Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

Community Health Needs Assessment

2018














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

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Executive Summary

During the period January through July 2018, a Community Health Needs Assessment was completed by Mt. Ascutney Hospital and Health Center in partnership with Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, Valley Regional Healthcare, New London Hospital and Visiting Nurse and Hospice for VT and NH, and the New Hampshire Community Health Institute. The purpose of the assessment was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. For the purpose of the assessment, the geographic area of interest was 13 municipalities in Vermont and New Hampshire comprising the Mt. Ascutney Hospital and Health Center service area with a total resident population of 44,035 people. Methods employed in the assessment included surveys of community residents made available on-line and paper surveys placed in numerous locations throughout the region; a direct email survey of key stakeholders and community leaders representing multiple community sectors; a set of community discussion groups; compilation of results from assessment activities focused specifically on behavioral health needs and gaps; and a review of available population demographics and health status indicators. All information collection activities and analyses sought to focus assessment activities on vulnerable and disproportionately served populations in the region including populations that could experience limited access to health-related services or resources due to income, age, disability, and social or physical isolation. The table on the next page provides a summary of community health needs and issues identified through these methods.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community and Key Stakeholder Surveys**	**Community Discussion Groups**	**Community Health Status Indicators**
Access to mental health services	Access to mental health care was the highest priority issue identified in combined responses of community survey and key stakeholder survey respondents. 'People in need of mental health care' was the top underserved population identified by key stakeholders.	Identified as a high and continuing priority for community health improvement by all community discussion groups including regional school nurses who identified this topic as the highest priority.	About 10% of adults in the service area report 14 or more days in the past 30 days when their mental health was not good, a measure that is correlated with depression and other chronic mental health concerns as well as overall health-related quality of life
Alcohol and drug misuse prevention, treatment and recovery	Prevention of substance misuse, addiction (#2) and access to substance misuse treatment and recovery services (#3) were top issues identified in combined responses of community survey respondents and key stakeholders.	All community discussion groups identified substance misuse issues as a high and continuing priority for community health improvement.	16% of adults in the service area reported binge drinking in the past 30 days. In 2016, the rate of all drug-related fatalities in Windsor County was 26.9 per 100,000 population; the second highest rate among Vermont counties.
Access to affordable health insurance, health care services and prescription drugs	Availability of affordable health insurance was the highest priority identified by community survey respondents and a high priority for key stakeholders along with the related issue of cost of prescription drugs.	Community discussion groups also identified health care costs and affordability insurance as significant concerns and barrier to services.	The estimated proportion of people with no health insurance has declined in the MAHHC service area from 10.8% in the last community health assessment to 7.5%.
Family strengthening including poverty and childhood trauma	Community survey respondents identified child abuse and neglect as a top priority across all age, income, and sub-regional groups.	Discussion group participants reported concerns about the effects of parental stress and poverty on health and welfare of children in the community.	About 35% of children in the MAHHC service area live in households with incomes below 200% of the federal poverty level
Availability of primary care services	Availability of primary care services was a high priority for community respondents and about 11% cited difficulty accessing primary care services in the past year, the highest percentage for any specific service type.	Access to care was a general discussion topic across community discussion groups, although availability of primary care was not specifically identified.	86% of adults in the service area report having a personal doctor or health care provider, a proportion similar to VT and NH overall, as is the rate of hospital stays for ambulatory care sensitive conditions for Medicare enrollees (45.5 per 1,000)
Health care for seniors	Improved resources for senior health care was a top 10 issue identified by community survey and key stakeholder respondents.	Discussion groups identified an aging population, limited resources for seniors, and future challenges of caring for frail elders as community health concerns.	The service area population has a higher proportion of seniors (19.5% are 65+) compared to NH (15.8%) and VT (17.0%) overall.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE (continued)			
Community Health Issue	**Community and Key Stakeholder Surveys**	**Community Discussion Groups**	**Community Health Status Indicators**
Affordable Housing	Affordable housing was a top concern identified by community survey respondents with incomes less than $50,000 and respondents ages 18-44.	The need for more low income housing was identified in each discussion group, as were relationships between this issue and other community health issues including substance misuse, family stress and childhood trauma.	About 34% of households in the MAHHC service area have housing costs >30% of household income and about 33% of housing units are categorized as 'substandard'.
Availability of affordable adult dental care	Availability of dental services was a mid-tier priority identified in the surveys relative to other priorities. However, it was the top service that people report leaving the local area to access.	Access to dental care was identified as an area of some improvement in recent years, although discussion participants also noted continuing access issues for individuals with Medicaid or transportation barriers.	About one third of adults in the MAHHC service area report not having visited a dentist or dental clinic in the past year.

