
# Summary of Community Health Improvement Efforts Planned Across the Upper Valley: 2023 to 2025

Compiled by:

Public Health Council of the Upper Valley

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# Acknowledgements


Developing this summary document has taken direct assistance from many partners and gleaning information from a tremendous amount of work being done across the greater Upper Valley region.

For direct assistance, I would like to call out Barbara Farnsworth and the Community Health Team at Dartmouth Hitchcock, Liz Swanton at Alice Peck Day Memorial Hospital, Jill Lord and Melanie Sheehan at Mt. Ascutney Hospital and Health Center, Anthony Knox at VNH, and Katja Evans at Gifford Health Care. Also, Maggie Coleman who supported data gathering and writing up the first draft.

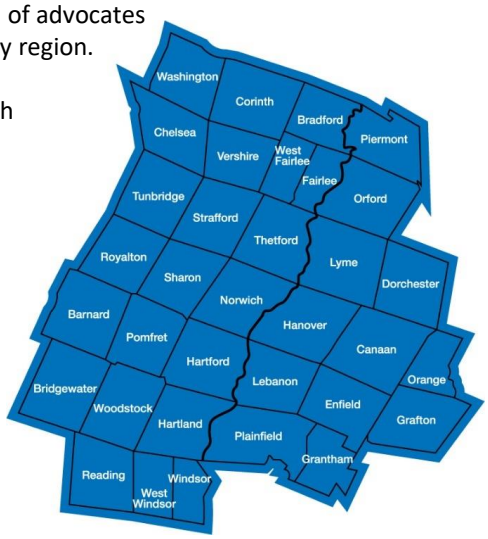
I would like to thank members of the PHC Board of Directors and Advisory Council members for setting the framework for this summary document and reviewing drafts.

Last, but certainly not least, all the people in organizations, committees and coalitions across the Upper Valley who shared their goals and plans and agreed to be included in this document.

Thank you all for the work we do together. – Alice R. Ely, PHC Executive Director

# Introduction

The Public Health Council of the Upper Valley (PHC) is a broad coalition of advocates on public and community health issues serving the greater Upper Valley region.




Our MISSION is to improve the health of Upper Valley residents through shared public health initiatives and services within a network of community stakeholders.

PHC partners share the VISION that by working together, our Upper Valley community will be healthy, safe, supportive, and vital.

**How We Operate**

- Listening to community needs;
- Building a shared public health agenda;
- Promoting collaborative solutions; and
- Bringing support to underserved areas.

Every three years, PHC and our partners compile a Community Health Improvement Plan (CHIP) that highlights work occurring in health care, social service and many other organizations across our region. The CHIP starts with the results of the most recent Community Health Needs Assessments conducted by the region's health care organizations to set the priority health concerns. We then gather information about the many ways partners plan to address the priority health concerns, especially through collaboration with others. The CHIP gives us a road map of what is being done, what is being planned, how we can participate, and what gaps we can fill to improve health in the Upper Valley.

**Priority Health Concerns: 2023 to 2025**

- Access to Mental Health Services
- Cost of Health Care Services, Health Insurance and Dental Care
- Access to Healthy and Affordable Food
- Alcohol and Drug Misuse Prevention, Treatment and Recovery
- Child Wellbeing
- Socio-Economic Conditions: Housing and Others
- Public Health Emergency Preparedness

**Our Limitations**

This summary Community Health Improvement Plan certainly does not include all the community health work going on in our region nor does our listing of Lead Partners contain all the people, organizations and institutions collaborating to improve our community's health. Please forgive us for glaring omissions and reach out to us to discuss what we can do better to reflect how our community responds to priority health concerns.

High level indicators should be reliable, comparable and available over time. We have selected a narrow set of indicators that meet these criteria. As strategies are further developed, we will look for ways to measure the process and impact of the work as well, but those measures are not yet available to include in this document. We will also be looking for ways to capture health disparities data for traditionally marginalized groups, explore measures of social vulnerability, and embrace new data sources and tools as they become available.

# Uncovering Community Health Priorities and Improvement Strategies Across Three Hospital Service Areas (HSAs)

The Upper Valley, however people define it, is fortunate to have multiple hospitals and health care organizations that work collaboratively to understand and address the community health priorities of our residents. The communities served by the Public Health Council fall within the hospital service areas of Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, and Gifford Health Care. The Visiting Nurse and Hospice of VT and NH works closely with these hospitals as well.

Not-for-profit hospitals such as ours are required to conduct community health needs assessments (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. In the Upper Valley, Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice of VT and NH use the same approaches and survey tools to conduct their CHNAs and each receives a report specific to their service areas. This provides our broader region access to data allowing us to identify top concerns across the region as well as by communities within our regions.

- In 2021, Dartmouth-Hitchcock Medical Center, Alice Peck Day Memorial, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice for VT and NH collected CHNA data using community resident surveys (1,642 responses), direct email survey of community leaders (207 responses), virtual community discussion groups, and review of available population demographics and health status indicators.
- During this same period, Gifford Health Care completed its CHNA through a review of state, federal, and local nonprofit agency reports, results of 530 completed digital and paper surveys, and consultation with the Randolph Executive Community Council.

