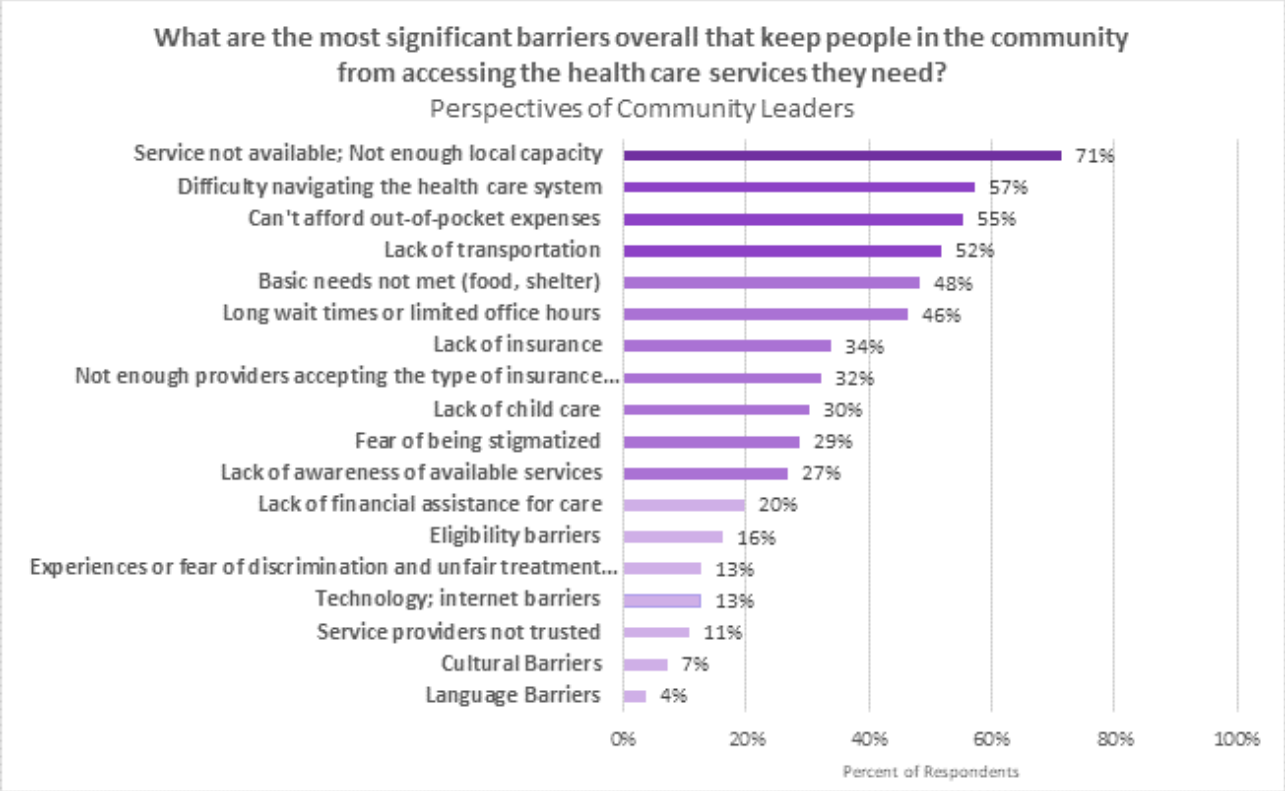
*"Non-clinical community health programs have become less available since the last assessment making it very difficult for needs to be met in our community."*
*.- Community Resident Survey Respondent*

*"Need for additional resources for the elderly living in their homes. Need to have social services to address and anticipate the long term needs of this population . . . to get extra supports in the home earlier before it becomes a crisis mode.*
*.- 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, 2% of respondents indicated that they or someone in their household had **"Often"** missed getting health care or social services because of unfair treatment, 11% indicated **"Sometimes",** and 83% 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' (71% of community leaders chose this barrier) followed by 'Difficulty navigating the health care system (57%), 'Can't afford out-of-pocket expenses' (55%), and 'Lack of transportation' (52%).

**| Figure 13 |**

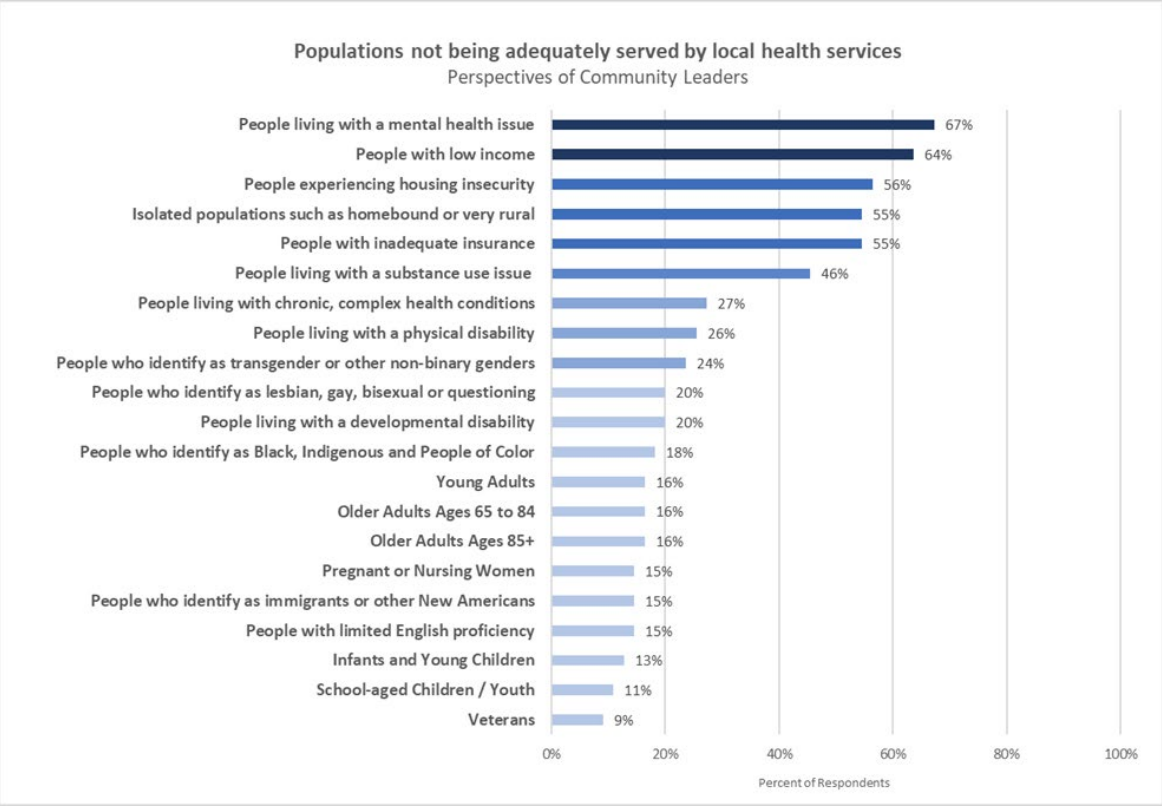



*"Primary care providers .... constant revolving door, people keep leaving, patients just get to know someone and they leave putting even more stress on the providers that stay so they leave, and so on and so on . . . . this system is really broken for adults.*
*- Community Leader / Medical care sector*

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 respondents as underserved were people living with a mental health issue, people with low income, people experiencing housing insecurity, isolated populations such as homebound or very rural, and people with inadequate health insurance (Figure 14). These results for underserved populations and provider capacity needs are similar to the results of the 2021 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?" About three-quarters of respondents (76%) responded affirmatively. Primary care was the most commonly cited service with insufficient capacity or availability (64% of those indicating any specific type of provider or service) followed closely by about 61% of community leader respondents reporting a need for additional mental health provider capacity. About 30% of respondents commented on the need for more dental care capacity.

**| Figure 14 |**

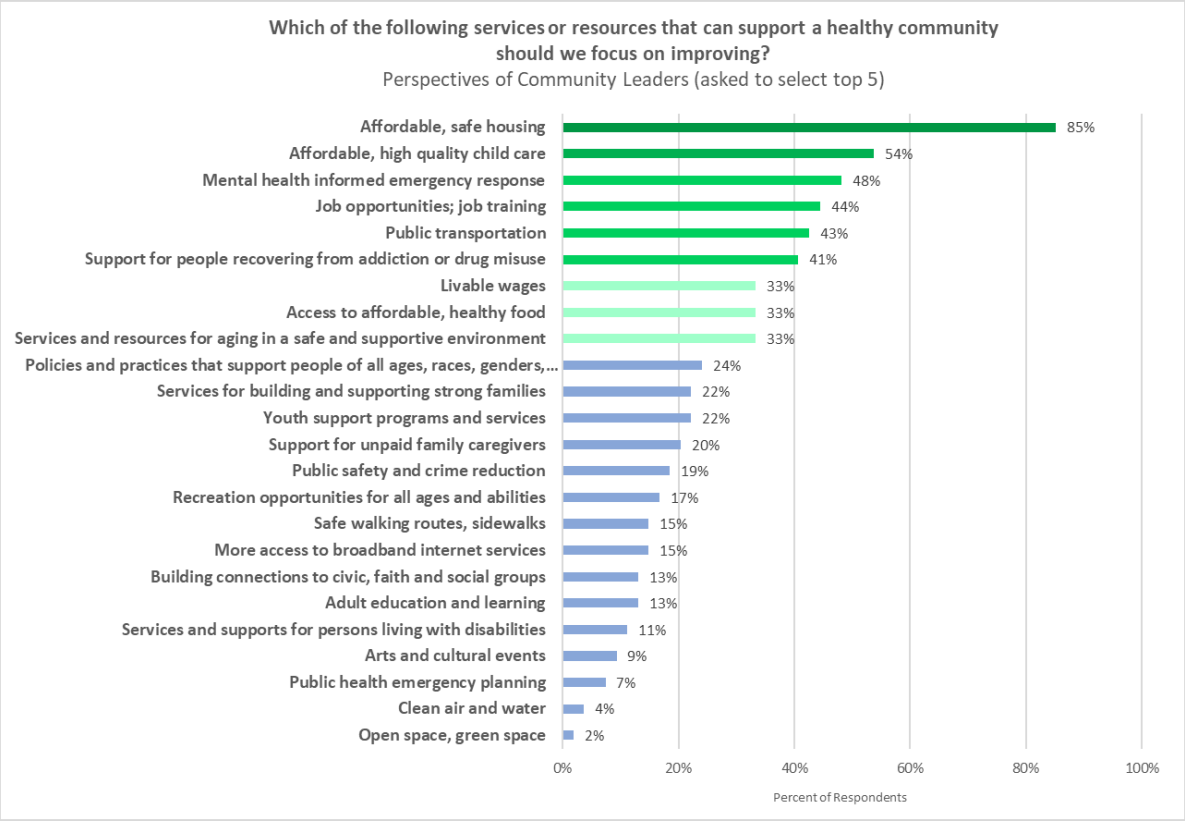



*"We desperately need more counselors and mental health providers. We have so many patients on waiting lists for 1-3 years who need help now."*
*.- Community Leader / Behavioral Health sector*