Mt. Ascutney Hospital and Health Center

2018 Community Health Needs Assessment

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A. COMMUNITY AND KEY STAKEHOLDER SURVEY RESULTS WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total population of the primary service area of Mt. Ascutney Hospital and Health Center is 44,035 people according to the United States Census Bureau (2016), which is a decrease of 1.4% or about 640 people since the year 2010. The 2018 Community Health Needs Assessment Survey conducted by Mt. Ascutney Hospital and Health Center yielded 1,071 individual responses of which 83% were residents of towns within the primary service area or approximately 3% of the total adult population. As shown by Table 1, survey responses were received from throughout the service area, although Windsor is relatively over-represented among survey respondents in comparison to its proportion of the overall service area population, while Claremont and Hartford are under-represented. It is also important to note that 2018 survey respondents were more likely to be female (73% of respondents) and older (43% age 65 years or more) compared to the overall adult population in the service area.

Table 1: Service Area Population by Town;
Comparison to Proportion of 2018 Community Survey Respondents

	2016 Population	Zip Code*	% Service Area Population	% of Survey Respondents
MAHHC Service Area	**44,035**			
Claremont NH	13,022	03743	29.6%	6.9%
Hartford VT (includes White River Jct and Quechee)	9,758	05059 05001 05047 05088 05084	22.2%	4.9%
Windsor VT	3,463	05089	7.9%	26.0%
Hartland VT	3,423	05048 05052 05049	7.8%	8.9%
Woodstock VT	2,986	05091 05071 05073	6.8%	9.2%
Weathersfield VT (05156 shared with Springfield	2,792	05156 05151 05030	6.3%	8.4%
Plainfield NH	2,584	03781 03770	5.9%	1.7%
Cornish NH	1,664	03745 03746	3.8%	4.1%
West Windsor VT	1,000	05037	2.3%	5.6%
Pomfret VT	954	05067 05053	2.2%	1.6%
Bridgewater VT	880	05034 05035	2.0%	1.3%
Barnard VT	851	05031	1.9%	1.9%
Reading VT	658	05062 05153	1.5%	2.3%
Other	Charlestown NH (1.8%), Lebanon NH (1.5%), Chester VT (1.5%), Norwich VT (1.2%), and 51 other locations			17.1%

*Survey respondents were asked to indicate the zip code of their current local residence.