A summary of the priority health concerns identified by each hospital service area is provided on the following page.

| PRIORITY HEALTH CONCERNS IDENTIFIED IN 3 REGIONAL CHNAs (2021/2022) | | |
|---|---|---|
| **DHMC/APD/VNH (link)** | **MAHHC (link)** | **GIFFORD (link)** |
| Availability of mental health services | Availability of mental health services | Access to primary care providers |
| Cost of health care services and affordability of health insurance | Cost of health care services and affordability of health insurance | Mental health counseling and treatment |
| Improved resources and environment for healthy eating, nutrition, and food affordability | Alcohol and drug use prevention, treatment, and recovery | Lifestyle disease prevention |
| Alcohol and drug use prevention, treatment, and recovery | Socio-economic conditions affecting health and well-being such as housing affordability, livable wages, and affordable, dependable childcare | Dental care access for adults |
| Affordability and availability of dental care services | Affordability and availability of dental care services | |
| Socio-economic conditions affecting health and well-being such as housing affordability, livable wages, and affordable, dependable childcare | Prevention of child abuse and neglect (Strengthening Families) | |

After completing the CHNA, each hospital or health care organization develops a Community Health Improvement Plan that describes how it intends to invest in strategies to address the priorities identified in the CHNA. The strategies identified by the hospitals in the Upper Valley as they align with the community health priorities addressed in this CHIP as summarized on the following three pages.

# Community Health Improvement Plans by HSA

| | Dartmouth Hitchcock Health Center | Gifford Medical Center | Mt. Ascutney Hospital and Health Center | Alice Peck Day Memorial Hospital |
|---|---|---|---|---|
| **Access to Mental Health Services** | Support Mental Health First Aid and Connect Suicide Prevention community trainings.<br><br>Reduce access to lethal means (for attempting suicide) | Active recruitment to expand psychiatry and counseling team.<br><br>ED psychiatric care via partnership with Alpine Telehealth | | Emergency Department Rapid Referral Program, streamlined access to behavioral health care for patients |
| **Cost of Health Care Services, Health Insurance and Dental Care** | Support COVID-19 vaccination clinics<br><br>Support public flu vaccination clinics.<br><br><u>Dental Health</u><br><br>Faciliate school-based dental clinics in the Upper Valley & Sullivan County<br><br><u>Senior Health</u><br><br>Support services for older adults including home-based care for homebound patients, Aging Resource Center<br><br>Fund safety net programs for older adults such as transportation, home delivered meals, and case management. | Continuation of school-based health clinic<br><br><u>Dental Health</u><br><br>Partnership with HealthHub's mobile dental trailer<br><br><u>Senior Health</u><br><br>Support group focused on grief | <u>Dental Health</u><br><br>Convene local and regional resources to analyze options and opportunities to improve dental care services.<br><br><u>Senior Health</u><br><br>To increase the connection of individuals aged 50+ to needed resources in the Mt. Ascutney Hospital service area.<br><br>Connect groups and organizations supporting individuals aged 50+ in our service area to each other for development, networking, and outreach. | Prescription Assistance Program & pharmacy voucher program<br><br>Provide hands-on Medicaid enrollment assistance to uninsured community members.<br><br><u>Dental Health</u><br><br>Upper Valley Smiles, a school-based oral health program<br><br>Financially support and refer MAT patients to dental care.<br><br><u>Senior Health</u><br><br>Senior Care Team's home-based primary care for frail elders<br><br>Host "Elder Forum" networking & educational forum for health and human services organizations<br><br>Elder Friend program matching frail elders with volunteer home-visitors.<br><br>Collaboration with APD Life Care (Harvest Hill & The Woodlands) |
| **Access to Healthy and Affordable Food** | Grow fresh produce for community through Farmacy Garden with Willing Hands<br><br>Provide culinary medicine classes<br><br>Provide health food prescriptions for pediatric patients and their families<br><br>Provide farm shares for patients in multiple clinics<br><br>Contribute to community-based summer meals programs in the Upper Valley | Partnerships with local food banks and food shelves | Increase access to nourishing food for all people in our communities over the next 3 years.<br><br>Apply message framing principles to market food security resources to area residents, with the intent of increasing awareness and reducing barriers to access.<br><br>Identify gaps and barriers to food access in our region by conducting a food resources inventory. Use the results to develop and implement a plan for increasing access to nourishing and culturally appropriate food. Include in the plan what will be done, who will do it, and by when. | Support free summer meals program for children living in low-income housing sites<br><br>Offer Emergency Food Bags and Meal Cards to patients expressing need for food supports |

# Community Health Improvement Plans by HSA

| | Dartmouth Hitchcock Health Center | Gifford Medical Center | Mt. Ascutney Hospital and Health Center | Alice Peck Day Memorial Hospital |
|---|---|---|---|---|
| **Alcohol and Drug Misuse Prevention, Treatment and Recovery** | Support safe syringe disposal in the Upper Valley & Sullivan County<br><br>Maintain overdose harm reduction efforts<br><br>Facilitate regional SUD Continuum of Care teams in the Upper Valley & Sullivan County<br><br>Continue DHMC Addiction Treatment Program<br><br>Maintain Recovery Coaches in Emergency Department, Addiction Treatment, Moms in Recovery & Psychiatry<br><br>Continue SBIRT screening for ages 12 and up<br><br>Reduce youth access and use of vaping and tobacco products through school and community prevention trainings and compliance checks | | Act as a network to promote prevention and reduce barriers to treatment and recovery, and respond to ongoing community needs related to substance use.<br><br>Increase reach of WeAreWorthwhile self-stigma campaign.<br><br>Fully implement Overdose to Action grant. | Offer meeting spaces for AA & Al-Anon groups<br><br>Screen adult, young adult & teen patients for substance use disorders and refer to local resources<br><br>Provide collaborative support and MAT for patients with substance use disorder |
| **Child Well-Being** | Support recovery-friendly, trauma-informed pediatric practices<br><br>Continue Early Childhood Wellbeing screening including maternal depression and Social Determinants of Health<br><br>Provide trauma-informed care trainings for early childhood providers/professionals<br><br>Continue support for community resources through CHaD Family Center, Women's Health Resource Center, and Molly's Place<br><br>Support Circle of Security program by hosting parent trainings and offering train-the-trainer to increase capacity<br><br>Support Family Resource Centers<br><br>Project Launch (wrap-around care) for families affected by parental substance use | Continuation of school-based health clinic | To increase social connectedness of caregivers in the MAH service area within the next 5 years.<br><br>Implementing facilitated playgroups in Vermont towns in the Hospital Service Area<br><br>Coordinated Circle of Security parent education offerings in this region (VT & NH) | |