## 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 social 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 15 |**



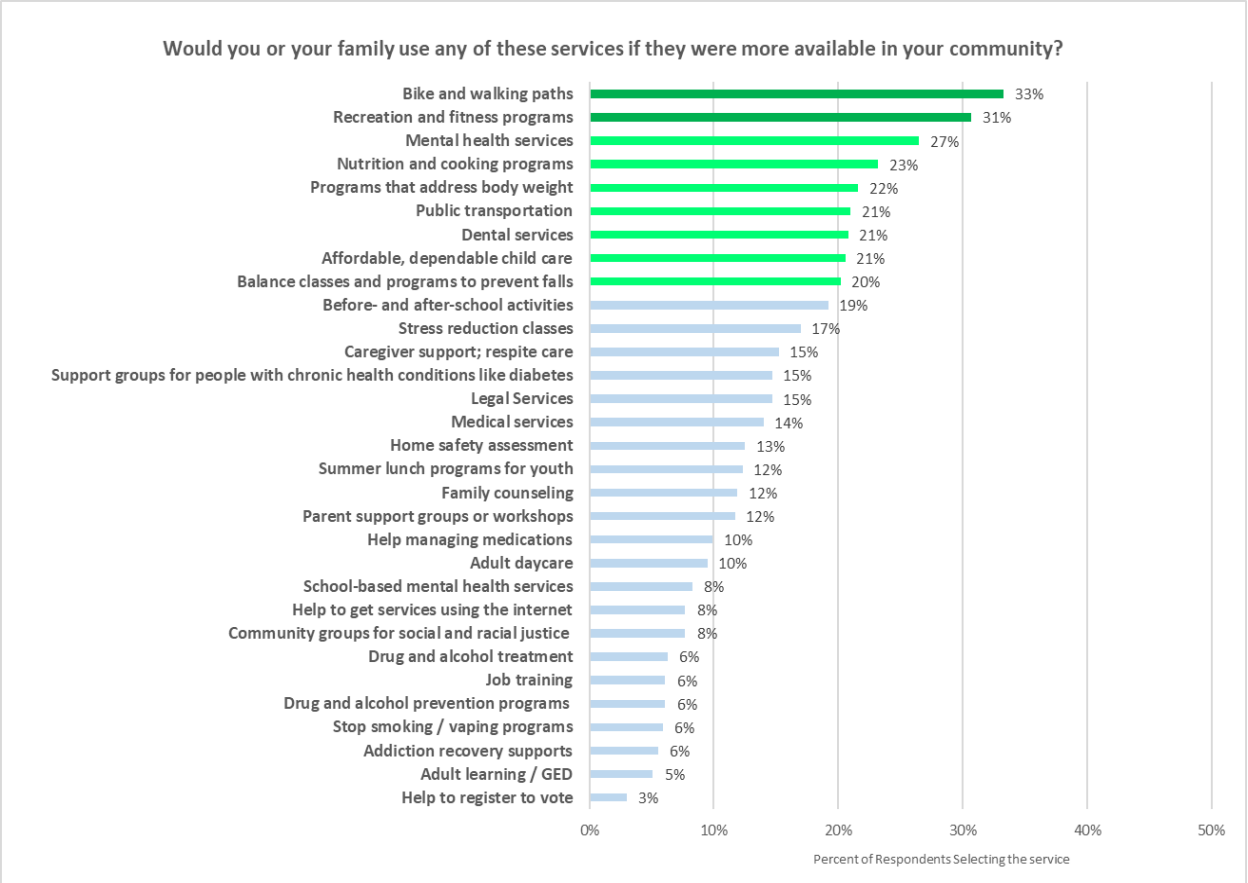

As displayed by Figure 15, 'Affordable, safe housing' was by far the most frequently selected resource; identified by 85% of respondents as an area the community should focus on to support community health improvement. Other top focus areas are Affordable, high quality child care; Mental health informed emergency response; Services and resources for aging in a safe and supportive environment; Job opportunities, job training; Public Transportation; and Support for people recovering from addiction or drug misuse.

> *"In order to improve wellness, we have to meet basic needs---we need housing, safety, adequate health care for all, access to food, etc."*
> *- Community Leader, Volunteer*

## 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. As displayed by the chart, the highest amount of interest was reported for using Biking and Walking Paths and Recreation and Fitness programs. Other services most frequently mentioned were mental health services, nutrition programs, programs that address body weight, public transportation, dental services, affordable, dependable child care, and balance classes / programs to prevent falls. These results are similar to the results from the 2021 Community Health Needs Assessment.

**| Figure 16 |**



The table below 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' and 'Public Transportation' 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 9 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.

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

| Age 18-44 (n=70) | | Age 45-64 (n=156) | | Age 65+ (n=260) | | Households with children (n=101) | |
|---|---|---|---|---|---|---|---|
| Bike and walking paths | 60% | Bike and walking paths | 43% | Balance classes and programs to prevent falls | 24% | Bike and walking paths | 51% |
| Recreation and fitness programs | 56% | Recreation and fitness programs | 37% | Recreation and fitness programs | 22% | Recreation and fitness programs | 48% |
| Mental health services | 51% | Mental health services | 35% | Programs that address body weight | 22% | Before- and after-school activities | 44% |
| Nutrition and cooking programs | 46% | Affordable, dependable child care | 28% | Bike and walking paths | 21% | Affordable, dependable child care | 40% |
| Affordable, dependable child care | 44% | Nutrition and cooking programs | 26% | Dental services | 18% | Mental health services | 37% |
| Before- and after-school activities | 44% | Before- and after-school activities | 25% | Public transportation | 17% | Nutrition and cooking programs | 30% |
| Family counseling | 39% | Dental services | 23% | Mental health services | 17% | Family counseling | 27% |

*"Community nursing in the Mt Ascutney region is one of the highest profile and wonderful services offered. Mt Ascutney had been a strong advocate and leader in this effective community service. So grateful!*
*- Community Resident Survey Respondent*

Table 10 on the next page displays results for the same question about 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 were similar

across towns including the top three services that were the same: Bike and walking paths, Recreation and fitness programs, and Mental Health Services. Respondents from Windsor and Claremont were more likely than respondents from other towns in the service area to select Dental Services.

**| TABLE 10. Top services or resources people would use if more available, by Town Group |**

| Lower Income Towns (n=182) | | Middle Income Towns (n=145) | | Higher Income Towns (n=93) | |
|---|---|---|---|---|---|
| **Bike and walking paths** | 34% | **Bike and walking paths** | 32% | **Bike and walking paths** | 30% |
| **Recreation and fitness programs** | 31% | **Recreation and fitness programs** | 28% | **Recreation and fitness programs** | 30% |
| **Mental health services** | 28% | **Mental health services** | 26% | **Mental health services** | 24% |
| **Dental services** | 28% | **Programs that address body weight** | 23% | **Affordable, dependable child care** | 19% |
| **Balance classes and programs to prevent falls** | 26% | **Nutrition and cooking programs** | 23% | **Before- and after-school activities** | 18% |
| **Programs that address body weight** | 24% | **Public transportation** | 23% | **Nutrition and cooking programs** | 17% |
| **Nutrition and cooking programs** | 23% | **Affordable, dependable child care** | 20% | **Public transportation** | 17% |

Lower income communities include Windsor and Claremont. Middle income communities are Cornish, Barnard, Hartland, Reading, Weathersfield, Hartford, and Bridgewater. Higher income communities are Plainfield, Woodstock, West Windsor, Pomfret.

*"We definitely need safe places close to neighborhoods for kids to play and ride bikes."*
*- Community Resident Survey Respondent*

*"More effort needs to be made, at the earliest possible age, to ensure the understanding- and lifelong pursuit of wellness. There are so many diseases that can be prevented through simple life-style choice. Let's try to educate children/youth more about these choices, and at an earlier age."*
*- Community Leader, Volunteer*

The 2024 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 319 survey respondents (56%) provided written responses to this question. Table 11 provides a summary of the most common responses by topic theme.

**| TABLE 11 |**

**"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 | **106 comments (33% of total)** |
| Affordability of health care including prescriptions, low cost or subsidized services; health insurance costs; health care payment reform | **41 (13%)** |
| Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition | **21 (7%)** |
| Affordable housing; workforce housing | **19 (6%)** |
| Senior services; concerns of aging; home health care, assisted living; supports for adults with disabilities | **17 (5%)** |
| Caring community, culture; community diversity and acceptance; facilities and opportunities for social interaction; reducing social isolation | **16 (5%)** |
| Healthy lifestyle education; focus on wellness and prevention; resources for supporting healthy youth and families | **14 (4%)** |
| Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness | **13 (4%)** |
| Availability, affordability of mental health services; mental health awareness and stigma | **13 (4%)** |
| Substance misuse prevention including tobacco; substance use treatment; illegal drug availability | **13 (4%)** |
| Basic needs including livable wages, cost of living, poverty and employment (note: comments specific to affordable food or affordable housing grouped separately above) | **11 (3%)** |
| Affordability, availability of dental services | **8 (3%)** |
| Improved transportation services, public transportation; medical transportation | **6 (2%)** |
| Community Safety; physical infrastructure and accessibility | **6 (2%)** |
| Affordable child care; before and after school programs | **6 (2%)** |
| Improved awareness, communication of available services and resources | **3 (1%)** |
| Other comments; no changes | **6 (2%)** |

## C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

### 1. Overview

Over the period from March to May 2024, the Community Health Needs Assessment Planning Committee worked with community partners to convene discussion groups with area residents representing various communities of different lived experiences and perspectives.

In total, four discussion groups were conducted. The discussion groups sought to identify 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 our communities' health. The four discussion groups were comprised Behavioral Health Case Managers from agencies across the region, representatives of the LGBTQIA+ community, the Dartmouth Affinity and Belonging Council, and Upper Valley Business Leaders. As part of the discussion activities, priority issues from similar community conversations were shared and participants were asked if they thought those issues were still the most important and if there are new or different issues that are a higher priority. Those former 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 34 individuals participated in the discussion groups. An optional survey recording participant demographics was completed by 13 participants (38%). Table 12 shares the demographic composition of those participants.

**| TABLE 12. Discussion Group Participant Demographics |**

| Gender (n=13) | | | Age (n=13) | | | |
|---|---|---|---|---|---|---|
| Woman | Man | Other gender identity | 18-34 | 35-54 | 55-64 | 65+ |
| 54% | 38% | 8% | 39% | 46% | 15% | 0% |

## 2. Health Concerns and Priorities – Main Themes

The following sections summarize the main health-related themes identified through the discussion groups. Anonymous comments are included to more directly illustrate important themes.