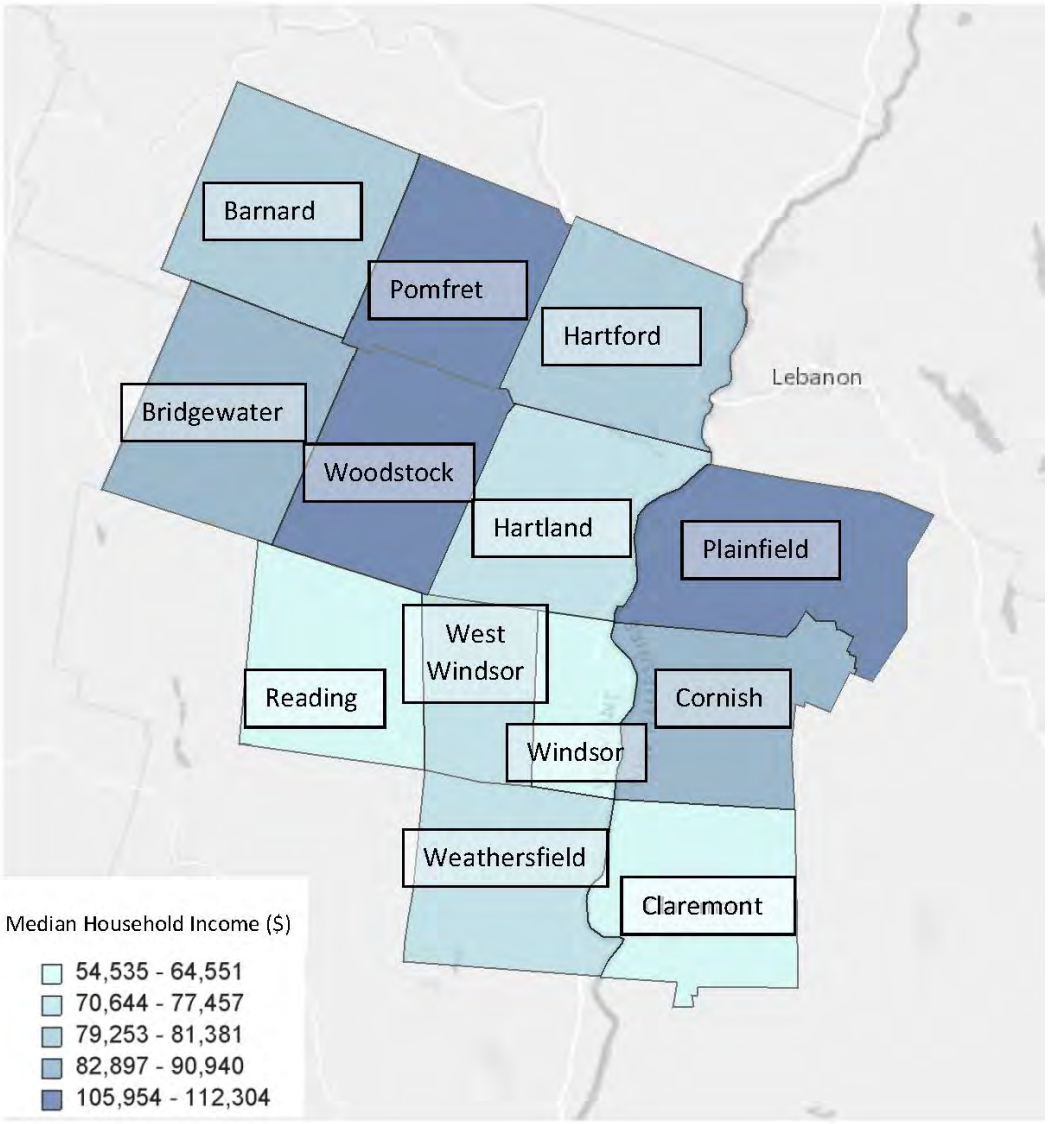
Table 2 below displays additional demographic and economic information for the towns of the Mt. Ascutney Hospital and Health (MAHHC) Center Service Area. On this table, municipalities are displayed in order of median household income with comparison to the median household income in the region and two states overall. As displayed by the table, the median household income in the MAHHC service area overall is similar to the median household income in New Hampshire. The proportion of households with incomes under 200% of the federal poverty ranges from 11.0% (Woodstock) to 38.7% (Reading). Figure 1 following this table displays a map of the service area with shading depicting the median household income by town in 5 categories from low to high median household income.