# Community Health Improvement Plans by HSA

| | Dartmouth Hitchcock Health Center | Gifford Medical Center | Mt. Ascutney Hospital and Health Center | Alice Peck Day Memorial Hospital |
|---|---|---|---|---|
| **Socio-Economic Conditions: Housing and Others** | Contribute to safety net services supporting the Upper Valley<br><br>Maintain embedded resource specialist in Addiction Treatment Program<br><br>Support Community Health Workers (& similar) in primary care and community settings<br><br>Contribute to supported, workforce and low-income housing projects in DHMC communities | | Promote and create conditions for a broad cross-sector regional effort to increase housing availability.<br><br>Creation of new units within existing structures by way of safe home sharing practices, renting rooms, and creating accessory apartments.<br><br>Develop a broad base of public support for creating new housing that meets community needs and desires. | Screen adult patients for housing needs and assist with applications/referrals<br><br>Increase minimum wage for APD employees (& adjust wages for existing employees)<br><br>Continue Employee Navigator position to assist employees with non-work-related stressors |
| **Physical Health** | | | | FitScripts program offering monthly memberships at local fitness centers<br><br>Support Mascoma River Greenway, APD Nature Trails, and UV Trails Alliance<br><br>Provide bike helmets to children, patients, and staff and support other efforts to increase biking in the community.<br><br>Advocate for community infrastructure that increased community health including sidewalks & bus routes |

# Access to Mental Health Services

### INDICATORS

Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Access to Mental Health Providers: Ratio of population to mental health providers

### COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

Mental health care was identified as a continuing and top priority for community health improvement by all community discussion groups including concerns for insufficient local capacity, particularly for higher levels of care, and increased need resulting from anxiety, stress and isolation impacts of COVID-19.

In Sullivan County, Psychiatrist FTEs per 100k population (1.8) are less than half the FTE capacity in NH overall (5.0 per 100K population).

There are not enough counselors, therapists, psychiatrists, or social workers. One agency worker explained that they have the highest number of clinical staff vacancies in 50 years.

Orange County (via Gifford CHNA): 15 percent of Orange County high school students made a suicide plan in the past 12 months; this is higher than both Washington (14%) and Windsor (12%) counties as well as above the state average (13%).

### Collaboration & Service Improvement

- Three Community Mental Health Agencies in region will become Certified Community Behavioral Health Centers by 2026.
- Work with law enforcement agencies to increase use of mobile mental health crisis response to improve connections between individuals in crisis and community-based services.
- Facilitate a process to improve navigation of health insurance options, social service programs, and other resources available to people in need to identify and close gaps. Implement or create a tool to increase access to information and increase coordination among providers.
- To increase the connection of individuals aged 50+ to needed resources in region.

### Education

- Increase the number of community members trained in Mental Health First Aid to reduce stigma and increase appropriate responses to people in mental health crisis.
- Increase the number of community members trained in CONNECT Suicide Prevention to reduce stigma and increase appropriate responses to people in mental health crisis.
- Promote resources for mental health crisis response to increase community awareness of appropriate services based on need (includes Mobile Crisis Response, 988 and other hotline services).
- Promote and replicate (as needed) Mental Health Resource Guide created by MAHHC.

### Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.

### Health Equity

- Conduct a systematic review of health care and behavioral health care access in the Upper Valley from the perspective of traditionally marginalized groups and their overall wellbeing.
- Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance.

# Cost of Health Care Services, Health Insurance and Dental Care

## INDICATORS

Percentage of population under age 65 without health insurance.

Preventable Hospital Stays: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.

ED Visits for Non-Traumatic Dental Conditions per 1,000 residents

## COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

Community discussion participants identified health care costs and financial barriers to care as significant and ongoing concerns. It was also the most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health.' (DH/APD/VNH CHNA)

Among respondents with household income less than $50K, 72% indicated difficulty accessing one or more type of health or human service in the past year." (DH/APD/VNH CHNA)

Cost of health care services including health insurance and prescription drug costs were the 2nd highest priorities identified by general community survey respondents and 3rd highest priority identified by community leaders. Two thirds of respondents with household income less than $50K indicated difficulty accessing one or more types of health or human service in the past year. (MAHHC CHNA)

### Collaboration & Service Improvement

- Expand access to free health care services with new Good Neighbor Health Clinic in Lebanon, NH.
- Increase workforce development opportunities for early career Dental Assistant's with training program at HACTC and preceptorships with local dental practices.
- Facilitate a process to improve navigation of health insurance options, social service programs, and other resources available to people in need to identify and close gaps. Implement or create a tool to increase access to information and increase coordination among providers.
- To increase the connection of individuals aged 50+ to needed resources in region.

### Education

- Engage Town Welfare Officers in discussion around the importance of addressing health care costs and referral for support during bi-annual meetings facilitated by the PHC.

### Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.
- Promote the value of Community Paramedicine Programs and advocate for insurance reimbursement for these community-based services.
- Promote alternative approaches to fund health and dental care for un- and under-insured people.

### Health Equity

- Offer free flu vaccine clinics and COVID-19 vaccine clinics in community settings to reduce barriers to receiving vaccine.
- Offer free dental services in school-based dental clinics.
- Conduct a systematic review of health care and behavioral health care access in the Upper Valley from the perspective of traditionally marginalized groups and their overall wellbeing.
- Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance.

Across three hospital service areas, the CHNA revealed this as one of the region's top priorities.