These sections outline responses to the first three questions asked of discussion group and interview 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?*
    - 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)
3. *Are there other health issues that should be added to the list or are of a higher priority?*

Community participant responses to these questions have been summarized into five priority health sections based on common recurring discussion group themes:

- Access
- Provider Education and Cultural Competence
- Mental Health
- Intersectionality and Minority Stress
- Community Support and Education

### Access

With regard to what people worry about most when it comes to their health, and what should be (or, in this instance, remains) a high priority, nearly all participants echoed the same concern in some form: *access*.

The issue of access in these discussions took the shape of three main motifs: accessibility, or ease of access, availability, and financial barriers.

**Accessibility.** Healthcare access in general continues to be a recurring issue. The main challenges concerning healthcare access included **practice location and transportation and a general lack of**

**transparency** or understanding about resources or services that exist, especially specialty services like gender-affirming care and substance use treatment.

> *"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."*

Several times primary care access was mentioned specifically, and participants indicated that either they or people they know are choosing to stay with a primary care physician (PCP) who does not understand/know them, who they do not trust, and/or who they do not feel supported by because they **do not know if they will be able to find a new PCP in a timely manner – if at all.**

Finally, a less frequent (though consistent) concern of participants when discussing ease of access had to do with **systems integration.** Participants expressed frustration at the various systems or platforms that providers use, especially in terms of cross-communication between those platforms (or lack thereof). Further, it was noted in several discussions that different hospitals and provider offices or practices don't communicate well with one another, creating a concern that pertinent patient information may be slipping through the cracks.

**Availability.** Availability of general community services and resources that have a direct influence on health and well-being were discussed at length. These issues include:

- ***Workforce challenges.*** This concern was noted repeatedly throughout all discussion groups. It generally took the form of three issues:
    - Continuity of care: many noted that they'd experienced a high rate of provider turnover, resulting in having multiple doctors or care teams that participants felt didn't know them as patients or, worse yet, being left with no primary provider at all.

> *"Turnover at health centers and primary care offices is high… you'll have a doctor one month and a different one the next, or no doctor at all when yours leaves."*

    - Staffing shortages: feeding into the continuity of care issue, participants mentioned – from the perspective of both patient and healthcare worker – staffing shortages being a major barrier to accessing or providing appropriate care and services. This was especially pronounced for specialty services, like mental health counselors or therapists (especially for children), senior care/home care, and substance use treatment (e.g. positive changes in treatment options such as the establishment of embedded MAT being undermined by not having anyone to actually provide the services).
    - Provider recruitment: the actual 'supply' of providers and healthcare workers in the area was reiterated among several discussion groups. Being a more rural service area introduces recruitment challenges, such as simply finding adequate housing for

providers moving to the area or the general cost of living in the area compared to what practices are able to pay.

> *"[We are] having trouble with finding masters-level clinicians and counselors – the cost of living in the area is high and we cannot outpace what others are able to pay."*

- ***Social drivers of health.*** The lack of availability of many of the social drivers of health continuously permeated participant conversations. Social drivers are the non-medical factors that affect a person's health, and include factors like safe housing, education, income, physical environment, and more.
  The following factors were recurring issues for participants and/or people they know.
  - Housing. Both the lack of available housing units and the increasing costs of rent and utilities were noted as major obstacles to overall well-being and people's ability to thrive. Options for lower-income housing that are safe and healthy were noted as being extremely limited in several discussion groups.
  - Child care. Noted as limited and extremely expensive, discussions centered around child care being a central concern to participants. Workforce shortages and the lack of adequate pay as a deterrent to staffing were noted as compounding problems.
  - Public transportation. Lack of accessible transportation options underlay many health issues identified, with participants noting that this problem worsened the ability to access healthcare services, healthy foods, job opportunities, safe and/or affordable child care, etc.
  - Healthy food. A topic mentioned less frequently regarding the availability of social determinants was access to healthy foods – including knowing where to get healthy food and about resources available to support healthy eating. It's been included here as it was mentioned at least once in all group discussions.

**Costs.** The costs of healthcare were mentioned frequently as a pervasive issue experienced by participants, with several references to **unaffordable insurance, high deductibles, and a consistent decrease in the services covered** by insurance.

More frequently mentioned than healthcare costs, however, was the increasing cost of living in general, mirrored in the costs of essential social drivers of health. Priority concerns included the cost of housing, childcare, and food.

- ***Housing.*** The cost of rent in the area and its continuous inflation was mentioned as a frequent barrier to wellbeing. And a distinct lack of affordable housing and low-income housing options was noted repeatedly amongst participants. These problems were identified as being more acute for marginalized populations.
- ***Childcare.*** As mentioned in the section above, childcare was consistently referred to as extremely expensive and as another social determinant that is only continuing to cost more.
- ***Food.*** Inflation of everyday necessities – especially food – was identified as an outsized barrier to participant health and wellbeing.

"Access" as a theme is broad. It encompasses many health issues that overlap and underlie each other: a lack of public transportation, for instance, can serve as a barrier to social supports and opportunities, which can increase mental health challenges and loneliness, which drives the need for mental health services to outpace the availability of mental health providers. Increased housing expenses can compound the cost of child care, which in turn affect a household's ability to afford healthy foods, which can lead to a deterioration of overall health. The discussions followed this sense of interconnectedness among access to health-related resources, services, and care. There are multiple examples of the ways in which the availability and ease of access to these resources can influence community health and wellness, and the difficulties of addressing any one, singular issue without addressing this interconnectedness.

*"It used to be five years ago that if you were really sick, you knew you'd get care. That's not the case anymore."*

## Provider Education and Cultural Competence

The need for provider education and cultural competence was also raised frequently. The term 'providers' here not only refers to health care professionals, but also to community leaders who provide a service that influences health and well-being (teachers, counselors, school leadership, therapists, family resource specialists, community program coordinators, etc.).

**LGBTQIA+ education and representation.** A population frequently referred to in the groups and interviews was the LGBTQIA+ community. Participants noted that students they know who are a part of this community often experience social issues, mental health problems, and greater barriers to support or care. It was noted that well-intentioned teachers or counselors who want to help, but do not have appropriate training on how to work with LGBTQIA+ youth, can further cause mental and emotional damage.

*"A lot of trans folks feel like they have to educate their doctors."*

This issue doesn't just exist in schools. Healthcare for transgender individuals was also a common topic, with emphasis on the need for cultural trainings, furthered research, and continuing education.

Examples of these problems include: providers misgendering patients; insensitivity towards young people about their identity; an inability to provide medically safe and competent care, especially for transgender patients; ongoing misinformation about LGBTQIA+ lifestyles; a misunderstanding about what abuse looks like in LGBTQIA+ relationships; privacy concerns, such as providers inadvertently 'outing' patients, and; providers making assumptions based on identity and further perpetuating biases and stigmas based on those assumptions.

*"I get a lot of paperwork from PCPs that misgender a child, use the wrong pronouns, or are very insensitive to the young person's identity."*

Several discussion groups also touched on concerns regarding provider education surrounding specialty care. Specific priority care areas included gender-affirming care, cultural and age appropriate mental health care, and senior care.

## Mental Health

Mental health as a priority is another widely-encompassing issue. "Availability of mental health services" was a priority identified during the previous community health needs assessment, and was the most frequent response to the question "*Do you think these [previously identified health priorities] are still the most important health-related issues for our community?"*

> *"Speaking to the mental health piece of it, psychiatrists cannot handle the mental health needs of our community. There has been so much effort. The need outpaces the workforce and our infrastructure."*

Other themes among discussion groups encompass this topic in many ways: **access** to mental health services, **provider education** on mental health awareness, increased **awareness** of community mental health resources and services, and so on. But as mental health concerns were indicated in every discussion as an intrinsic and pervasive need, the topic merits its own designation.

Throughout the discussion groups and interviews, the need for mental health services and providers across every demographic was perceived as being higher than ever. However, this need was especially distinct among two populations: youth and the LGBTQIA+ community.

**Youth.** The mental health of young people – as well as the availability of mental health professionals for young people – was a chronic concern among discussion groups. Finding pediatric and adolescent mental health resources was described as challenging, and many participants who had lived experience trying to access these said they were most often referred outside the local area for services. Other challenges included:

- Extremely long waitlists for even intake appointments (before even knowing if a provider is a good fit for a child/teen)
- High costs associated with care and barriers to ensuring insurance coverage
- A lack of awareness about mental health services that are available for young people

> *"Accessing culturally responsive mental health services is such an enormous issue. Kids have to split themselves into pieces to get any kind of help - they'll talk about depression with a therapist, but not gender identity or body dysmorphia. The emotional experience and message that sends to our young people is so damaging."*

Participants who were providers or parents/caregivers themselves remarked on how youth are increasingly feeling overwhelmed and don't have the assurance that things will get better.

**LGBTQIA+ Community**

The concern about mental health services for the LGBTQIA+ community overlapped frequently with the concerns mentioned above for young people. Young people who belong to this community were noted as having an increasing and dire need for mental health support services. Participants across groups discussed LGBTQIA+ youth feeling unsafe in their communities, their identities unsupported, and that they have to stay with providers who don't understand them or support them simply because they won't be able to find a new provider if they left.

*"Schools are ill-equipped to handle bullying or promote an inclusive environment."*

Bullying of individuals within this community was another topic related to mental health, along with how many schools are unable or unaware of how to address it.

A theme of intersectional trauma being a rising concern was clear, with a need for mental health providers who can work with patients with the full context of their identity (race, class, ability, gender identity, sexual orientation, body size, etc.).

**Individuals with Substance Use Disorder (SUD)** Stigmas surrounding addiction and a general misunderstanding of substance use disorders was noted as a priority, as was the effect these issues have on the mental health of someone living with an addiction or disorder. The lack of appropriately trained mental healthcare providers aggravates this growing need, and the issues triggered by untreated mental health issues among this community were flagged as unmistakable and significant.

## Intersectionality and Minority Stress

This topic is noted within several other priority health concerns, but was discussed with such frequency as to warrant its own analysis.

Intersectionality refers to the inherent interconnectedness of social drivers, demographics or identity, and ability. The way all of these factors – like race, sexual orientation, and gender – interact and compound one another has a significant influence on an individual's experiences and opportunities.

Minority stress is, in a way, the result of intersectionality. It is the mental and emotional strain that individuals experience due to others' perceptions of and subsequent treatment toward people of marginalized identities.

*"Access and minority stress are intersectional obstacles. It's harder for people of color who are also queer it's harder for people of color who are income insecure, etc… intersectionality can compound already existing obstacles."*

The need for providers (of all kinds) to be knowledgeable of the many forms of intersectionality that patients experience was repeated throughout discussions. Participants noted that healthcare professionals and community leaders (specifically teachers/school administrators/counselors) often don't understand – or aren't mindful of – how the multiple forms of inequality, discrimination, or privilege significantly affect a person's

ability to navigate social situations, access appropriate, effective health care services, or feel represented. These factors leading to chronic minority stress among families and youth was a continuing theme throughout these conversations.