Table 2: Selected Demographic and Economic Information

	Median Household Income	% with income under 200% Poverty Level	% family households with children headed by a single parent	% population with a disability
Pomfret VT	$87,054	13.2%	14.9%	11.6%
Plainfield NH	$84,700	14.8%	22.2%	8.1%
Cornish NH	$78,542	15.8%	36.0%	10.0%
Woodstock VT	$75,482	11.0%	48.9%	15.8%
New Hampshire	**$68,485**	**21.7%**	**29.1%**	**12.3%**
Bridgewater VT	$66,053	30.9%	4.8%	15.5%
West Windsor VT	$65,114	21.6%	30.3%	12.1%
Weathersfield VT	$61,625	26.9%	24.7%	15.5%
Barnard VT	$60,769	20.3%	30.4%	3.8%
Hartford VT	$59,565	23.9%	36.0%	16.0%
Hartland VT	$58,804	21.0%	21.2%	13.7%
MAHHC Service Area	**$57,930**	**25.6%**	**36.7%**	**15.2%**
Vermont	**$56,104**	**28.8%**	**32.4%**	**14.0%**
Reading VT	$49,861	38.7%	14.3%	10.8%
Claremont NH	$47,555	32.6%	48.6%	17.5%
Windsor VT	$41,289	34.5%	43.5%	18.7%

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

2012-2016 American Community Survey; Map source: American Factfinder



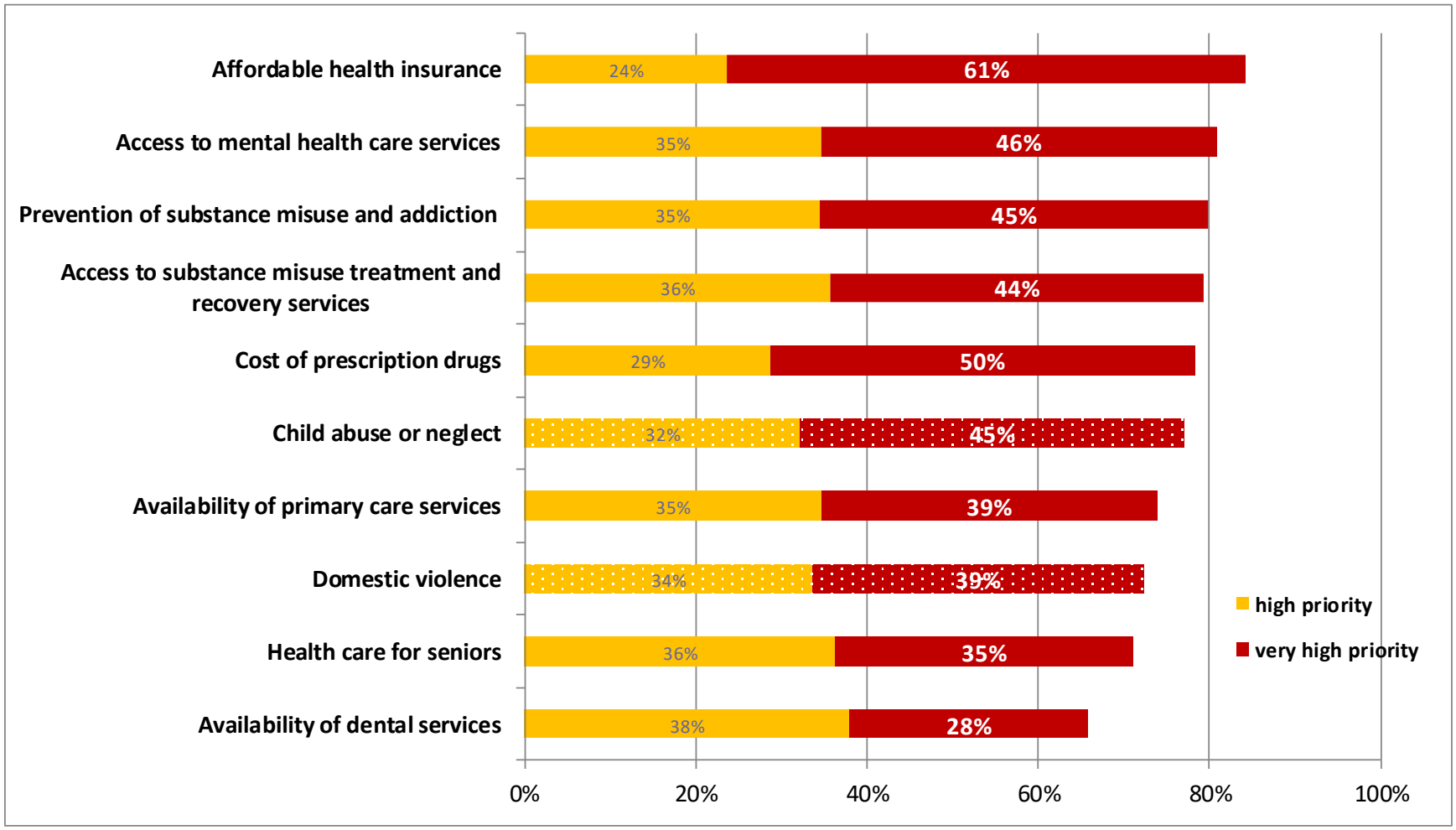
1. Most Important Community Health Issues Identified by Community Survey Respondents