# Access to Healthy and Affordable Food

### INDICATORS

Food Environment Index: % Limited Access to Healthy Food

Food Environment Index: % Food Insecurity

### COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

An estimated 10% of service area households experienced food insecurity in 2019. (DHMC/APD/VNH CHNA)

Disparities in access to other resources such as childcare, affordable food and transportation were described as significant problems pre-pandemic made much worse by the pandemic. (MAHHC CHNA)

When asked which factors were most important for a healthy community… 'Access to healthy food' was noted as important by 41.4 percent of respondents." (Gifford CHNA)

"Stigma around accessing food resources is very prominent and real." (UV Community Health Summit Participant)

## Collaboration & Service Improvement

- Support strategic planning within the Upper Valley Hunger Council to identify opportunities to increase coordination of services and address gaps.
- Map food security assets to identify gaps and opportunities.
- Increase use of Hunger Vital Signs as a screening tool to identify food insecurity in healthcare and social service settings, especially for children.
- Expand access to meals for children at school and during summer breaks.
- Increase the number of community gardens and gleaning providing fresh produce to people experiencing food insecurity.

## Education

- Support strategic planning within the Upper Valley Hunger Council to identify opportunities to increase education about resources and healthy food options.

## Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.
- Advocate for the expansion of low-barrier meal programs for children at school and during summer breaks.
- Advocate for Livable Wages

## Health Equity

- Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance.
- Advocate for Livable Wages

Gleaning with Willing Hands

# Alcohol and Drug Misuse Prevention, Treatment and Recovery

### INDICATORS

Number of drug poisoning deaths per 100,000 population

Percentage of adults reporting binge or heavy drinking (age-adjusted)

### COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

Vermont has experienced one of the highest increases in drug overdose deaths in the country during the COVID-19 pandemic; increasing by 39% in 2020 compared to the prior year. In Windsor County, the rate of opioid-related overdose fatalities more than tripled in 2020 compared to the prior year. (MAHHC)

Respondents were asked to identify the biggest "health challenges" in the Gifford community. 'Drug addiction' was one of the top three community health challenges identified (selected by 31.9% of respondents). (Gifford)

"We are blaming and shaming those who are struggling with substance misuse… as a society we need better tools to help those who are struggling, no matter what they are struggling with." (UV Community Health Summit Participant)

## Collaboration & Service Improvement

- Implement recommendations from 2022 Coalition Capacity Assessment to sustain and improve collaboration within All Together coalition.
- increase access to SUD treatment and recovery support.
- increasing access to medication assisted treatment programs.
- Support harm reduction strategies such as Naloxone training and Drug Take Back Days.

## Education

- Disseminate informational material across sectors, promoting awareness of/access to harm reduction resources.
- Promote and replicate (as needed) Mental Health Resource Guides created by MAHHC and All Together.
- Increase reach of WeAreWorthwhile self-stigma campaign.

## Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.
- Collaborate with All Together partners to reduce stigma associated with substance misuse and addiction.
- Provide information for community members about changes in substance misuse related policy, such as cannabis legalization.

## Health Equity

- Conduct qualitative needs assessments with the support of members of marginalized groups to identify health disparities and opportunities to address them.
- Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance.


Upper Valley Drug Take Back Day 2022

# Child Well-Being

### INDICATORS

Percentage of people under age 18 in poverty

Childcare costs for a household with two children as a percent of median household income

Young Children (Ages 3 and 4) Not in School

### COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

Prevention of child abuse and neglect was one of the most frequently selected community health priority by community leader survey respondents (38%) and was also top concern among the general community (selected as a top priority by 26% of survey respondents)." (MAHHC)

Disparities in access to other resources such as childcare and transportation were described as significant problems pre-pandemic made much worse by the pandemic. (DHMC/APD/VNH)

Discussion group participants reported concerns about the effects of parental stress, poverty and substance misuse on the health and welfare of children in the community including effects of childhood trauma on health and wellbeing later in life." *(*MAHHC)

"We're seeing a huge cliff effect come kindergarten, especially for students with disabilities… [there's a] lack of infrastructure and capacity to support all children." (PHC Early Childhood Mental Wellbeing System Assessment Interviewee)

## Collaboration & Service Improvement

- Facilitate Child Wellbeing Summit to review results of Early Childhood Mental Wellbeing System Assessment (completed October 2022) and identify action items.
- Facilitate train-the-trainer for Circle of Security program across community partners.
- Increase social connectedness of caregivers and promote facilitated paygroups.
- Connect pregnant and parenting families to home-visiting programs

## Education

- Continue to provide professional development in evidence-based programs aimed at improving social-emotional development and children.

## Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.
- Advocate for funding and other supports to maintain and grow capacity within family resource centers.

## Health Equity

- Conduct qualitative needs assessments with the support of members of marginalized groups to identify health disparities and opportunities to address them.
- Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance.

"I have loved learning about the circle and better understanding my son's needs. I want to shout from the rooftops how wonderful this program is and that everyone should take it." – *Circle of Security Parent, 2021*

# Socio-Economic Conditions: Housing and Others

### INDICATORS

Income Inequality: Ratio of household income at the 80th percentile to income at the 20th percentile

Severe Housing Cost Burden: Percentage of households that spend 50% or more of their household income on housing

Percentage of households that spend greater than 30% of their household income on rent

### COMMUNITY HEALTH NEEDS ASSESSMENT EXCERPTS

About 35% of households in the MAHHC service area have housing costs >30% of household income. The service area is also characterized by a wide range in community wealth where median household income in the wealthiest communities is about 75% higher than the communities with lowest median household incomes" (MAHHC)

When asked which factors were most important for a healthy community (factors that most improve the quality of life in a community), 31.9 percent of respondents said affordable housing. (Gifford)

"There just aren't a lot of places to live, and clearly there's a lot of contributing factors to that… I put in applications to every place that I possibly could and was competing against 10 people for each place; I took a place sight unseen." (UV Community Health Summit Participant)

## Collaboration & Service Improvement

- Support implementation of Keys to the Valley strategy recommendations to increase the number of housing units across the Upper Valley.

