



Public Health Council
of the Upper Valley

CELEBRATING 25 YEARS

**Community Health Improvement Plan
Executive Summary**

The 2026–2028 Community Health Improvement Plan (CHIP) is grounded in the [DH/APD 2025 Community Health Needs Assessment](#) (CHNA) and [PHC's Strategic Plan](#), and provides a roadmap for health and social service partners to address system wide issues that create barriers to measurable improvements in shared priority areas through strengthened partnerships, collaboration and advancement of equitable, community-centered solutions.

The CHNA identified three overarching priority areas:

- Access to Care: Including primary, specialty, dental, and mental health services, affordability, workforce shortages, and system navigation.
- Basic and Social Needs: Including housing, transportation, childcare, food access
- Support for Older Adults

Strategic Approach

This CHIP positions PHC as a backbone organization, enabling partners to collectively design and implement solutions that improve health outcomes and advance equity across the Upper Valley through more coordinated systems, sustainable funding, and improved infrastructure.

CHIP cross-cutting strategies to address system level issues that impact regional priorities:

1. **Expanding Community and Municipal Engagement & Education:** Improve health literacy, strengthen communication, and build municipal capacity through training, shared messaging, and cross-town collaboration.
2. **Creating Improved Referral Pathways and Shared Approaches to Communicating Resources:** Investigate and support coordinated, user-friendly systems for sharing up-to-date resources and improving service navigation for residents and providers.
3. **Increasing Access to Community-Based Care:** Expand care delivery in accessible, nontraditional settings to reduce barriers and advance health equity.
4. **Building Resilient Funding Approaches that Reward Collaborative Work:** Promote joint funding strategies, shared grant opportunities, and sustainable financing to support multi-partner initiatives.
5. **Advancing Innovation:** Strengthen PHC's role as an incubator and facilitator for collective action initiatives.

Implementation will follow a phased timeline:

- **2026:** Define challenges, engage partners, and build consensus
- **2027:** Design solutions, formalize partnerships, and secure funding
- **2028:** Implement, evaluate, and refine strategies

Community Health Improvement Plan 2026-2028

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

Its mission is to improve the health of all Upper Valley residents through shared public health initiatives and services within a network of community stakeholders. We can accomplish this by first unifying the public health priorities of the region and then working alongside partners to develop actionable plans and best practices to address the community’s most pressing needs.

The Upper Valley’s greatest strength is its deep culture of partnership, with nonprofits, healthcare providers, schools, grassroots groups, and public agencies collaborating to meet community needs. These collaborations fuel innovation – from food access initiatives to shelter-based healthcare – but they require stronger infrastructure, open communication, sustainability planning and support for small organizations.

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2025 DH-APD Community Health Needs Assessment

PHC uses the 2025 DH-APD Community Health Needs Assessment (CHNA) data and priorities to drive our community health improvement planning. The top community priorities identified in the 2025 CHNA are:

1. Access to Care
 - Availability of primary & sub-specialty care
 - Cost of health care services
 - Access to dental care for adults
 - Availability of mental health services
 - Health and human services workforce shortages
 - Navigating the health care system
2. Basic and Social Needs
 - Affordable housing
 - Transportation
 - Affordable childcare
 - Food access
3. Support for Older Adults

PHC CHIP Development Process

There are many ways to approach community health priorities and PHC’s hospital partners have developed separate CHIPs describing how their organizations will approach the work. Appendix A contains links to the needs assessments and CHIPs for Mt. Ascutney Hospital and Health Center, Alice Peck Day Memorial Hospital, Gifford Health Care, and Dartmouth Health.

This 2026–2028 Community Health Improvement Plan (CHIP) is a roadmap for health and social service partners to collaborate and address system wide issues that create barriers to measurable improvements in accessing care, addressing basic needs, and supporting older adults. Strategies were selected after considering:

- A. Input from PHC’s Advisory Council, a committee of partners representing diverse sectors that provides insight into how PHC approaches its work, that suggested our new Community Health Improvement Plan (CHIP) should intentionally align with the hospital systems’ CHIPs and build on shared goals, while identifying and filling critical gaps through stronger regional partnerships. We should lean into our proven strengths—building trust with grassroots organizations, brokering connections, and facilitating paradigm shifts—by emphasizing resource-sharing, collaborative innovation, and co-creating new ways of working together. In this unique and challenging moment, we should move deliberately, center new and diverse voices, and design inclusive strategies so every partner can clearly see their role and contribution, fostering adaptability, mutual trust, and collective ownership of the path forward. More detailed notes from each PHC facilitated session can be found in Appendices B to D.
- B. PHC’s new Strategic Plan for Fiscal Years 2026 to 2028, completed in 2025. Over 10 months, PHC engaged a wide range of partners—community organizations, municipal officials, board members, public health professionals, and regional leaders—to gather insights and assess evolving public health challenges and opportunities. Through surveys, interviews, and facilitated discussions, the PHC connected with more than 200 individuals across the Upper Valley to create a comprehensive plan to respond to both current and future public health challenges. Many of the strategies developed through this input reflect a desire to address the persistent system and organizational issues that hold back improvements.