Community respondents to the 2018 Community Health Needs Survey were presented with a list of 14 health-related topics that have been identified as priorities in previous community health assessments in the greater Upper Valley region of New Hampshire and Vermont including the MAHHC service area. For each topic, respondents were asked to indicate the extent to which they thought it should remain a priority for community health improvement work relative to other potential priorities. A second question presented respondents with a list of 14 more topics, including an "other' write-in option, which could be considered priorities for the region. Respondents were again asked to indicate the extent to which they thought each topic should become a priority for community health improvement work relative to other potential priorities.

Chart 1 on the next page displays the top priority topics for health improvement efforts identified by community respondents. The topics displayed with solid colors are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring are topics that rose to a high level priority from the second set of potential topics. The chart displays the percentage of respondents indicating the topic as a high priority or very high priority (needs are mostly unmet). Other response choices were moderate priority, somewhat low priority and low priority (needs are mostly met). The median percentage for all 28 items (half above, half below) with respect to the combined percentage of high and very high priority responses is 63%, ranging from 32% (preventing accidents and injuries) to 84% (affordable health insurance).

Affordable health insurance, access to mental health services, substance misuse prevention, treatment and recovery, and cost of prescription drugs are each top priorities from prior community health needs assessments that remain among the highest priorities. Child abuse or neglect and domestic violence are two high priorities not specifically identified in prior needs assessments, although 'strengthening and supporting families' is a related topic that was previously identified as a high priority for community health improvement efforts. Other priorities previously identified community health priorities that remain high priorities are availability of primary care, health care for seniors, and availability of dental services.

Chart 1: High Priority Community Health Issues; Community Respondents



The chart displays the percentage of respondents indicating the topic is a high priority (yellow) or very high priority (needs are mostly unmet; red). Other response choices were moderate priority, somewhat low priority and low priority (needs are mostly met).

The table below displays the top community health improvement priorities identified by community survey respondents by age group. The percentages shown are the total percentages within each age group selecting the topic as a high priority or very high priority. In general, there is substantial similarity across age groups for the highest community health improvement priorities. Among respondents age 18-44 years or older, 'affordable housing' was reported as a higher priority (relatively) than other age groups, while 'cost of prescription drugs' and 'availability of primary care services' were higher on the list for older age groups.