## Education

- Continue Vital Communities' Business Leaders Breakfast on Housing (1x/year) to educate business leaders in economic impact of the current housing crisis.

## Advocacy

- Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities.
- Educate policy makers and others about the health impacts of the current housing crisis.

## Health Equity

- Educate policy makers and others about the health impacts of the current housing crisis on low-income and other marginalized groups.
- Improve referral networks and capacity to support vulnerable populations in the places where they live.

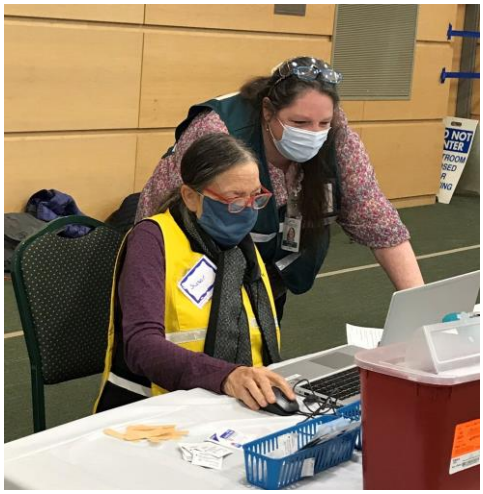
# Public Health Emergency Preparedness

### INDICATORS

Updated emergency response plans available for implementation

Number of trainings and drills provided to ensure emergency response workforce is ready

Number of active members of the UV Medical Reserve Corps



UV MRC Members Assist with COVID Vaccine Clinics

## Collaboration & Service Improvement

- Provide leadership and coordination to improve regional emergency preparedness and the capacity for partner organizations to mitigate, prepare for, respond to, and recover from public health incidents and emergencies
- Ensure capacity to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.
- Develop and implement emergency operation plans as needed for community-wide vaccine distribution.

## Education

- Coordinate with the State(s) to complete required exercises and activities required by federal agency funding.
- Coordinate and collaborate with agency and department resources to train and educate members of the public and those within the Medical Reserve Corps.

## Advocacy

- Provide feedback to the States of New Hampshire and Vermont regarding resources and support needed to maintain adequate public health emergency response capacity.

## Health Equity

- Coordinate with hospital-based health care systems, municipalities, and additional entities serving individuals with functional needs and/or providing other health and wellness services in the region to assess risk and/or vulnerabilities.
- Reduce access barriers (language, mobility, transportation, vision, and hearing access, etc) to vaccination services (for COVID-19, influenza, monkey pox and other infectious vaccine preventable diseases.
- Identify needed vaccination clinics and provide testing kits to those who are underinsured, uninsured, homebound or have other barriers or hesitancy.

UV MRC Sponsored Stop the Bleed Training

# Access to Mental Health Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Three Community Mental Health Agencies in region will become Certified Community Behavioral Health Centers by 2026. | WCBH, HCRS, Clara Martin Center |
| Work with law enforcement agencies to increase use of mobile mental health crisis response to improve connections between individuals in crisis and community-based services. | WCBH, HCRS |
| Facilitate a process to improve navigation of health insurance options, social service programs, and other resources available to people in need to identify and close gaps. Implement or create a tool to increase access to information and increase coordination among providers. | PHC, Service Link & Area Council on Aging Partners, Upper Valley Service Coordinators Roundtable |
| To increase the connection of individuals aged 50+ to needed resources in region. | MAHHC, Service Link & Area Council on Aging Partners |
| Increase the number of community members trained in Mental Health First Aid to reduce stigma and increase appropriate responses to people in mental health crisis. | DH All Together, WCBH, NAMI-NH |
| Increase the number of community members trained in CONNECT Suicide Prevention to reduce stigma and increase appropriate responses to people in mental health crisis. | DH All Together, DH Injury Prevention Center, NAMI-NH |
| Promote resources for mental health crisis response to increase community awareness of appropriate services based on need (includes Mobile Crisis Response, 988 and other hotline services). | WCBH, HCRS, Headrest |
| Promote and replicate (as needed) Mental Health Resource Guide created by MAHHC. | PHC & Multiple Partners |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC & Multiple Partners |
| Conduct a systematic review of health care and behavioral health care access in the Upper Valley from the perspective of traditionally marginalized groups and their overall wellbeing. | PHC, UVEAR and UVCHEP Steering Committee |
| Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance. | UVCHEP Steering Committee |
| Improve referral networks and capacity to support vulnerable populations in the places where they live. | Multiple healthcare, service coordination & housing partners |

# Cost of Health Care Services, Health Insurance and Dental Care Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Expand access to free health care services with new Good Neighbor Health Clinic in Lebanon, NH. | GNHC |
| Increase workforce development opportunities for early career Dental Assistants with training program at HACTC and preceptorships with local dental practices. | DH, APD, HACTC, local dental providers |
| Facilitate a process to improve navigation of health insurance options, social service programs, and other resources available to people in need to identify and close gaps. Implement or create a tool to increase access to information and increase coordination among providers. | PHC, Service Link & Area Council on Aging Partners, GNHC, Upper Valley Service Coordinators Roundtable, Local Hospitals |
| To increase the connection of individuals aged 50+ to needed resources in region. | MAHHC, Service Link & Area Council on Aging Partners |
| Engage Town Welfare Officers in discussion around the importance of addressing health care costs and referral for support during bi-annual meetings facilitated by the PHC. | PHC |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC |
| Promote the value of Community Paramedicine Programs and advocate for insurance reimbursement for these community-based services. | PHC, DH, Local Municipalities |
| Promote alternative approaches to fund health and dental care for un- and under-insured people. | PHC, GNHC, RLDC & Multiple Partners |
| Offer free flu vaccine clinics and COVID-19 vaccine clinics in community settings to reduce barriers to receiving vaccine. | PHC, DH, UVRPHN, VDH/WRJ |
| Offer free dental services in school-based dental clinics. | APD, HealthHub |
| Conduct a systematic review of health care and behavioral health care access in the Upper Valley from the perspective of traditionally marginalized groups and their overall wellbeing. | PHC, Equity Partners & Multiple Partners |
| Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance. | UVCHEP Steering Committee & Multiple Partners |