PHC’s 2026–2028 Strategic Plan includes these five core focus tracks:

1. Expanding Community Engagement and Education
2. Advancing Health Equity
3. Strengthening Local Governance and Municipal Public Health Capacity
4. Advancing Innovation through the Public Health Program Incubator
5. Enhancing Board Governance.

- C. To develop deeper insight into how regional partners are addressing the priorities topics – what they see is missing and potential areas of collaboration – we convened partners in three separate facilitated sessions. In each of the sessions, partners shared stories of success, identified areas of improvement, brainstormed strategies to address community needs and recognized opportunities to leverage collaboration and coordination. What emerged was a set of strategies that span all three priority areas, require underlying system improvements and/or infrastructure, and point to collaborative work that can be undertaken by partners in our network in ways PHC is poised to support.

Cross Cutting Strategies

Given our analysis of the above considerations, we have selected the following cross-cutting strategies for the next three years:

1. Expanding Community and Municipal Engagement and Education
2. Creating Improved Referral Pathways and Shared Approaches to Communicating Resources
3. Increasing Access to Community-Based Care
4. Building Resilient Funding Approaches that Reward Collaborative Work
5. Advancing Innovation through the Public Health Program Incubator

PHC's Approach

With each of the strategies identified, PHC will support staged processes to better understand what systems currently exist, what collective solutions are available and feasible, and develop implementation plans that involve as many partners as possible. More detail on each is provided in the next section.

Our intent is to facilitate – gather, encourage, and prompt. Our hope is that our partners will embrace the work, take roles for themselves and their staff, and invest in building collective solutions to benefit us all – organizations and the people we serve. If at any point, partner input indicates that a particular strategy is no longer a priority or feasible, we will put that strategy aside and explore what work should take its place.

We will call upon our partners at various levels to use their strengths to drive towards solutions:

- Front Line Staff: To make clear what works well and doesn't work well in carrying out your role to provide service and to help people, especially the most vulnerable.
- People Who Use Services: To reflect back to us what works well, how best to play to their strengths, and what should be improved.
- Organizational Leaders: To find ways to 1) make sustainable, internal changes that lead to service improvement, and 2) commit to shared approaches across organizations that reduce duplication and competition whenever possible.

- Systems Change Partners: PHC's Greater Upper Valley Integrated Services Team (GUVIST) Program and Dartmouth Health's Center for Advancing Rural Health Equity (CARHE), among others, will provide technical assistance to support change processes. PHC will also mentor student interns completing discrete projects feeding this work.

These ambitious strategies and work plans will follow the general approach laid out below:

2026

- Further clarification of challenges to be addressed
- Engaging key partners
- Researching and brainstorming solutions
- Reaching consensus on proposed direction at appropriate levels

2027

- Mapping feasible solutions
- Re-engaging key partners
- Developing agreements
- Fundraising

2028

- Implementation
- Testing, revision, and collection of data

This timeline may shift due to external factors. A more detailed plan for how PHC will support these priorities can be found below.

Strategy 1: Expanding Community and Municipal Engagement and Education

Justification

Expanding community engagement and education is essential to advancing public health in the Upper Valley as articulated through the PHC strategic planning process and across all three priority-specific planning sessions.

There is a critical need for accessible, actionable health information that empowers individuals and families to make informed decisions about their well-being. By improving health literacy and supporting residents with clear, trustworthy resources, PHC can help bridge gaps in understanding, build trust, and strengthen the community's capacity to respond to emerging health challenges. Exploring new strategies for community education with partners will enable PHC to better connect partners' expertise with the everyday needs of local residents.

Methodology

This CHIP strategy aligns with two of the PHC's strategic plan focus tracks: *expanded community engagement and education* and *strengthened municipal public health capacity*.

- PHC intends to determine what community education channels already exist, clarify needs and develop a shared vision statement for community education and partner engagement.
- In regard to municipal capacity, PHC intends to equip town officials with tools, training, and collaborative structures that improve preparedness, address priority health concerns, and foster coordinated regional responses. Investment in these relationships and clarifying roles will pave the way for collaborative models and best practices to be shared across town lines.
- Open lines of communication between municipal officials, public health and human service partners reduce service gaps, and regular cross-town convenings create a culture of collaboration and improve readiness for emergencies.
- PHC can be the backbone and trusted regional partner to facilitate these communication channels and foster this culture.