Areas where this was of heightened importance were regarding substance use and within the LGBTQIA+ community.

### Community Support and Education

A core theme woven throughout discussion group conversations centered around community support and community education.

Community support was largely in reference to struggles faced by the LGBTQIA+ community and those living with a substance use disorder who are seeking treatment or support.

- ***LGBTQIA+.*** Multiple mentions of the challenges this community faces when it comes to feeling supported, represented, and safe within their communities highlighted a lack of general support and belonging. This was only heightened for transgender individuals, who participants noted as often feeling unsafe and misunderstood.
- ***Substance use.*** Discussion group participants noted how stigmas negatively impact those who live with substance use problems, and how this lack of community support often leads to individuals not seeking the care they need for fear of being judged.

> *"The stigma around mental illness and substance use is still at the top of the list of reasons people don't get help. This is something we need to improve far beyond what we've been able so far to chip away at."*

Community education was discussed in two veins: the need for education against misinformation and harmful stereotypes and the need for education regarding available services and resources.

**Misinformation Education**

- ***LGBTQIA+.*** Concerns regarding misinformation about LGBTQIA+ healthcare, lifestyles, and challenges were abundant, with an emphasis on misinformation around transgender individuals. This was discussed in regards to schools (feelings that teachers and counselors are ill informed/ill equipped to support these students), healthcare (many sentiments described in the "Provider Education and Cultural Competence" section above apply here as well), and legislation. This final concern was emphasized, with fears about local/state legislation targeting transgender individuals and gender-affirming care based on incorrect information and harmful stigmas.

> *"Trans healthcare, sexual reproductive healthcare, access to care… those of us providing this care have pivoted to defensive medicine because of legislation threatening that access."*

- ***Substance use.*** Similar to the concerns discussed regarding community support of those with substance use problems, participants noted that many of the stigmas associated with substance use perpetuated misinformation about the individuals who use, and that community education about addiction would be beneficial.

**Knowledge of Community Resource & Services**

- ***Alcohol and drug use***. Participants were unaware of what services supporting prevention, treatment, and harm reduction exist in their communities, how to find that information, or how to access any existing services (finding places to live that are close to services or have transportation options to them).
- ***Parent/Guardian Resources.*** Participants with young children or school-aged kids who are differently abled – or who are familiar with the struggles of such families – noted that there needed to be better transparency about what resources were available to help support their student(s). It was also noted that there was a lack of understanding and transparency about what special education *is* within schools: what is a 504, an IEP, etc.
- ***Caregiver support.*** Caregivers expressed they were unaware if resources existed that may be available to help support their families (financially, emotionally, socially, etc.) as well as to support their own mental, social, and emotional needs. Whether support groups for caregivers exist or how to find those was noted as well.
- ***Healthcare options.*** Participants expressed frustration about not knowing where they can receive health care besides Dartmouth Hitchcock.

## 3. Perceived Improvements

Participants in the discussion groups and interviews were asked "*Have you noticed any improvements in the past few years on any of the issues we have talked about?"* Perceived improvements identified by participants can be generally summarized in three categories:

- Substance Use
- Improvements and Changes to Healthcare Resources
- Community Education and Support

### Substance Use

Improvements in substance use prevention, response, and treatment were common responses to this question in discussion groups. Participants noted a greater willingness throughout communities to support substance use prevention and treatment, greater understanding and education around substance use

> *"The launch/expansion of programs like 988, the NH Mobile Crisis Line, and The Doorways supports people who might need help in the moment before it escalates to needing a higher level of care."*

disorders, expanded training opportunities on the topics for healthcare professionals and service providers, and education about the positive impacts of Harm Reduction strategies. As a result, there was a perceived change in the kind of vernacular used to discuss substance use, as well as a reduction in substance use biases.

### Improvements and Changes to Healthcare Resources

Several improvements related to healthcare services were noted:

- ***Telehealth.*** Teleheatlh was noted to be a positive change in access to healthcare services, allowing for flexibility in reaching patients and being able to meet varying needs (specifically younger patients were mentioned here).
- ***Patient service centers.*** The establishment of patient service centers was mentioned as an improvement, with participants sharing positive feedback and heightened interest from other healthcare departments.
- ***Provider education.*** Increasing the variety and number of provider trainings and continuing education came up as an improvement, especially for working with LGBTQIA+ individuals, using more inclusive language, and DEI in general. A significant drawback to this improvement, however, is that many trainings are opt-in and there was a sense that "...the people who need it the most choose not to be in the room."

### Community Education and Support

Finally, there was the perception that there have been greater efforts made in communities and through schools to be more inclusive, to increase the visibility of minority populations, and to greater public awareness and education surrounding medical affirmation for LGBTQIA+ individuals. Few participants noted how school curriculum has seemed to be evolving, including things like social emotional learning, preventing abuse, preventing substance use, and being inclusive of LGBTQIA+ youth in ways that nurtures, values, and protects them.

## 4. Loneliness and Social Isolation

The discussion groups included a special focus on the topic of loneliness and how it can affect health, both mentally and physically. Participants were asked whether they think the issue of loneliness is a big concern in their community and, if so, what they perceived to be the root causes. They were also asked if they had opinions about what should be done to address loneliness. (*Loneliness here was specified to refer to feeling a lack of connection with other people, and a desire for more, or more satisfying social relationships.)*

Every group that discussed this question agreed that loneliness and isolation are big issues for them personally, people they know, and/or their communities as a whole.

### Perceived Sources of Loneliness

**Community considerations and volunteerism** A common thread identified among participants as a possible cause of loneliness had to do with the composition – geographic and abstract – of their communities.

***Geographic composition.*** Group participants almost wholly lived in rural communities. The lack of physical closeness to people, gathering places, and recreational spaces was repeatedly mentioned as a cause of loneliness. Limited or nonexistent public transportation aggravates this issue further. Many noted that even where their communities and neighborhoods *are* physically close, there's a clear deficit of social opportunities, activities, and programming in the area. This issue was identified as especially pronounced for seniors in the area who have less access overall.

***Sense of Community.*** A limited sense of the experiential makeup of the participants' communities was an underlying contributor to loneliness. Groups discussed a decrease in community volunteerism, social barriers to community connectedness, and a stunted sense of belonging among certain demographics (e.g. young professionals or young adults with children not having a community to lean on). Examples like Rotary clubs and Lions clubs were made, noting that, while these used to be social groups people joined to solve the problems of social exclusion or loneliness, their memberships are declining because of current members aging out and younger people not joining.

**Intersectionality** The idea of intersectionality lending to feelings of isolation was discussed at length, with many participants explaining how gender identity, sexual orientation, substance use, mental health problems, race, and even age all compounded to create isolation. Individuals who belong to one or more of these various communities lack personal relationships in the area, don't have a sense of community, feel they aren't

> *"What are we putting on our websites? Our walls? On social media? We need to make people feel less isolated and seen, included. Right now, it's very heteronormative. All white people. No intergenerational families."*

represented by their geographic communities, and typically struggle more severely with loneliness and detachment.

**Local business stressors** Several participants brought up struggles faced by business owners in the area. Staffing and recruitment challenges experienced in rural locations cause extra stress on business owners to keep their businesses open. Many of these professionals end up working alone for long hours and shifts, increasing the mental stress and isolation.

### Potential Solutions

Groups had many suggestions for how to improve community connection and reduce isolation and loneliness. Suggestions included:

- Adding transportation programs and investing in public transportation
- Increasing virtual programming for seniors
- Creating peer-to-peer support groups, outreach programs, and affinity groups for young professionals, young parents, LGBTQIA+ individuals, Indigenous individuals, etc. to foster neighborhood connection
- Getting providers involved:
    - 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 (veterans, senior men, etc.)

## D. Community Health Status Indicators

This section of the 2024 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 13 town service area identified as the Mt. Ascutney Hospital and Health Center Service Area (identified in the following tables as MAHHC service area).

In some instances, population health data are only available at the county or health district / regional level. For example, some indicators included here report statistics for Windsor County, Vermont. All 10 Vermont municipalities in the MAHHC service area are within Windsor County and comprise about 48% of the total population of Windsor County. In a few instances, Vermont health data are reported for the White River Junction and Springfield Health Districts, which are larger geographic areas that incorporate the northern and southern Vermont municipalities of the MAHHC service area respectively (6 municipalities are in the White River Junction Health District comprised of 22 municipalities in total; 4 municipalities are in the Springfield Health District with 17 total municipalities). For New Hampshire municipalities in the MAHHC service area, some population health information is reported for the Greater Sullivan County Public Health Region that includes Claremont and Cornish, which together comprise about 32% of the total population of that public health region.

### 1. Demographics and Social Drivers of Health

Social 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.

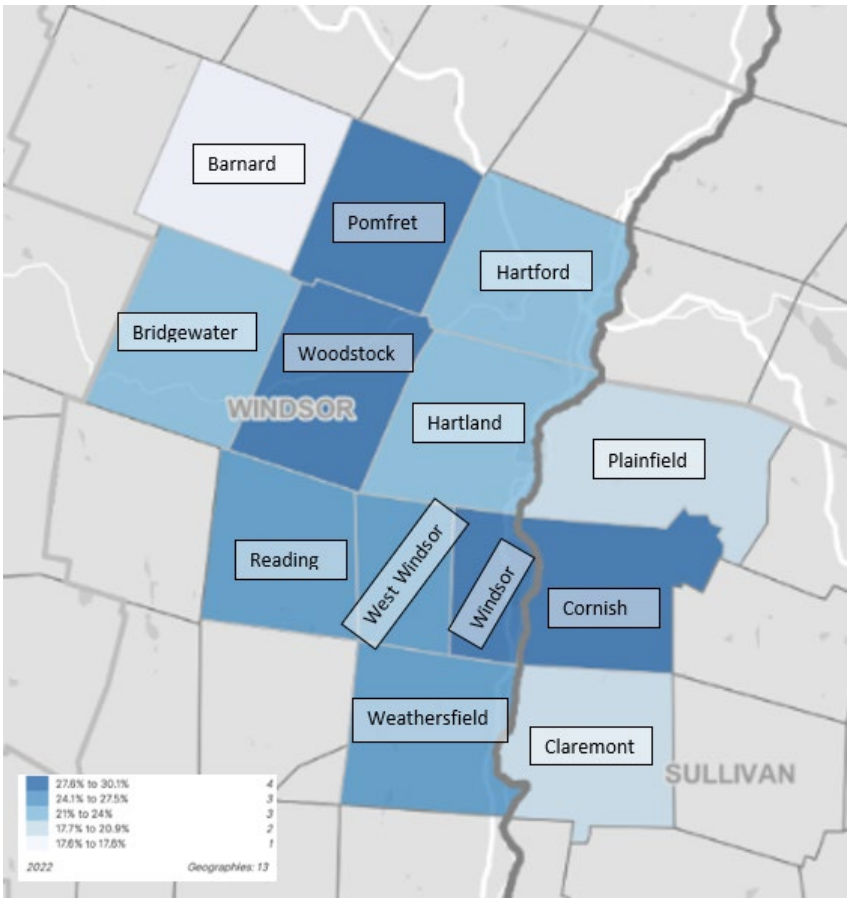
Between 2019 and 2022, the population of the service area grew by an estimated 3.6%, about 1,600 people overall including an estimated population increase of more than 1,000 people in Hartford. The population of the Mt. Ascutney Hospital and Health Center Service Area is somewhat older on average than in Vermont and New Hampshire overall (Table 14). The service area map on the next page displays the percent of the population 65 years of age and older by town.