# Access to Healthy and Affordable Food Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Support strategic planning within the Upper Valley Hunger Council to identify opportunities to increase coordination of services and address gaps. | UVHC |
| Map food security assets to identify gaps and opportunities. | MAHHC Food Security Workgroup, MARC, TROPC |
| Increase use of Hunger Vital Signs as a screening tool to identify food insecurity in healthcare and social service settings, especially for children. | UVHC, NH Hunger Solutions |
| Expand access to meals for children at school and during summer breaks. | HCC, FOMF, School Districts & Multiple Partners |
| Increase the number of community gardens and gleaning providing fresh produce to people experiencing food insecurity. | UVHC, VC, Willing Hands, Housing Partners |
| Support strategic planning within the Upper Valley Hunger Council to identify opportunities to increase education about resources and healthy food options. | PHC, UVEAR, UVCHEP |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC |
| Advocate for the expansion of low-barrier meal programs for children at school and during summer breaks. | PHC, UVHC |
| Advocate for Livable Wages | PHC & Multiple Partners |
| Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance. | UVCHEP Steering Committee & Multiple Partners |
| Support strategic planning within the Upper Valley Hunger Council to identify opportunities to increase coordination of services and address gaps. | UVHC |

# Alcohol and Drug Misuse Prevention, Treatment and Recovery Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Implement recommendations from 2022 Coalition Capacity Assessment to sustain and improve collaboration within All Together coalition. | PHC, DH All Together |
| increase access to SUD treatment and recovery support. | PHC, The Doorway/ATP, & Multiple Partners |
| increasing access to medication assisted treatment programs. | PHC, The Doorway/ATP, Habit OPCO & Multiple Partners |
| Support harm reduction strategies such as Naloxone training and Drug Take Back Days. | PHC, DH All Together, MAHHC, HCC, local Police Depts. |
| Disseminate informational material across sectors, promoting awareness of/access to harm reduction resources. | PHC, DH All Together, & Multiple Partners |
| Promote and replicate (as needed) Mental Health Resource Guides created by MAHHC and All Together. | PHC, MAHHC, DH All Together |
| Increase reach of WeAreWorthwhile self-stigma campaign. | MAHHC |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC & Multiple Partners |
| Collaborate with All Together partners to reduce stigma associated with substance misuse, addiction and co-occurring disorders. | PHC, DH All Together, & Multiple Partners |
| Provide information for community members about changes in substance misuse related policy, such as cannabis legalization. | PHC, DH All Together, New Futures, MAHHC, HCC |
| Conduct qualitative needs assessments with the support of members of marginalized groups to identify health disparities and opportunities to address them. | UVCHEP Steering Committee & Multiple Partners |
| Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance. | UVCHEP Steering Committee & Multiple Partners |

# Child Well-Being Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Facilitate Child Wellbeing Summit to review results of Early Childhood Mental Wellbeing System Assessment (completed October 2022) and identify action items. | PHC, Young Child Wellness Council Partners |
| Continue convening Circle of Security program facilitators across region to sustain and grow program reach. | Project Launch, MAHHC Strengthening Families Workgroup |
| Increase social connectedness of caregivers and promote facilitated playgroups. | MAHHC |
| Connect pregnant and parenting families to home-visiting programs | Project Launch, DH (OB, Moms in Recovery, Peds), FRCs, VDH/WIC & MCH |
| Continue to provide professional development in evidence-based programs aimed at improving social-emotional development and children. | Project Launch |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC |
| Advocate for funding and other supports to maintain and grow capacity within family resource centers. | PHC, FRCs & Multiple Partners |
| Conduct qualitative needs assessments with the support of members of marginalized groups to identify health disparities and opportunities to address them. | PHC, Young Child Wellness Council Partners, UVEAR, UVCHEP, Disabilities Provider Orgs. |
| Increase capacity of grassroots and small organizations representing people with lived experience of health inequities to address the concerns of their communities independently through grantmaking and technical assistance. | UVCHEP Steering Committee & Multiple Partners |

# Socio-Economic Conditions: Housing and Other Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Support implementation of Keys to the Valley strategy recommendations to increase the number of housing units across the Upper Valley, with special focus on equity. | VC, RPCs, Twin Pines Housing, Lebanon Housing Authority, Windham & Windsor Housing Trust, Springfield Housing Authority, Municipalities |
| Continue VC Business Leaders Breakfast on Housing (1x/year) to educate business leaders in economic impact of the current housing crisis. | VC |
| Host Bi-State Legislative Breakfast every two years to engage state policy makers in discussion of local health priorities. | PHC |
| Educate policy makers and others about the health impacts of the current housing crisis. | PHC, VC, RPCs |
| Educate policy makers and others about the health impacts of the current housing crisis on low-income and other marginalized groups. | PHC, VC, RPCs |
| Improve referral networks and capacity to support vulnerable populations in the places where they live. | Multiple healthcare, service coordination & housing partners |