Milestones

1. Develop a shared vision statement for community education and partner engagement that reflects regional priorities and values.
 - Clarification: Work with partners to understand what community education they would like PHC to lead and how this would coordinate with their own efforts. Also, establish a shared understanding of regional priorities and values. (Complete by Y1/Q2)
 - Visioning: Lead a process to develop a shared vision for community education and outreach that reflects regional priorities and values and lays the groundwork for an implementation plan. (Y1/Q3)
 - Planning: Develop a communications and partner engagement plan that identifies goals, strategies, timelines, and resources. Develop partnership agreements to ensure buy-in for implementation. (Y2/Q1)
 - Implement and Reiterate Plan: Work with partners to acquire resources, develop community education messages/channels, and evaluate impact in an iterative process. (Y3/Q4)
2. Build a Municipal Engagement Approach:
 - Build practical capacity for local officials by offering tools, training, and opportunities for cross-municipal collaboration, information sharing, and consistent engagement.
 - Align support with local priorities by helping municipalities define their role in addressing health needs and strengthening solutions through collaboration with nonprofits and service partners.

- Advance regional preparedness and coordination by convening regular cross-town discussions to strengthen public health emergency readiness and ensure plans and systems are in place for coordinated response
- Planning: Develop educational materials and presentations for municipal partners regarding the scope of public health functions and promote PHC's body of work and capacity. (Y1/Q2)
- Work with Emergency Preparedness colleagues to design shared and/or coordinated work plans for municipal engagement that promotes emergency preparedness and response as part of a multi-function public health system. Develop a detailed plan for quarterly meetings between PHC and town leaders including agendas, learning objectives, and topics based on interviews with key informants and review of available survey results. (Y1/Q2)
- Implement and Reiterate Plan: Using information gathered in 2025 from municipal partners, conduct direct outreach to municipal leaders through presentations at Selectboard and other gatherings to discuss and receive feedback on our planned approach to municipal support and engagement. (Ongoing)
- Begin quarterly meetings with town officials and reiterate the meeting plan based on feedback. Look for opportunities for town- or region-specific technical assistance. (Start by Y1/Q3 and ongoing)
- Design and implement regular municipal communications to provide timely, relevant, and important public health information. (Y1/Q2)
- In each of these, tailor messaging to take into account any particular municipality's readiness to engage.

What will success look like?

This strategy will explore new strategies for and coordinate an approach to community education and municipal engagement that creates a stronger, more resilient and responsive public health infrastructure across the region and bridges gaps in understanding, building trust for partners and families alike.

Measurable outcomes:

- Stronger regional alignment around public health education priorities, creating consistent and coordinated messaging.
- Expanded reach into new audiences through collaboration with nontraditional partners (businesses, schools, municipalities, civic groups).
- Increased skills, confidence, and resources for municipal officials across the Upper Valley to address public health priorities.
- Clear, practical tools and training available to towns, leading to measurable improvements in implementation of public health functions.
- Demonstrated collaborative models that can be replicated across towns in the region.
- Stronger referral networks connecting municipal officials with public health and human service partners, reducing service gaps.

- Regular cross-town convenings create a culture of collaboration and improve readiness for emergencies.
- Cohesive, accessible and effective community education messages and channels, with a measurable impact on partner engagement, improved health literacy and increased community capacity to make informed decisions during both everyday health situations and public health emergencies.

Strategy 2: Creating Improved Referral Pathways and Shared Approaches to Communicating Resources

Justification

Some of our partners’ strongest examples of collaboration stem from shared referral pathways, which have strengthened ties between hospitals, nonprofits, and community groups across the Upper Valley. While multiple channels exist for information sharing on certain resources, community needs are rapidly outpacing current systems, leaving information fragmented for both staff and residents. Community members require reliable, accessible navigation tools in everyday settings—like town offices, libraries, and community centers—to connect with a full range of services, from health insurance guidance to benefits eligibility and advance planning support. Partners increasingly seek more sustainable ways to maintain accurate resource information, ideally through approaches that empower the organizations responsible for services to directly update key details such as hours and eligibility. A shared vision emerges for collaborative platforms that centralize resources, streamline referrals, enhance data exchange, and incorporate lived experiences—ultimately making access to care and essential supports more equitable and efficient for everyone involved.

Methodology

PHC’s commitment to *expanding community engagement and education* encompasses this work, as building and maintaining a trusted information hub is important for user-friendly, evidence-based resources and tools tailored to the Upper Valley.

- While partners request new systems for shared referrals and centralized resources, we need to understand how the current pathways and platforms succeed or fail in meeting the need, and also identify the fundamental factors that fulfill the need.
- PHC plans to explore developing or adopting a platform, in collaboration with partners, to provide sustainable and multi-user access to resource information.