**| TABLE 14 |**

| Indicators | MAHHC Service Area | Vermont | New Hampshire |
|---|---|---|---|
| Total Population | 45,568 | 643,816 | 1,379,610 |
| Age under 5 years | 4.9% | 4.4% | 4.6% |
| Age 5 to 17 years | 13.8% | 13.8% | 14.0% |
| Age 65 and older | 23.6% | 20.3% | 19.0% |
| Age 85 and older | 2.4% | 2.2% | 2.1% |
| Change in population (2019 to 2022) | +3.6% | 3.1% | +2.3% |

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

**| Figure 17. 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 18% in Barnard to about 30% in Pomfret and Windsor.

## 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 percentage of Mt. Ascutney Hospital service area residents ages 25 and older who have earned at least a high school diploma is similar to the percentage across New Hampshire overall. The comparisons begin to deviate more as the levels of education get higher – the percent of those with a Bachelor's degree and higher is much lower than NH's.

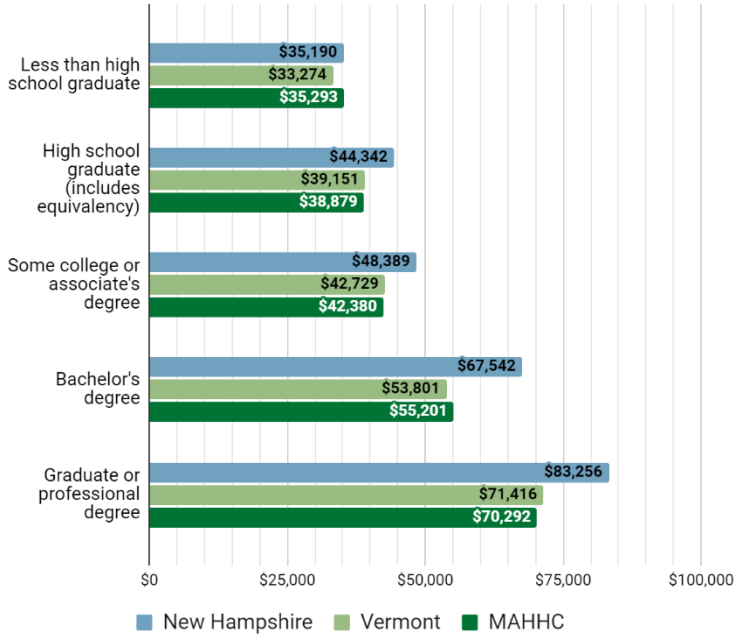
**| TABLE 15 |**

| Percent of Population Aged 25+ | MAHHC Service Area | Vermont | New Hampshire |
|---|---|---|---|
| High School Diploma (or Equivalent) and Higher | 94% | 94% | 94% |
| Some College or Associate's Degree | 25% | 25% | 28% |
| Bachelor's Degree and Higher | 38% | 42% | 39% |

*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 18 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 17. Median Earnings by Educational Attainment |**



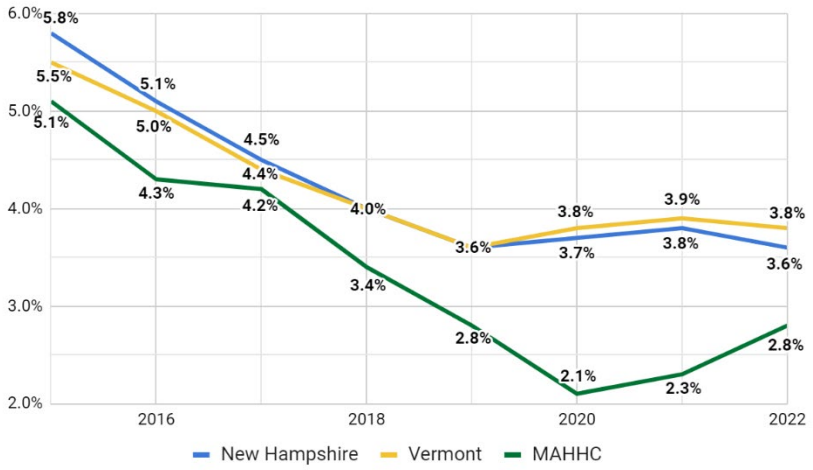

## Employment

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 2015 to 2022, NH and VT saw similar decreases in unemployment rates before leveling off near 4%. Unemployment in the MAAHC service area continued to decrease to around 2% before increasing somewhat during the COVID-19 pandemic.

**| Figure 18. Annual Unemployment Rate, 2015 – 2022 |**




## Income and Poverty

The strong connection between economic well-being and good health is widely recognized. Conversely, 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 essential for maintaining good health.

Some information describing household income and poverty status was included in the first overview section of this report. The table below presents 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. The estimated percentage for households with children below the poverty level is by far the highest for Claremont (23%) with the next highest percentage in Weathersfield (12%). For context, the Federal Poverty Level for an individual in 2023 was $14,580 and for a family of four was $30,000.

**| TABLE 16 |**

| Percent of people in households with income below the Federal Poverty Level (FPL) | | | |
|---|---|---|---|
| **Population Group** | **MAHCC Service Area** | **Vermont** | **New Hampshire** |
| All people with household income below the FPL | 10.1% | 10.4% | 7.3% |
| Children (under 18) in households with income below the FPL | 10.1% | 11.3% | 8.5% |
| Adults 65+ years in households with income below the FPL | 6.4% | 8.0% | 7.0% |

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

## 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 MAHHC service area along with the corresponding percentages in NH and VT overall. The most recent estimates from the Census Bureau for the service area are that 0.2% of households (about 45 households) are limited-English speaking households. A limited English speaking household is defined as one in which no member 14 years old and over either speaks only English or speaks a non-English language and speaks English very well.

**| TABLE 17 |**

| Languages Spoken at Home | MAHHC Service Area | Vermont | New Hampshire |
|---|---|---|---|
| English only | 94.2% | 92.6% | 89.7% |
| Spanish | 0.9% | 1.6% | 2.9% |
| German | 0.9% | 0.6% | 0.5% |
| French, Haitian, or Cajun | 1.0% | 2.2% | 2.2% |
| Other Languages | 3.0% | 3.0% | 4.7% |
| **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.

The table below 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. More than 1 in 4 owner occupied housing units and over half of renters in the service area have housing costs exceeding this threshold.

**| TABLE 18 |**

| Percent of Households with High Cost Burden, Substandard Housing or No Internet Access | MAHHC Service Area | Vermont | New Hampshire |
|---|---|---|---|
| **Housing Costs >30% of Household Income (%)** | **27.4%** | 24.8% | 25.1% |
| **Rental Costs >30% of Household Income (%)** | **54.0%** | 50.6% | 46.8% |
| **Occupied Housing Units Lacking Complete Plumbing Facilities (%)** | **0.5%** | 0.5% | 0.5% |
| **Occupied Housing Units Lacking Complete Kitchen Facilities (%)** | **1.1%** | 0.9% | 0.7% |
| **Without Internet Subscription** | **11.9%** | 13.3% | 8.8% |
| **No Computer in the household** | **5.6%** | 6.7% | 5.0% |

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

Another attribute of housing that can have implications for the health of families and communities is the age of structures. This could be due to 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 about 53% of occupied housing units being within structures that were built in 1979* or earlier (53% and 57% respectively) and the MAHHC service area has a higher percentage at about 67%.

**| TABLE 19. 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 |
|---|---|---|---|---|---|---|
| **MAHHC Service Area** | 30% | 12% | 25% | 23% | 11% | 0.1% |
| **Vermont** | 26% | 9% | 23% | 26% | 16% | 0.2% |
| **New Hampshire** | 20% | 10% | 23% | 30% | 17% | 0.3% |

*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, were 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. The next table presents data on the percent of households that have no vehicle available.

**| TABLE 20 |**

| Area | Percent of Households with No Vehicle Available |
|---|---|
| **Mt. Ascutney Hospital service area** | 5.5% |
| **Vermont** | 6.4% |
| **New Hampshire** | 4.6% |

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

About 5% of households in the service area report having no vehicle available, a percentage estimate similar to New Hampshire and Vermont overall. Towns with the highest estimates for households with no vehicle available are Claremont (9%), Hartford (7%), and Windsor (6%).

## 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 Mt. Ascutney Hospital service area who report having at least one disability = about 15% - is similar to Vermont and New Hampshire overall.

**| TABLE 21 |**

| | Total Population (Noninstitutionalized) with a Disability | | |
|---|---|---|---|
| Age Group (in years) | **MAHHC Service Area** | **Vermont** | **New Hampshire** |
| **Percent Disabled <18** | **4.6%** | 5.6% | 4.7% |
| **Percent Disabled 18-64** | **13.1%** | 12.1% | 10.5% |
| **Percent Disabled 65+** | **28.9%** | 30.0% | 29.4% |
| **Total** | **15.1%** | 14.5% | 12.9% |