# Public Health Emergency Preparedness Strategies by Lead Partners

*Partners involved with strategies may expand and/or change over time. This is not intended as an exhaustive list and we apologize for any omissions.*

| | |
|---|---|
| Provide leadership and coordination to improve regional emergency preparedness and the capacity for partner organizations to mitigate, prepare for, respond to, and recover from public health incidents and emergencies | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |
| Ensure capacity to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel. | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |
| Develop and implement emergency operation plans as needed for community-wide vaccine distribution. | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |
| Coordinate with the State(s) to complete required exercises and activities required by federal agency funding. | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |
| Coordinate and collaborate with agency and department resources to train and educate members of the public and those within the Medical Reserve Corps. | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |
| Provide feedback to the States of New Hampshire and Vermont regarding resources and support needed to maintain adequate public health emergency response capacity. | UVPHEP(NH), VDH PHEP |
| Coordinate with hospital-based health care systems, municipalities, and additional entities serving individuals with functional needs and/or providing other health and wellness services in the region to assess risk and/or vulnerabilities. | UVPHEP(NH), VDH PHEP |
| Reduce access barriers (language, mobility, transportation, vision, and hearing access, etc) to vaccination services (for COVID-19, influenza, monkey pox and other infectious vaccine preventable diseases. | UVPHEP(NH) |
| Identify needed vaccination clinics and provide testing kits to those who are underinsured, uninsured, homebound or have other barriers or hesitancy. | UVPHEP(NH), VDH/WRJ |
| Provide leadership and coordination to improve regional emergency preparedness and the capacity for partner organizations to mitigate, prepare for, respond to, and recover from public health incidents and emergencies | UVPHEP(NH), VDH PHEP, UV RCC, UV MRC |

# Indicators Catalog & Baseline Data, Page 1

| Priority | Indicator | Source | Baseline Year | Baseline Data | | Desired Direction of Change |
|---|---|---|---|---|---|---|
| **Access to Mental Health Services** | | | | | | |
| | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | County Health Rankings, BRFSS | 2019 | Grafton County | 4.6 | ▼ |
| | | | | Windsor County | 4.4 | ▼ |
| | | | | *U.S.* | *4.5* | |
| | Access to Mental Health Providers: Ratio of population to mental health providers | County Health Rankings, CMS, National Provider Registration | 2021 | Grafton County | 190:1 | ▼ |
| | | | | Windsor County | 170:1 | ▼ |
| **Cost of Health Care Services, Health Insurance and Dental Care** | | | | | | |
| | Percentage of population under age 65 without health insurance. | County Health Rankings, Small Area Health Insurance Estimates | 2019 | Grafton County | 9% | ▼ |
| | | | | Windsor County | 6% | ▼ |
| | Preventable Hospital Stays: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. | County Health Rankings, Mapping Medicare Disparities Tool | 2019 | Grafton County | 2,972 | ▼ |
| | | | | Windsor County | 3,029 | ▼ |
| | ED Visits for Non-Traumatic Dental Conditions per 1,000 residents | Uniform Hospital Discharge Dataset: NH & VT datasets may not be comparable due to differences in definitions and presentation | 2016 | Grafton County | 11.3 | ▼ |
| | | | | New Hampshire | 8.4 | ▼ |
| | | | | Vermont | 8.2 | ▼ |
| **Access to Healthy and Affordable Food** | | | | | | |
| | Food Environment Index: % Limited Access to Healthy Food | County Health Rankings, USDA Food Environment Atlas, Map the Meal Gap from Feeding America | 2019 | Grafton County | 3% | ▼ |
| | | | | Windsor County | 1% | ▼ |
| | | | | *U.S.* | *6%* | |
| | Food Environment Index: % Food Insecurity | County Health Rankings, USDA Food Environment Atlas, Map the Meal Gap from Feeding America | 2019 | Grafton County | 10% | ▼ |
| | | | | Windsor County | 10% | ▼ |
| | | | | *U.S.* | *11%* | |

# Indicators Catalog & Baseline Data, Page 2

| Priority | Indicator | Source | Baseline Year | Baseline Data | | Desired Direction of Change |
|---|---|---|---|---|---|---|
| **Alcohol and Drug Misuse Prevention, Treatment, and Recovery** | | | | | | |
| | Percentage of adults reporting binge or heavy drinking (age-adjusted). | County Health Rankings, BRFSS | 2019 | Grafton County | 20% | ▼ |
| | | | | Windsor County | 21% | ▼ |
| | Number of drug poisoning deaths per 100,000 population. | County Health Rankings, National Center for Health Statistics - Mortality Files. | 2018-2020 | Grafton County | 47 | ▼ |
| | | | | Windsor County | 42 | ▼ |
| **Child Well-Being** | | | | | | |
| | Percentage of people under age 18 in poverty. | County Health Rankings, US Census Bureau, Small Area Income and Poverty Estimates | 2020 | Grafton County | 11% | ▼ |
| | | | | Windsor County | 19% | ▼ |
| | Childcare costs for a household with two children as a percent of median household income. | County Health Rankings, US Census Bureau, The Living Wage Calculator, Small Area Income and Poverty Estimates | 2020-2021 | Grafton County | 21% | ▼ |
| | | | | Windsor County | 29% | ▼ |
| | Young Children (Ages 3 and 4) Not in School | Annie E. Casey Kids Count Data Book: 2022 | 2016-2020 | New Hampshire | 46% | ▼ |
| | | | | Vermont | 43% | ▼ |
| **Socio-Economic Conditions: Housing and Others** | | | | | | |
| | Income Inequality: Ratio of household income at the 80th percentile to income at the 20th percentile. | County Health Rankings, American Community Survey, 5-year estimates | 2016-2020 | Grafton County | 4.6 | ▼ |
| | | | | Windsor County | 4.5 | ▼ |
| | Severe Housing Cost Burden: Percentage of households that spend 50% or more of their household income on housing. | County Health Rankings, American Community Survey, 5-year estimates | 2016-2020 | Grafton County | 14% | ▼ |
| | | | | Windsor County | 13% | ▼ |
| | Percentage of households that spend greater than 30% of their household income on rent. | NH WISDOM | | UVPHN | 46.5% | ▼ |
| **Public Health Emergency Preparedness** | | | | | | |
| | Updated emergency response plans available for implementation. | Local PHEP Records | | | | ▲ |
| | Number of trainings and drills provided to ensure emergency response workforce is ready. | Local PHEP Records | | | | ▲ |
| | Number of active members of the UV Medical Reserve Corps | Local PHEP Records | | | | ▲ |