Milestones

1. Build or adopt a trusted information hub with user-friendly, evidence-based resources and tools tailored to the Upper Valley. This strategy builds off of Community Education and Partner Engagement Milestone #1 and focuses on referral networks and “resource guides.”
 - Clarification: Work with partners, especially front line providers, to understand 1) what platforms are used or planned for resources and referrals, and 2) what tools and strategies are being used by providers to catalog referral resources and share

- information with clients. Includes assessment of what works well, what doesn't and where time is spent maintaining resource lists. (Y1/Q3)
- Visioning: Use assessment information to engage agency leaders in discussion of how a more unified information and communications system could work and determine infrastructure needs and agreements to make it sustainable. (Y1/Q4)
 - Planning: Scope out new system options, develop partner agreements as needed to ensure buy-in and sustainability, identify resources, and plan for developing system prototypes. (Y2/Q3)
 - Implement and Reiterate Plan: Build or adopt any new systems and tools, work with partners to test and improve, monitor implementation and uptake to make improvements. (Y3/Q4)

What will success look like?

This strategy will clarify shared needs and solutions for health information to be accessible and actionable to empower individuals and families, and for organizations to have the relationships and frameworks in place to efficiently connect community members to needed services.

Measurable outcomes:

- Expanded reach into new audiences through collaboration with nontraditional partners (businesses, schools, municipalities, civic groups).
- Stronger, more coordinated and closed loop referral networks.
- Accessible, up to date and centralized resources for both families and public health partners.
- More seamless, consistent, and effective support for residents who access multiple services.

Strategy 3: Increasing Access to Community-Based Care

Justification

Community-based, equity-focused models of care are a top regional priority and the future of effective public health. The most transformative initiatives deliver services directly into communities—through home-visiting nurses, mobile clinics, workplace recovery mentorship, shelter-based health care, pop-up dental services, and culturally responsive programs—building access and trust at the grassroots level. These approaches promise to strengthen affordable, accessible mental health, primary, specialty, dental, in-home, and long-term care for all populations. While community health workers, nursing programs, meal delivery, and grassroots efforts remain vital in rural areas, rising needs and shrinking capacity threaten progress. Partners see investment in these modalities, with PHC's support, as a key strategy for addressing multiple priorities.

Methodology

PHC's commitment to *advancing health equity, advancing innovation through the Public Health Program Incubator, and strengthening municipal public health capacity* aligns well with the stated needs of our stakeholders. With partner collaboration, we will:

- Support community-based care models that deliver services outside traditional settings to reduce rural barriers and build trust.
- Scale and replicate successful initiatives, develop new models, and leverage additional community access points.
- Foster collaboration among municipalities, hospitals, community organizations, and trusted local hubs.
- Deepen public health-municipal partnerships to replicate effective models in underserved areas.

Milestones

Increase health care and related services available in community locations when people can more easily reach them, including on the basis of geography and other health equity measures.

- Clarification: Work with partners to inventory current models, geographies, populations, scope and capacity to explore what is working well and where gaps exist. Also, explore what additional programs or expansions are feasible and culturally competent. (Y1/Q3)
- Visioning: Work with partners to develop a shared goal for what health care and related services should be available and where. The vision should acknowledge which partners are best suited to lead on various aspects of the vision and identify what role PHC (and other regional partners) can play in implementation (e.g., shared funding approaches) (Y2/Q1).
- Planning: Based on the vision statement and understanding of what is needed and feasible, develop a detailed plan that includes the role of PHC and other committed partners. Develop agreements as needed. (Y2/Q2)
- Implement and Reiterate Plan: With partners, begin plan implementation, set milestones, maintain routine communications to take new and changing circumstances into account, hold partners accountable for agreements. (Y3/Q4)

What will success look like?

This strategy will create a system of community based care, defining the landscape of successful work and remaining gaps, facilitating partnership and agreements, and supporting increased or new engagement in modalities that provide ancillary services in addition to traditional settings.

Measurable outcomes

- Demonstrated collaborative and community-based models that can be replicated across towns in the region.
- An interconnected system of community-based care models, with a clear

landscape of partners, modalities, geographies and populations served.

- Clear communication which reduces duplication and gaps, and allows assessment of capacity for community-based care opportunities.
- Increase partner engagement and presence, as well as engagement of new partners to explore new modalities and opportunities.
- Stronger referral networks and partner agreements that connect health systems and community-based care models, increasing regional capacity and reducing service gaps.
- Inclusion and representation of marginalized community members leading to collective action on root causes of inequity.
- PHC incubation of grassroots and community-led efforts which foster innovation and equity.
- Measurable progress toward shared goals, coordinated strategies, and more efficient service delivery amongst partner organizations.