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

# 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

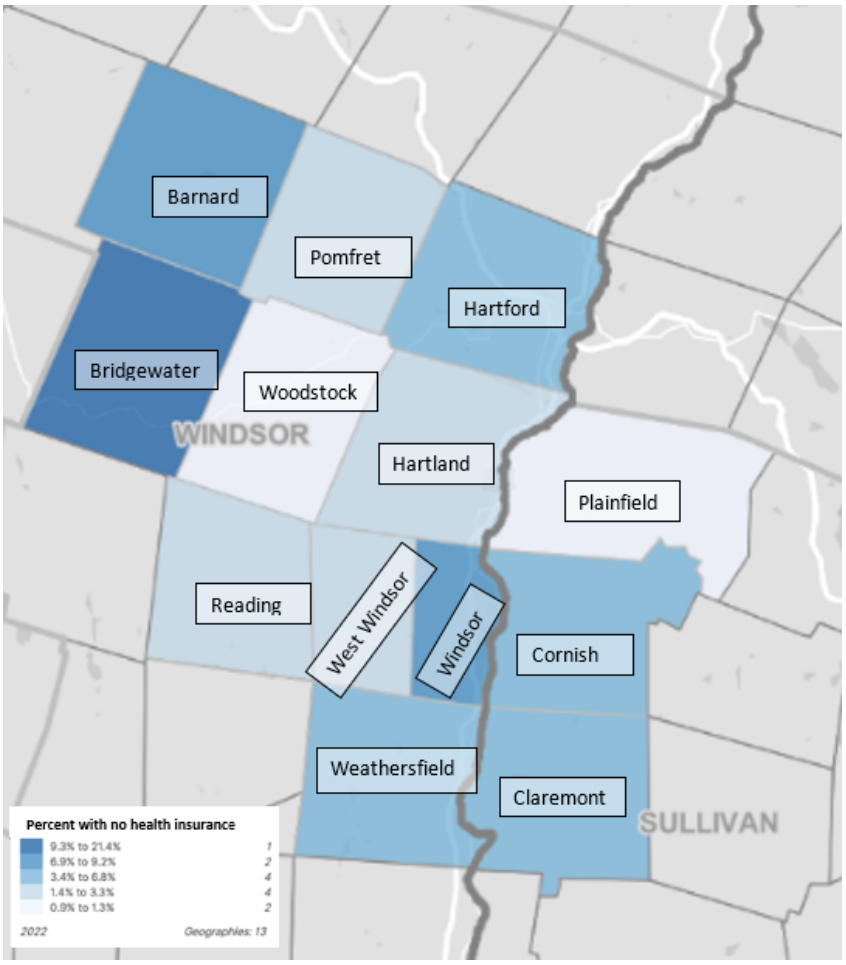
Table 22 displays town level estimates of the proportion of residents in the Mt. Ascutney Hospital Service area who do not have any form of health insurance coverage, as well as the proportion of residents with Medicare, Medicaid or Veterans Administration coverage. Overall, the percent of the service area population with no insurance (6%) is similar to the percent in Vermont (4%) and New Hampshire (6%) although there are several service area towns with uninsurance rates of 9% and higher. Also of note is the substantially higher percentage of Medicaid coverage in Vermont compared to New Hampshire.

## | TABLE 22: 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 |
|---|---|---|---|---|
| Bridgewater | 21% | 31% | 29% | 0% |
| Barnard | 9% | 19% | 18% | 11% |
| Windsor | 9% | 30% | 26% | 3% |
| Weathersfield | 7% | 28% | 25% | 3% |
| Hartford | 6% | 24% | 19% | 2% |
| New Hampshire | 6% | 20% | 13% | 2% |
| Claremont | 6% | 27% | 25% | 4% |
| **MAHHC Service Area** | **6%** | **26%** | **20%** | **3%** |
| Cornish | 5% | 31% | 6% | 2% |
| Vermont | 4% | 22% | 23% | 2% |
| West Windsor | 3% | 24% | 10% | 3% |
| Hartland | 3% | 28% | 22% | 3% |
| Pomfret | 3% | 30% | 16% | 2% |
| Reading | 2% | 28% | 17% | 1% |
| Plainfield | 1% | 20% | 5% | 4% |
| Woodstock | 1% | 30% | 11% | 2% |

*Data Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates, 2018-2022.*

**| Figure 21: Percent of MAHHC Service Area Population Who Are Uninsured |**




*The estimated percentage of service area residents with no health insurance coverage ranges from 1% in Plainfield and Woodstock to 21% in Bridgewater.*

## 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 Greater Sullivan region, about 15% of respondents to the NH Behavioral Risk Factor Survey reported being unable to see a doctor because of cost (2019 data, most recent available).

**| TABLE 23 |**

| Area | Percent of Population Who Could Not See a Doctor because of Cost |
|---|---|
| Windsor County | 6% |
| Greater Sullivan Public Health Region | 15% |
| Vermont | 6% |
| New Hampshire | 11% |

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

## Provider Capacity

Access to high-quality, cost-effective healthcare is influenced by adequate health care professional availability in balance with population needs. Table 24 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.

**| TABLE 24 |**

| Area | Ratio of Population to Primary Care Physicians | Ratio of Population to Dentists | Ratio of Population to Mental Health Providers |
|---|---|---|---|
| Windsor County | 999:1 | 1,655:1 | 170:1 |
| Sullivan County | 1,404:1 | 2,585:1 | 449:1 |
| 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 16% of residents in the Greater Sullivan Public Health region responded on the Behavioral Risk Factor Survey that they do not have a 'personal doctor or health care provider'.

**| TABLE 25 |**

| Area | Percent of Population (18+) Without a Primary Care Provider |
|---|---|
| Windsor County | 12% |
| Greater Sullivan Public Health Region | 16% |
| 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 Greater Sullivan PHN, which is classified as rural. The SORH has also reported that health disparities exist between rural and non-rural populations as measured by select primary care-associated health indicators including primary care access.[3] One measure of access to primary care is travel time to health care visits. As displayed by the table below, about twice as many primary care visits for rural populations – including for residents of the Greater Sullivan region - require one-way travel time of 30 minutes or more compared to non-rural populations. Among the 13 PHN regions across the state, the Greater Sullivan region had the third highest percentage on this measure.

**| TABLE 26 |**

| Area | Percentage of primary medical care visits with travel times greater than 30 minutes, one way |
|---|---|
| Greater Sullivan Public Health Region | 30.8% |
| 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.[4] Compared to other rural and non-rural counties in Vermont and New Hampshire, a larger percentage of the populations of Windsor and Sullivan county live greater than 15 miles to the nearest hospital providing birthing services.

**| TABLE 27 |**

| Area | Greater than 15 Miles to Nearest Birthing Center, % of total population |
|---|---|
| Windsor County | 66.3% |
| All Rural Vermont | 42.8% |
| All Non-Rural Vermont | 11.2% |
| Sullivan County | 95.4% |
| All Rural New Hampshire | 40.9% |
| All Non-Rural New Hampshire | 4.8% |

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

[3] Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection, NH State of Rural Health and Primary Care, December 2022.
[4] 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 Windsor County and Sullivan County in 2021 were similar to the overall state rates.

**| TABLE 28 |**

| Area | Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees |
|---|---|
| Windsor County | 2,100 |
| Sullivan County | 2,350 |
| 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 service area report not having had a dental visit in the past year (2018 data, most recent available).

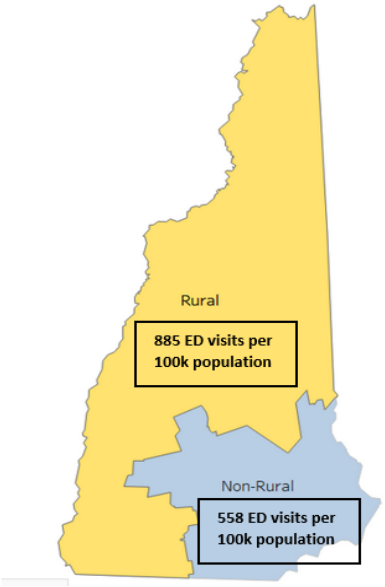
**| TABLE 29 |**

| Area | Percent of adults who visited a dentist or dental clinic in the past year |
|---|---|
| Windsor County | 66% |
| Sullivan County | 64% |
| Vermont | 68% |
| New Hampshire | 69% |

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

Sullivan County experiences significantly more hospital emergency department visits for non-traumatic reasons (i.e., not resulting from an acute injury) than across the state overall. This measure provides an estimate of unmet dental needs where timely primary dental care can prevent the need for emergency care. Ambulatory care sensitive dental conditions represent approximately 3% of all emergency department visits in New Hampshire. As displayed by the map, there is a significant difference on this measure across all of the more rural regions 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.

**Non-traumatic dental conditions emergency department visits); Rural/Non-Rural comparison; All ages, age-adjusted rate; 2017 - 2021**




**| TABLE 30 |**

| Area | Emergency Department visits for non-traumatic dental condition; Age-adjusted rate per 100,000 |
|---|---|
| Sullivan County | **1,022**** |
| New Hampshire | 636 |

*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 31 |**

| Area | Percent of Households Experiencing Food Insecurity |
|---|---|
| Windsor County | 11.0% |
| Sullivan County | 11.7% |
| Vermont | 11.7% |
| New Hampshire | 9.7% |

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

Table 32 shows the percentage of households in receiving support through the Supplemental Nutrition Assistance Program (SNAP). About 8% of households in the Mt. Ascutney Hospital service area receive SNAP support. Among these households about 34% have children in the household and about 340 have at least one household member aged 60 years or older.

**| TABLE 32 |**

| 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) |
|---|---|---|---|
| MAHHC Service Area | 8% | 34% | 40% |
| Vermont | 10% | 34% | 42% |
| New Hampshire | 6% | 45% | 37% |

*Data Source: Data Source: U.S. Census Bureau, 2021 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 33 |**

| Area | Percent of Adults Participating in Physical Activity Outside of Work, past month |
|---|---|
| Windsor County | 84% |
| Sullivan County | 76% |
| Vermont | 84% |
| New Hampshire | 81% |

*Data Source: 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 34 |**

| Area | +Percent of Medicare enrollees receiving an annual flu vaccine | ^Ever Had a Pneumococcal Vaccination, ages 65+ |
|---|---|---|
| Windsor County | 46% | 74% |
| Sullivan County | 42% | 73% |
| 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 35 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.

**| TABLE 35 |**

| Area | Binge Alcohol Use | | | Heavy Alcohol Use, All Adults |
|---|---|---|---|---|
| | All Adults | Adult females | Adult males | |
| Windsor County | **13%*** | | | 8% |
| Greater Sullivan Public Health Region | 19% | 15% | 23% | 9% |
| Vermont | 18% | 14% | 22% | 10% |
| New Hampshire | 17% | 13% | 21% | 8% |

*Data Source: VDH and NH DHHS, Behavioral Risk Factor Surveillance System, 2022*

**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.

In Windsor County the percentage 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.

**| TABLE 36 |**

| 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^ |
| Windsor County | 21% | 10% | 34% |
| Greater Sullivan Public Health Region | 22% | 11% | 27% |
| Vermont | 25% | 12% | 32% |
| New Hampshire | 23% | 12% | 29% |

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

*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 prescription drug and opioid crisis, much like many other states in the United States, 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.
- *Lack of 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 37 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 37 |**

| 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) |
|---|---|---|---|
| Windsor County | 9% | | |
| Vermont | 11% | | |
| Greater Sullivan Public Health Region | | 20% | 4% |
| New Hampshire | | 24% | 2% |

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

According to recent results from the Youth Risk Behavior Survey (YRBS), about 8% of high school students in the Mt. Ascutney Hospital service area reported having ever taken a prescription drug without a doctor's prescription and in Windsor County about 2% 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 38 |**

| 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 |
| Windsor County | 8% | 2% |
| Greater Sullivan Public Health Region | 8% | 6% |
| Vermont | 8% | 2% |
| New Hampshire | 9% | 5% |

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

**| TABLE 39 |**

| Area | High School Students | | | |
|---|---|---|---|---|
| | Used Cocaine in past 30 days | Ever Used Cocaine | Every Used Heroin | Ever Used Inhalants |
| Windsor County | | 2% | 1% | 7% |
| Greater Sullivan Public Health Region | 3% | | 3% | 8% |
| Vermont | | 2% | 1% | 7% |
| New Hampshire | 3% | | 2% | 7% |

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

### Marijuana

Recent results from the YRBS The tables below explore data from the 2023 Youth Risk Behavior Survey. About 1 in 5 students self report having used marijuana in the past 30 days prior to survey administration. A similar proportion of high school age youth report having been offered, sold, or given an illegal drug on school property.