| Name or Abbreviation | Name, Explanation, and/or Link |
|---|---|
| APD | Alice Peck Day Memorial Hospital |
| Area Council on Aging Partners | Includes Grafton County Senior Citizens Council, Senior Solutions, Bugbee Senior Center, Thompson Senior Center, DH Aging Resource Center and others. |
| BBF | Building Bright Futures |
| Bugbee Senior Center | Bugbee Senior Center |
| Clara Martin Center | Clara Martin Center |
| DH | Dartmouth Hitchcock (or Dartmouth Health) |
| DH Aging Resource Center | DH Aging Resource Center |
| DH Injury Prevention Center | DH Injury Prevention Center |
| DTIRC Project Launch | Dartmouth Trauma Interventions Research Center, Project Launch Upper Valley: Promoting a healthy start for young children and their caregivers |
| ECEA | Early Care and Education Association |
| Equity Partners | See UVEAR & UVCHEP Steering Committee |
| FOMF | Friends of Mascoma Foundation |
| FRCs | Family Resource Centers, including The Family Place, TLC Family Resource Center & Waypoint Family Resource Center |
| GCSCC | Grafton County Senior Citizens Council |
| GHC | Gifford Health Care |
| GNHC | Good Neighbor Health Clinic |
| GUVIST | Greater Upper Valley Integrated Services Team |
| Habit OPCO | Habit OPCO |
| HACTC | Hartford Area Career and Technology Center |
| HCC | Hartford Community Coalition |
| HCRS | Health Care & Rehabilitation Services |
| Headrest | Headrest: Assisting those affected by substance use disorder and/or experiencing a crisis. |
| High Horses | High Horses Therapeutic Riding Program |
| Housing Partners | Includes Twin Pines Housing Trust, Lebanon Housing Authority, Windham & Windsor Housing Trust, Springfield Housing Authority, RPCs, VC & others |
| KTTV | Keys to the Valley Housing Initiative |
| LHA | Lebanon Housing Authority |
| MAHHC | Mt. Ascutney Hospital & Health Center |
| MARC | Mt. Ascutney Regional Commission |
| NAMI-NH | National Alliance on Mental Illness -- NH |
| New Futures | New Futures: NH-based advocacy organization |
| NHHS | NH Hunger Solutions |
| Organizations serving people living with disabilities | Includes Special Needs Support Center, Spark Community Center, High Horses Therapeutic Riding Program, Zack's Place, Visions for Creative Housing Solutions & others |

# Lead Partners

Page 1

| Name or Abbreviation | Name, Explanation, and/or Link |
|---|---|
| PHC | Public Health Council of the Upper Valley |
| RLDC | Red Logan Dental Clinic |
| RPCs | Regional Planning Commissions: MARC, TROPC, UVLSRPC |
| Senior Solutions | Senior Solutions |
| ServiceLink | Lebanon (Grafton County) ServiceLink: Aging & Disability Resource Center |
| SNSC | Special Needs Support Center |
| Spark | Spark Community Center |
| TFP | The Family Place |
| The Doorway/ATP | The Doorway/Addiction Treatment Program |
| Thompson Senior Center | Thompson Senior Center |
| TLC | TLC Family Resource Center |
| TPHT | Twin Pines Housing Trust |
| TRORC | Two Rivers Ottauquechee Regional Commission |
| Upper Valley Service Coordinators Roundtable | A quarterly group meeting of service coordinators in agencies across the region to share information, plan shared initiatives, and advocate for clients. |
| UV All Together | UV All Together |
| UV MRC | Upper Valley Medical Reserve Corps |
| UV RCC | Upper Valley Regional Coordinating Council |
| UV RPHN | UV Regional Public Health Network is one of 13 such networks in NH. Each RPHN includes a host agency (Dartmouth Health) that has a contract with the NH Department of Health and Human Services to conduct substance misuse programs, public health emergency preparedness and support a public health advisory council (PHAC). In the UV, PHC serves as the PHAC and convenes, coordinates, and facilitates public health partners. |
| UVCHEP Steering Committee | UV Community Health Equity Partnership Steering Committee (PHC project) |
| UVEAR | Upper Valley Equity Anti-Racism Leadership Team (housed within PHC) |
| UVHC | Upper Valley Hunger Council |
| UVLSRPC | Upper Valley Lake Sunapee Regional Planning Commission |
| UVPHEP(NH) | Upper Valley Public Health Emergency Preparedness Coordinator (NH) |
| VC | Vital Communities |
| Visions | Visions for Creative Housing Solutions |
| VDH PHEP | Public Health Emergency Preparedness Specialist (VtDOH/WRJ) |
| VDH/WRJ | Vermont Department of Health, White River Junction District Office |
| Waypoint FRC | Waypoint Family Resource Center |
| WCBH | West Central Behavioral Health |
| Willing Hands | Willing Hands |
| Young Child Wellness Council | Includes reps. of Project Launch, TFP, GUVIST, MAHHC, BBF, ECEA, and others. |
| Zack's Place | Zack's Place |

# Lead Partners

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