CHIP Strategy 4: Building Resilient Funding Approaches that Reward Collaborative Work

Justification

In an era of uncertain funding and persistent workforce shortages, organizations in the PHC network recognize that enhanced inter-organizational communication, community engagement, and collaborative strategies are essential to improving access to care and essential supports. Sustaining and optimizing these vital efforts—while expanding capacity—demands intentional planning and innovative, diversified funding approaches. By securing resources that support multiple partners and seed new initiatives, PHC can help embed sustainable elements like stable funding streams, workforce development pipelines, and long-term commitments from the outset, reducing fragility and enabling broader, more resilient impact.

Methodology

PHC's strategic plan includes a commitment to *advance innovation and integration through the public health program incubator*. PHC will leverage its reputation as a trusted partner to open discussions about funding and how joint initiatives may give us opportunities for new funding sources. This will include engaging partners in joint grant writing efforts and supporting new ideas as they emerge.

Milestones

1. Create a climate among health and human services partners where funding discussions are encouraged and lead to greater collaboration.
 - Include opportunities for partners to raise questions or requests about funding at PHC Partner Meetings.
 - Host meetings to share information about funding opportunities that may be appropriate for collaborative projects.

- Offer PHC facilitation of discussion about joint funding requests involving multiple partner organizations. Offer grant writing support as needed.
2. Pursue regional funding opportunities with partner support.
 - Research significant community funding opportunities (e.g., Robert Wood Johnson, W. K. Kellogg Foundation) and develop descriptions of what makes a successful application.
 - Work with partners to determine if any of the opportunities fit Upper Valley goals and milestones.
 - Lead on developing any applications as agreed upon by partners.

What will success look like?

This strategy will identify and move forward innovative, diversified funding approaches that support multiple partners and their collective and collaborative initiatives.

Measurable outcomes

- Identification of funding to support public health initiatives for shared services.
- Tracking and support for applications for diversified funding and shared service opportunities in the region.
- Measurable integration of service delivery and collective action across the region.

Strategy 5: Advancing Innovation

Justification

The Upper Valley thrives on collaboration. Small, nimble organizations are often at the heart of this innovation, but they need infrastructure to be sustainable. A focus on collaboration and true partnership is a standalone strategy of this CHIP as collaboration is the differentiator between successful programming and a successful ecosystem. Much of the successes noted in CHIP planning sessions were partnerships between hospitals, nonprofits and community groups. True partnership allows grassroots efforts to grow, vulnerable populations to be prioritized, and co-development of programming, data aggregation, centralized resources, and shared referral pathways.

Methodology

Partners asked for facilitation to engage, lead and support collaborative efforts, which aligns with PHC's strategic priority of *advancing innovation and integration through the public health program incubator*. PHC can play several roles to ensure programs complement each other rather than compete.

- This includes an assessment of how we work together and approaches to be more streamlined.
- Support grassroots, community-led initiatives with infrastructure, governance, and funding.

- Facilitate program integration among established organizations for collective impact. PHC can convene essential and atypical partners to lead partners through an integration process.
- PHC will work with other system level change makers (i.e. CARHE) to ensure projects have appropriate support.

Milestones

1. Increase efficiency of collaborative work by reimagining how we come together across sectors
 - Clarification: Gather information about all the meetings attended by partners in our region's organizations through a survey or similar audit of meeting frequency, time, audience, purpose and assessments of effectiveness. Work with organizational leaders to analyze and summarize the information to identify overlapping topics, audiences, and develop a shared understanding of relative benefits and burdens of the current state. (Y1/Q2)
 - Visioning: Develop a shared vision for an efficient approach to cross-sector collaborations that ensure opportunities to 1) share information among like-partners, 2) get input from partners in other sectors, and 3) build collaboration based on shared goals and action plans. (Y1/Q4)
 - Planning: Based on shared vision, develop a plan for the meeting structures (e.g., PHC Partner Meeting agenda template) and agreements needed to try a new approach. The plan should account for early adopters and more gradual adopters. (Y2/Q2)
 - Implement and Reiterate Plan: Begin plan implementation with a clear feedback loop to ensure it is working. Provide outreach to regional partners to be sure they understand the new approach. Provide information to external partners (e.g., state government and funding partners) to ensure they understand how the new system is working in the Upper Valley. (Y3/Q4)
2. Formalize the Public Health Program Incubator as a core PHC program and expand our current efforts to provide fiscal sponsorship and/or agency, technical assistance, and administrative infrastructure for emerging community-led initiatives.
 - Planning: Develop materials that detail what services PHC can provide, cost/fee structures, and agreement templates. (Y1/Q2)
 - Implementation: Ensure partners and community members understand what PHC offers. Deliver services as agreed. (Y1/Q3)
3. Incorporate GUVIST into PHC in 2026 under the Incubator umbrella, with continued focus on guiding partners through network development, integration implementation, sustainability planning, and evaluation.
 - Clarification: Establish a Design Team of advisors to help PHC clarify how to incorporate GUVIST's processes into PHC to meet partner needs (Y1/Q1)
 - Visioning: Update GUVIST's materials to reflect role within PHC. (Y1/Q2)
 - Planning: Create a marketing plan for revised services, as appropriate. (Y1/Q4)
 - Implement and Reiterate Plan: Implement the marketing plan. (Y3/Q4)