**| TABLE 40 |**

| 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 |
| Windsor County | 21% | 1% | 14% |
| Greater Sullivan Public Health Region | 20% | 7% | 19% |
| Vermont | 20% | 1% | 12% |
| New Hampshire | 20% | 5% | 20% |

*Data Source: Youth Risk Behavior Survey, NH 2023, VT 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 Mt. Ascutney Hospital service area region is similar to the percentage in Vermont and New Hampshire. The percentage of Windsor County high school students who reported smoking cigarettes in the past 30 days – about 1% - is also similar to high school age students across the Vermont overall.

**| TABLE 41 |**

| Area | Percent of High School Students Who Currently Smoke Cigarettes | Percent of Adult Population Who Currently Smokes Cigarettes |
|---|---|---|
| Windsor County | 1% | 14% |
| Greater Sullivan Public Health Region | 5% | 14% |
| Vermont | 1% | 13% |
| New Hampshire | 4% | 11% |

*Data Sources: Behavioral Risk Factor Surveillance System, NH 2022, VT 2022; Youth Risk Behavior Survey, NH 2023, VT 2021*

As displayed by the table below, there is a substantial difference between the percentage of high school students in Vermont compared to New Hampshire who reported current use of an electronic vapor product. Although the data available is from different reporting years, the difference is noteworthy.

**| TABLE 42 |**

| Area | Percent of High School Students Who Currently Use an Electronic Vapor Product |
|---|---|
| Windsor County | 4% |
| Greater Sullivan Public Health Region | 16% |
| Vermont | 5% |
| New Hampshire | 17% |

*Youth Risk Behavior Survey, NH 2023, VT 2021*

Rural residents have historically had higher rates of smoking during pregnancy than their non-rural counterparts. This observation is reflected in the table below, where about 1 in 7 females in the Greater Sullivan region who were pregnant between 2018 and 2022 reported smoking during pregnancy.

**| TABLE 43 |**

| Area | Percent of Female Population that Reported Smoking During Pregnancy (all ages) |
|---|---|
| Windsor County | NA |
| Greater Sullivan Public Health Region | 15%** |
| Vermont | 10% |
| New Hampshire | 7% |

*Data Sources: NH Vital Records Birth Certificate Data, 2018-2022; Vermont Pregnancy Risk Assessment Monitoring System Phase 8 Report, October 2024 (2022 data)*

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

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 44 |**

| Area | Percent of births associated with smoking during pregnancy that were preterm | Percent of births associated with smoking during pregnancy that were low birthweight |
|---|---|---|
| Windsor County | | NA |
| Greater Sullivan Public Health Region | 12.8% | |
| Vermont | | 15.1% |
| New Hampshire | 13.1% | |

*Data Source: NH Vital Records Birth Certificate Data, 2017-2021*

## Prenatal Care

Prenatal care is the 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.

The table below indicates 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. In 2022, the percent of Windsor County residents who received no or late prenatal care (5.4%) was higher than in Vermont overall (3.0%).

**| TABLE 45 |**

| Area | Percent of Female Population that Received No or Late Prenatal Care |
|---|---|
| Windsor County | 5.4% |
| Greater Sullivan Public Health Region | 2.0% |
| 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 46 |**

| Area | Full term low birthweight among WIC enrolled pregnant women | Low and Very Low Birthweight among WIC enrolled pregnant women, all births |
|---|---|---|
| Springfield Health District | | 7.9% |
| White River Jct. Health District | | 13.4% |
| Sullivan County | 8.8% | 11.8% |
| 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 Greater Sullivan region is more than twice the rate in NH overall, particularly among female teens ages 18-19.

**| TABLE 47|**

| Area | Teen Birth Rate (per 1,000 female teens) | | |
|---|---|---|---|
| | Total (ages 15-19) | Ages 15-17 | Ages 18-19 |
| Windsor County | 10.7 | | |
| Sullivan County | **12.7**** | 3.4 | **31.2**** |
| Vermont | 9.6 | | |
| New Hampshire | 6.1 | 2.1 | 11.9 |

*Data Source: NH Vital Records Birth Certificate Data, 2018 – 2022. VDH, Vermont Vital Statistics Annual Report, 2022.*
***Rate is significantly different and higher 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 48 |**

| 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 |
|---|---|---|
| Windsor County | | |
| Sullivan County | 6.5 | 124.9 |
| Vermont | 5.7 | 33.0 |
| New Hampshire | 4.7 | 63.0 |

*Data source: Annie E. Casey Foundation, Kids Count Data Center, VT, 2021 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 49 |**

| Area | Foster Care Entries, rate per 1,000 children |
|---|---|
| Windsor County | |
| Sullivan County | 5.7 |
| Vermont | 5.1 |
| 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. Ensuring children are tested for blood lead levels is crucial, especially given children, particularly infants and young children, are more vulnerable to the harmful effects of lead, as their bodies are still developing. 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, lower IQ scores, 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 2022, about one in every four children in each state aged 6 years and under had been tested for elevated BLL. Of the children tested in the Greater Sullivan region, 69 children (10%) had BLL of 3.5µg/dL or higher and 3% had EBLL of 5µg/dL or higher. These percentages were substantially higher than the state percentages of 4% and 1% respectively.

**| TABLE 50 |**

| Area | Percent Tested | % EBLL 3.5µg/dL or higher | % EBLL 5µg/dL or higher |
|---|---|---|---|
| Windsor County | | | |
| Greater Sullivan Public Health Region | 31% | 10% | 3% |
| Vermont | 23.8% | 9.0% | 4.4% |
| New Hampshire | 25% | 4% | 1% |

*Sources: NH DHHS, Division of Public Health Services, Healthy Homes & Lead Poisoning Prevention Program, 2022; VDH, Lead Poisoning Prevention: Report on 2022 Program Outcomes and Activities, Report to Vermont Legislature, 2022.*

## 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 (age 18 and older) 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 and in the Greater Sullivan region a higher percentage of males are considered obese than high school age males across New Hampshire.

**| TABLE 51 |**

| Area | Percent of adults who are obese | Percent of adults who are overweight |
|---|---|---|
| Windsor County | 31% | 34% |
| Sullivan County | 31% | 36% |
| Vermont | 27% | 35% |
| New Hampshire | 28% | 37% |

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

**| TABLE 52 |**

| Area | High School Students Considered Obese | Female High School Students | Male High School Students |
|---|---|---|---|
| Windsor County | 12% | 10% | 14% |
| Greater Sullivan Public Health Region | **18%**** | 13% | **23%**** |
| Vermont | 14% | 10% | 17% |
| New Hampshire | 13% | 10% | 16% |

*Data Source: NH DHHS Health Data Portal, 2021 & NH Youth Behavior Risk Survey, 2021*

***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 53 |**

| 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 |
|---|---|---|
| Windsor County | 34% | 79% |
| Sullivan County | 33% | 84% |
| Vermont | 32% | 80% |
| New Hampshire | 30% | 88% |

*Data Sources: Behavioral Risk Factor Surveillance System, NH 2021, VT 2022 (HBP), 2019 (Chol)*

Table 54 below 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 CHF and acute myocardial infarction (commonly called a heart attack) were significantly higher in Sullivan County compared to the rest of New Hampshire over the period 2017 to 2021.

**| TABLE 54 |**

| Area | Hypertension-Related Emergency Department Visits (primary diagnosis) rate per 100,000 | CHF hospitalizations (inpatient) age-adjusted rate per 100,000 | Heart attack hospitalizations (inpatient) age-adjusted per 100,000 |
|---|---|---|---|
| Windsor County | | | |
| Sullivan County | | **9.9**** | **180.3**** |
| Vermont | 144 | | |
| New Hampshire | | 3.8 | 153.3 |

*Data Source: NH Hospital Discharge Data Set for NH Residents, 2017 to 2021*
*Vermont Uniform Hospital Discharge Data Set (VUHDDS), 2019*
***Rate is significantly different and higher 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.

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. The mortality rates for coronary heart disease and cerebrovascular disease in the region are similar to the overall NH rates.

**| TABLE 55 |**

| Area | Heart Disease Mortality (per 100,000 people, age-adjusted) | Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted) |
|---|---|---|
| Windsor County | 151.7 | 34.6 |
| Sullivan County | 155.3 | 27.6 |
| Vermont | 160.3 | 29.0 |
| New Hampshire | 148.8 | 29.4 |

*Data Source: National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022*

## 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.

**| TABLE 56 |**

| Area | Percent of Adults Diagnosed with Diabetes |
|---|---|
| Windsor County | 11% |
| Sullivan County | 7% |
| Vermont | 8% |
| New Hampshire | 7% |

*Data Sources: VT BRFSS, 2019 & 2020; United States Diabetes Surveillance System, CDC, 2021*

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 discharges (primary or secondary diagnosis) and hospital admissions for long term complications of diabetes (primary diagnosis).

**| TABLE 57 |**

| Area | Diabetes-Related Hospital Discharges; age adjusted rate per 100,000 |
|---|---|
| Windsor County | |
| Sullivan County | 1,567 |
| Vermont | 1,577 |
| New Hampshire | 1,541 |

*Data Sources: NH Uniform Healthcare Facility Discharge Dataset, 2017-2021; Vermont Uniform Hospital Discharge Data Set (VUHDDS), 2019*

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus in Sullivan County was similar to the state overall over the period 2018 to 2022.

**| TABLE 58 |**

| Area | Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted) |
|---|---|
| Windsor County | 14.9 |
| Sullivan County | 22.2 |
| Vermont | 17.3 |
| New Hampshire | 19.8 |

*Data Source: National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022*

## 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.[5] 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: The table below displays screening rates for several of the most common forms of cancer including colorectal cancer, breast cancer, cervical cancer and prostate cancer. In 2022, the percentage of females who self-reported having a mammogram to screen for breast cancer was higher in the Greater Sullivan region than in NH or VT overall.

**| TABLE 59 |**

| Cancer Screening Type | Windsor County | Vermont | Greater Sullivan PHR | New Hampshire |
|---|---|---|---|---|
| Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2022) | 75% | 76% | 73% | 67% |
| Females ages 50-74 who had a Mammogram in the past 2 years (2022) | 69% | 76% | 90% | 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*

[5] 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). The overall cancer incidence rate and rates for specific cancer types in Sullivan County are similar to rates across the state.