What will success look like?

This strategy will further develop capacity to facilitate tiered levels of technical assistance, increasing cohesion and efficiency of collaborative work across sectors.

Measurable outcomes

- A clear and sustainable incubator model that attracts and supports grassroots and community-led efforts that prioritize collaboration.
- Measurable integration of service delivery and collective action across the region.
- Measurable progress toward shared goals, coordinated strategies, and more efficient service delivery through PHC facilitation of partner organizations.
- More seamless, consistent, and effective support for residents who access multiple services.
- Sustainable revenue for PHC.

Appendix A: Hospital Community Health Needs Assessments & Community Health Improvement Plans

Alice Peck Day Memorial Hospital

- Community Health Improvement Plan - FY 2025
- Community Health Needs Assessment - FY 2025

Dartmouth Health

- Community Health Improvement Plan - 2026 to 2028
- Community Health Needs Assessment - 2026 to 2028

Gifford Health Care

- Community Health Improvement Plan - 2025
- Community Health Needs Assessment - 2024

Mt. Ascutney Hospital and Health Center

- 2025 Community Health Implementation Plan
- 2024 Community Health Needs Assessment

CHIP Appendix B: PHC Partner Meeting

August 15, 2025

CHIP Planning Topic: Addressing Basic Needs

Key Insights

Partnerships are the engine of progress

- **Strength:** The Upper Valley thrives on collaboration. Examples include food access partnerships (farms + food shelves), healthcare-shelter linkages, and cross-sector work between nonprofits, schools, and public safety. Small, nimble organizations are often at the heart of this innovation.
- **Need:** Partnerships require more infrastructure to be sustainable – shared referral systems, data-driven decision making, and administrative support for grassroots groups.

Domain	What Needs Work	What's Going Well
Systems, Collaboration & Capacity	Shared referral systems; admin support for grassroots more data-driven planning; amplify lived experience	Robust collaboration across nonprofits, healthcare, police, co-ops; nimble grassroots orgs making fast change
Food & Nutrition	Food shelf accessibility (limited hours/locations); funding & workforce for farms; expand employer partnerships	Ferndean Farm producing year-round; Good Neighbor + Willing Hands; farm shares for moms in recovery; food linked with harm reduction
Housing	Cultural barriers to shared housing; more long-term solutions	Mechanic Street winter shelter collaboration; Landlord Incentive Fund; homesharing and ADUs; use of point-in-time data
Transportation	Limited transit options; need bike/e-bike programs	Early ideas for Transportation + Bike program emerging
Employment & Economic Stability	More opportunities; scholarship support; micro-initiatives and revolving funds	Supportive employment for behavioral health clients expanding
Childcare & Youth	Ongoing funding and staffing needs	CCBA working with DH and WCBH; trauma-informed education; 45 kids served in afterschool program

CHIP Appendix B: PHC Partner Meeting

August 15, 2025

CHIP Planning Topic: Addressing Basic Needs

Healthcare Access	Services need to “go where people are” (workplaces, faith spaces, community hubs); better senior awareness	Shelter-based healthcare (Leb winter shelter + GNHC + Dartmouth Med); OBDH/Cancer Center/partners; WIC + DHMC LEVY referrals
Social Connection & Inclusion	Social isolation; need for peer-to-peer trust building; more inclusive spaces	Memory cafés with med students; arts are a connector

Sharing success - collaboration, new ideas, and use of resources

- Current successes range from new organizations at the neighborhood level to larger collaborations across focus areas.
- Intelligent use of available resources and creativity has been key.
- Looking forward, funding and volunteers are nearly universal needs as groups look to expand their impact.

Successes	Examples	Looking ahead
Grassroots organizations	Friends of Mascoma, Kearsarge Neighborhood Partners, seasonal winter shelter in Lebanon	Expand volunteer/monetary resources and impact area, more administrative support
Cross-organizational coordination and collaboration	Partnership between GNHC and Willing Hands, Lebanon pop-up clinic, coordinated referrals to WIC, Rural Health Symposium	Increase efficiency of communication and funding, host events to bring people together
Economical use of volunteer/other resources	Med students staffing DH memory cafe, retired professionals at GNHC, seasonal winter shelter in unused space	More partnerships, expansion of impact
Organizations tackling multiple issues	LISTEN, GNHC	More funding and partnerships

CHIP Appendix B: PHC Partner Meeting

August 15, 2025

CHIP Planning Topic: Addressing Basic Needs

Additional successes	CCBA, program, Homeshare VT/Vital Communities/WRVC ADU pilot, Housing First Landlord Incentive Fund, supportive employment	More staff/volunteers, partnerships, training, and funds
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Opportunities - using what we already have is key

- There is an emphasis on harnessing available resources, including businesses, DHMC, and existing non-profits.
- There are a number of strategies to make more people aware of ongoing community work, for both volunteers and those in need.
- Integration across organizations and focus areas is brought up often, particularly for smaller groups.

Strategy Category	Examples
Professional support	Mentoring by retired professionals, partnerships with business groups
Service integration	Collaboration on continuum of care, unity among “__” friendly organizations, more participation from grassroots organizations, create clearing house entity, timeshare program, email share program, bring unlikely partners together, peer organization support and regular updates
Outreach	Contact list for support groups, advertise food pantry needs at grocery stores, post blurbs at DH about resources, more knowledge and use of food programs, involve service users in outreach, September block party
Geographic expansion	Increase food distribution network
Diversity of ideas	More meetings across organizations, include organizations focusing on social factors (race, age, disability), include people in need in conversations
Creative solutions	Neighborhood action groups, e-bike subsidies, rental car system, education through Community Health Service

CHIP Appendix C: PHC Partner Meeting

September 19, 2025

CHIP Planning Topic: Access to Care

Key Insights

- **Scaling must be paired with sustainability**: Replication alone is insufficient. PHC and partners must design scaling strategies that embed funding, workforce pipelines, and long-term organizational commitment from the start.
- **Collaboration is the differentiator**: Programs repeatedly identified the need for centralized resource-sharing platforms and intentional outreach beyond Lebanon/Hanover hubs to smaller towns and underserved groups. The real impact comes not from *individual programs* but from ecosystems of collaboration. PHC can play a central role in convening, standardizing information flow, and ensuring that programs complement rather than compete.
- **Community-based, equity-oriented models are the future**: The most impactful efforts are those that bring care and wellness support directly into the community: nurses visiting homes, mobile flu clinics, recovery mentorship in the workplace, and cultural access programs like Warm Welcome. Investing in community-embedded, equity-focused care models should be a top regional priority. These efforts are not just innovative add-ons; they represent a fundamental shift in how access and trust are built in public health.

What's Working Well:

- **Innovative Access Models**: Mobile and pop-up clinics, walk-in care at APD, and bringing clinical expertise into community spaces are expanding access for vulnerable populations.
- **Community Nursing**: Nurses embedded in towns are bridging home realities with hospital care. Regular cross-provider meetings strengthen care coordination.
- **Collaboration Momentum**: Partnerships between hospitals, nonprofits, and community groups are growing, from CCBA/APD wellness education to WISE referral protocols.
- **Equity-Oriented Programs**: Initiatives like the Montshire Museum's Warm Welcome Program and recovery-to-career mentoring are reaching marginalized groups

What Needs Work:

- **Workforce Capacity**: Recruiting and retaining healthcare staff remains one of the most pressing challenges. Nurses and community health workers are in short supply.
- **Coordination & Duplication**: Partners often operate in silos. Centralized resource lists, streamlined referrals, and improved data sharing are urgently needed.
- **Funding & Sustainability**: Cuts in funding and reliance on volunteer staff highlight the fragility of current programs. Long-term, blended funding strategies are required.

CHIP Appendix C: PHC Partner Meeting

September 19, 2025

CHIP Planning Topic: Access to Care

- **Access Gaps:** Dental care, pediatric coverage (with Medicaid cuts), and jobs without health benefits are recurring unmet needs.
- **Stigma & Engagement:** Stigma around recovery and healthcare access continues to keep some community members from engaging with available services.