**| TABLE 60 |**

| Cancer Incidence by Type per 100,000 people, age adjusted rate | | | | |
|---|---|---|---|---|
| **Cancer Type** | **Windsor County** | **Vermont** | **Sullivan County** | **New Hampshire** |
| Overall cancer incidence (All Invasive Cancers) | | 454.7 | 491.0 | 472.3 |
| **Cancer Incidence by Type** | | | | |
| Tobacco-associated Cancers | 182.9 | 179.7 | | |
| Obesity-associated Cancers | 176.0 | 165.9 | | |
| Alcohol-associated Cancers | 134.6 | 127.7 | | |
| Breast (Female) | | 131.8 | 135.2 | 138.9 |
| Prostate (male) | | 110.2 | 109.7 | 116.9 |
| Lung and Bronchus | 55.8 | 56.2 | 66.9 | 59.2 |
| Melanoma of Skin | 39.4 | 36.6 | 34.9 | 29.9 |
| Colorectal | | 33.2 | 35.2 | 34.2 |
| Uterus (female) | | 32.6 | 33.1 | 29.6 |
| Bladder | 24.8 | 23.0 | 31.2 | 26.0 |
| Non-Hodgkin Lymphoma | 15.7 | 18.6 | 18.8 | 20.0 |
| Kidney and Renal Pelvis | 15.7 | 16.2 | 18.9 | 17.1 |
| Thyroid | 14.9 | 14.0 | 14.8 | 13.2 |
| Pancreas | | 12.7 | 14.5 | 13.6 |
| Leukemia | 11.4 | 12.7 | 13.4 | 13.7 |
| Oral Cavity and Pharynx | | 12.6 | 13.4 | 12.6 |

*Data Source: NH State Cancer Registry, 2017-2021; VT State Cancer Registry, 2016-2020, Windsor County incidence by type data is from the VDH, Environmental Public Health Data Tracker, 2015-2019.*

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 cancer mortality rate and rates for specific cancer types in the region are similar to rates across the states. 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 2022.

**| TABLE 61 |**

| Cancer Mortality per 100,000 people, age adjusted | | | | |
|---|---|---|---|---|
| **Cancer Type** | **Windsor County** | **Vermont** | **Sullivan County** | **New Hampshire** |
| Overall cancer mortality (All Invasive Cancers) | 140.7 | 155.8 | 158.5 | 143.5 |
| **Cancer Mortality by Type** | | | | |
| Lung and bronchus | | 36.2 | 33.2 | 32.9 |
| Prostate (male) | | 21.1 | 22.9 | 18.8 |
| Breast (female) | | 16.4 | 15.1 | 17.6 |
| Colorectal | | 14.1 | **16.1**** | 11.1 |
| Pancreas | | 11.0 | 11.4 | 11.5 |
| Esophagus | | 5.1 | 7.7 | 4.7 |
| Non-Hodgkin's Lymphoma | | 5.7 | 6.6 | 4.7 |

*Data Source: NH State Cancer Registry, 2018 – 2022; VT State Cancer Registry, 2016-2020; Windsor County data from National Institute on Minority Health and Health Disparities, HDPulse, 2018-2022*

***Rate is significantly different and higher 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 2022, about 20% of adults responding to the Behavioral Risk Factor Survey from Sullivan County reported they currently have asthma. This percentage is notably higher than the overall state estimate of 13% although not statistically significant.

**| TABLE 62 |**

| Area | Percent of Children (ages 0 to 17) with Current Asthma | Percent of Adults (18+) with Current Asthma |
|---|---|---|
| Windsor County | *8%* | 15% |
| Sullivan County | | 20% |
| Vermont | 7% | 11% |
| New Hampshire | 5% | 13% |

*Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2022; VDH, Adult: 2020 and 2021, 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 and Sullivan Counties compared to the Vermont and New Hampshire rates.

**| TABLE 63 |**

| Area | Asthma Emergency Department Visits, age adjusted rate per 100,000 | Asthma Inpatient Hospitalizations age adjusted rate per 100,000 |
|---|---|---|
| Windsor County | **241**** | **146**** |
| Sullivan County | **391**** | **38**** |
| Vermont | 171 | 17 |
| New Hampshire | 285 | 27 |

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

***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 2018 to 2022 was similar in the region compared to the state overall. Compared to Vermont overall, the rate of death due to accidents and unintentional injury, which includes accidental drug overdose mortality, was significantly higher in Windsor County.

**| TABLE 64 |**

| Area | Unintentional (accidental) Injury Mortality, all causes Age adjusted rate per 100,000 |
|---|---|
| Windsor County | **84.6*** |
| Sullivan County | 65.9 |
| Vermont | 68.5 |
| New Hampshire | 60.2 |

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

**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. In Sullivan County the rate of ED visits by older adults for fall-related causes was lower than in NH overall over the 5 year time period from 2017 to 2021.

**| TABLE 65 |**

| 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) |
|---|---|---|
| Windsor County | | |
| Greater Sullivan Public Health Region | 32% | 5,853* |
| Vermont | 35% | 3,532 |
| New Hampshire | 29% | 6,854 |

*Data Sources: NH Behavioral Risk Factor Surveillance System, 2020. 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. Sullivan County experienced a significantly lower rate of emergency department visits and hospitalizations due to accidental opioid overdose compared to the state 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 | Opioid Overdose Hospitalizations (inpatient) age-adjusted per 100,000 |
|---|---|---|---|
| Windsor County | 18.0 | | |
| Sullivan County | | 69.3* | 14.3* |
| Vermont | 21.4 | | |
| New Hampshire | | 134.2 | 23.8 |

*Data Source: NH Hospital Discharge Data Set for NH Residents, 2017-2021*; VDH *Substance Use Data Dashboard, 2023 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 2018 to 2022, a total of 106 deaths due to opioid overdose occurred among residents of Windsor County and 66 deaths among residents of Sullivan County. The age group with the largest number of drug overdose deaths was 30-39 years of age.

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 67 |**

| Area | Opioid Overdose Deaths, age-adjusted per 100,000 | Alcohol-related overdose deaths, age-adjusted per 100,000 |
|---|---|---|
| Windsor County | 44.7 | |
| Sullivan County | 33.1 | 5.1 |
| Vermont | 35.7 | |
| New Hampshire | 31.7 | 4.9 |

*Data Source: NH Division of Vital Records Death Certificate Data, 2018 to 2022; VDH Opioid-Related Fatal Overdoses Among Vermont Residents, 2023 Annual Data Brief*

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) 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 among males in Sullivan County was significantly higher than the state rate. 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 68 |**

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

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

**| TABLE 69 |**

| 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 | Sullivan County | **160.4**** | 44.7 |
| | New Hampshire | 128.6 | 41.6 |
| Female | Sullivan County | 280.0+ | 56.3+ |
| | New Hampshire | 239.0+ | 64.1+ |
| All Sexes | Sullivan County | **218.6**** | 50.1 |
| | New Hampshire | 182.8 | 52.7 |

*Data Source: NH Hospital Discharge Data Set (HDDS) for NH Residents, 2017 to 2021; **Rate is significantly different and higher than the state rate; +Female rates 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. Between 2018 and 2022, the suicide mortality rate in Windsor County was higher than in Vermont overall although the difference was not statistically significant. However, the suicide mortality rate is significantly higher for males than females in Vermont and New Hampshire.

**| TABLE 70 |**

| Area | Suicide Mortality, age-adjusted rate per 100,000 | | |
|---|---|---|---|
| | Total | Female | Male** |
| Windsor County | 23.9 | | |
| Sullivan County | 15.6 | 5.9 | 26.3 |
| Vermont | 17.8 | 8.0 | 30.7 |
| New Hampshire | 16.9 | 7.3 | 26.8 |

*Data Sources: NH Vital Records Death Certificate Data 2018 to 2022; VDH, Annual Suicide Morbidity and Mortality Report, 2024; Regional rates are not significantly different than the state rates.*
***Rates among males are significantly different and higher than among females. Vermont state male/female rates are preliminary 2023 data and are not age adjusted.*

## 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 public health indicator of the health and wellbeing of a population. Infant mortality is an indicator of 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. The mortality rate for infants in Sullivan County was somewhat higher, but not different statistically than the overall state rate during the period 2018 to 2022.

**| TABLE 71 |**

| Area | Infant Mortality Rate per 1,000 Live Births |
|---|---|
| Windsor County | |
| Sullivan County | 4.4 |
| Vermont | 3.7 |
| New Hampshire | 3.8 |

*Data Source: NH Vital Records Birth Certificate Data, 2018-2022; VT 2020-2022*

## Leading Causes of Death

Diseases of the heart (e.g., congestive heart failure, coronary heart disease, heart attack) was the leading cause of death in the region and across the states over the five year period from 2018 to 2022. Malignant neoplasm (cancer) was the second leading cause and accidents were the third leading cause of death in the region and the state.

**| TABLE 72. Top 10 Leading Causes of Death |**
**(age-adjusted rate per 100,000)**

| Cause of Death | Windsor County | Vermont | Sullivan County | New Hampshire |
|---|---|---|---|---|
| Heart diseases | 151.7 | 160.3 | 154.5 | 148.7 |
| Malignant neoplasms | 140.7 | 150.2 | 158.5 | 144.1 |
| Accidents / Unintentional Injury | **84.6*** | 68.5 | 65.9 | 60.2 |
| Cerebrovascular diseases | 34.6 | 29.0 | 22.9 | 29.4 |
| Alzheimer's disease | 33.2 | 35.3 | **18.4^** | 25.9 |
| Chronic lower respiratory disease | 28.3 | 34.6 | 36.0 | 37.3 |
| COVID-19 | NA | 25.2 | 22.9 | 26.6 |
| Intentional self-harm (suicide) | 23.9 | 17.8 | 15.6 | 16.9 |
| Diabetes mellitus | 14.9 | 17.3 | 22.7 | 19.8 |
| Chronic liver disease | 11.0 | 10.0 | 10.5 | 12.6 |

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

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

*^Regional rate is significantly different and lower 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. It is important to note that in small geographic areas with very few deaths, very low population, or an unusual age distribution, estimates may not be reliable or stable over relatively short time frames.

**| TABLE 73. Life Expectancy at Birth (years) and by Sex |**

| Census Tract | Life expectancy | Male | Female |
|---|---|---|---|
| Windsor County | 79.0 | | |
| 975100 (Cornish, Plainfield) | 82.9 | 80.1 | 86.0 |
| 975901 (Claremont) | 76.0 | 74.0 | 77.5 |
| 975902 (Claremont) | 76.0 | 76.2 | 76.2 |
| Vermont | 79.2 | 76.1 | 81.4 |
| New Hampshire | 79.5 | 77 | 82.1 |

*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 74 |**

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

*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 2024 Mt. Ascutney Hospital and Health Center 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 determinants 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 Mt. Ascutney Hospital and Health Center service area.

> *"Mt. Ascutney does an excellent job of supporting collaborative approaches as we look to address the needs of our community."*
>
> *- Community Leader / Behavioral Health*

> *"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*