Strategy Area	What's Needed	Collaboration Opportunities
Data & Evaluation	Aggregate, share, and normalize data collection to measure outcomes and identify gaps	Partners can co-develop metrics and validate community needs
Collaboration & Communication	Centralized, user-friendly resource platforms; improved referrals; reduce duplication	Cross-sector partnerships (schools, aging networks, law enforcement, cultural orgs)
Workforce Development	Recruitment pipelines, retention strategies, expanded CHW/nursing roles	Engage local training programs, higher ed, and employers
Sustainability & Funding	Explore blended funding models (grants, philanthropy, municipal support)	Joint fundraising efforts; shared advocacy with legislators
Access Expansion	Scale mobile health, dental pop-ups, and home-based nursing	Municipalities and healthcare providers co-hosting clinics
Stigma & Equity	Normalize recovery-friendly workplaces and inclusive services	Community campaigns, peer support networks, equity-centered outreach

CHIP Appendix D: PHC Partner Meeting

October 17, 2025

CHIP Planning Topic: Supporting Older Adults

Strengths in the Region

- There is a deep regional culture of volunteerism that supplements formal systems and prevents isolation.
- Senior centers act as de-facto community hubs, offering meals, movement, connection, education, and early identification of needs.
- Community nurses, CHWs, and home-based supports are highly valued and improve trust and access, but capacity remains limited.
- The region benefits from multiple points of access to resources (senior centers, ServiceLink, libraries, churches), though information is still fragmented.
- Grassroots programs (HomeShare, Chore Corps, food pantries) fill critical gaps and support aging in place.
- Social belonging and human touch (check-ins, shared meals, and neighbor networks) are viewed as important as clinical care for healthy aging.

Gaps and Areas for Improvement

Need Category	Specific Gaps Identified	Consequences
Prevention & Education	Aging prep starting earlier (40s–50s), advance directive education	Crisis-based support; stress on caregivers & systems
Care Coordination & Navigation	Medicaid/CFI help, tax relief forms, central resource map	People fall through cracks; missed benefits
Workforce & Capacity	Home care aides, personal care workers, palliative services	Long waitlists; facility strain; burnout
Transportation	Limited volunteer drivers, rural transportation access issues	Delayed care, isolation, higher long-term costs
Housing & Aging in Place	Downsizing options, home safety supports	Risk of homelessness or unsafe living conditions
Mental & Behavioral Health	Support for aging adults & isolated elders	Declining mental health & quality of life
Dental & Healthcare Access	Lack of affordable dental care, gaps in in-home medical care	Compounded health issues & inequity
Communication & Outreach	“How do elders find resources?”	Under-utilization of strong existing programs

CHIP Appendix D: PHC Partner Meeting

October 17, 2025

CHIP Planning Topic: Supporting Older Adults

Strategies to Strengthen Aging Supports

Build a shared volunteer & transportation network	<ul style="list-style-type: none">● Central recruitment, training, and coordination● Expand volunteer driver programs
Create a regional aging-navigation system	<ul style="list-style-type: none">● Regular drop-in navigation hours at senior centers, libraries, and town offices● Proactive support for Medicare/Medicaid, CFI, and advance directives
Invest in home-based supports	<ul style="list-style-type: none">● Expand community nurses, CHWs, and personal care workers● Home safety, meal delivery, and check-ins to prevent crisis
Normalize early aging preparation	<ul style="list-style-type: none">● Outreach and education starting in mid-life (40s–50s)● Focus on financial planning, benefits, directives, connection
Strengthen communication & awareness	<ul style="list-style-type: none">● Simple, shared messaging and resource visibility● Use trusted local hubs and intergenerational outreach

Partnership Priorities

Advancing healthy aging in the Upper Valley will require strengthening the community-driven networks already in place and deepening collaboration among the organization's stakeholders repeatedly highlighted. Partners emphasized the importance of shared navigation resources, coordinated volunteer systems, integrated home-based support models, and transportation solutions that connect rural residents to care and community life. Senior centers, visiting nurses, and volunteer groups already play essential roles; formalizing relationships among these groups can expand reach, prevent duplication, and ensure older adults receive timely support for housing, transportation, social connection, and daily needs.

CHIP Appendix D: PHC Partner Meeting

October 17, 2025

CHIP Planning Topic: Supporting Older Adults

Key Partners & Collaborated Cited by Stakeholders:

- Senior centers & hubs: senior centers across the region; LOH free movie program
- Clinical & home-based supports: Dartmouth-Hitchcock Aging Resource Center; community nurses; visiting nurses; MIH (Mobile Integrated Health)
- Navigation & benefits assistance: ServiceLink (aging + disability resource center)
- Food & nutrition: Meals on Wheels; Lyme Food Pantry; community meal programs
- Housing & aging-in-place support: HomeShare VT; COVER home repair/ramps; Chore Corp volunteers
- Volunteer-driven supports: local volunteer networks; Listen (MIH/Listen partnership)
- Transportation partners: volunteer transportation programs; Tri-Valley Transit; vaccine clinic transport programs
- Peer support & social connection: peer support networks; elder forums
- Other identified partners: local nonprofits, municipal partners, medical follow-up teams, food box delivery programs, neighbor-to-neighbor volunteer models