Table 3: COMMUNITY HEALTH IMPROVEMENT PRIORITIES
BY AGE GROUP; Community respondents

18-44 years	n=167	45-64years	n=345	65+ years	n=393
Access to mental health care services	88%	Affordable health insurance	86%	Affordable health insurance	83%
Affordable health insurance	82%	Access to mental health care services	83%	Cost of prescription drugs	80%
Prevention of substance misuse and addiction	81%	Access to substance misuse treatment and recovery services	81%	Prevention of substance misuse and addiction	78%
Access to substance misuse treatment and recovery services	79%	Prevention of substance misuse and addiction	81%	Access to substance misuse treatment and recovery services	78%
Child abuse or neglect	76%	Cost of prescription drugs	81%	Availability of primary care services	77%
Affordable Housing	71%	Child abuse or neglect	78%	Child abuse or neglect	76%

The table below displays the top community health improvement priorities identified by community survey respondents by income group. As with the previous table, the percentages shown are the total percentages within each age group selecting the topic as a high priority or very high priority. There is substantial similarity across income groups with top priorities in common including affordable health insurance, access to mental health services, prevention of substance misuse, and child abuse or neglect. 'Affordable housing' is near the top of improvement priorities for respondents with household income under $50,000, while. 'Availability of primary care services' was identified as a relatively higher priority by respondents in the highest income group.

Table 4: COMMUNITY HEALTH IMPROVEMENT PRIORITIES
BY INCOME CATEGORY; Community respondents

Less than $50,000	n=314	$50,000 to $99,999	n=291	$100,000 or more	n=190
Affordable health insurance	84%	Affordable health insurance	86%	Prevention of substance misuse and addiction	88%
Cost of prescription drugs	81%	Access to mental health care services	82%	Access to substance misuse treatment and recovery services	87%
Access to mental health care services	81%	Access to substance misuse treatment and recovery services	82%	Access to mental health care services	85%
Prevention of substance misuse and addiction	76%	Prevention of substance misuse and addiction	81%	Affordable health insurance	84%
Affordable Housing	76%	Cost of prescription drugs	80%	Child abuse or neglect	77%
Child abuse or neglect	76%	Child abuse or neglect	79%	Availability of primary care services	73%

The table below displays the top community health improvement priorities identified by community survey respondents by geographic sub-regions. As with age and income, there is substantial similarity across groups by geography with the top seven priorities the same except for the Windsor area where 'Domestic Violence' was rated as a high priority or very high priority by 72% of respondents. (Primary care availability is the next priority in the Windsor area with 71% of respondents rating the issue as a high or very high priority; not shown).

Table 5: COMMUNITY HEALTH IMPROVEMENT PRIORITIES
BY RESIDENT LOCATION; Community respondents

Windsor Area	n=421	Woodstock Area	n=156	Claremont Area	n=105	All Other Locations	n=141
Affordable health insurance	84%	Access to substance misuse treatment and recovery services	82%	Affordable health insurance	87%	Affordable health insurance	88%
Access to mental health care services	83%	Affordable health insurance	81%	Cost of prescription drugs	83%	Access to mental health care services	84%
Prevention of substance misuse and addiction	81%	Prevention of substance misuse and addiction	80%	Prevention of substance misuse and addiction	83%	Access to substance misuse treatment and recovery services	83%
Cost of prescription drugs	79%	Access to mental health care services	80%	Access to substance misuse treatment and recovery services	80%	Prevention of substance misuse and addiction	80%
Access to substance misuse treatment and recovery services	79%	Child abuse or neglect	78%	Availability of primary care services	79%	Cost of prescription drugs	79%
Child abuse or neglect	75%	Availability of primary care services	73%	Child abuse or neglect	78%	Child abuse or neglect	77%
Domestic Violence	72%	Cost of prescription drugs	71%	Access to mental health care services	77%	Availability of primary care services	76%

Windsor area includes Windsor, West Windsor, Reading, Weathersfield and Hartland. Woodstock area includes Woodstock, Hartford, Pomfret, Bridgewater and Barnard. Claremont Area includes Claremont NH, Plainfield NH and Cornish NH.

2. Most Important Community Health Issues Identified by Key Stakeholder Survey Respondents

In addition to the survey of community residents, the 2018 Community Health Needs Assessment included a similar survey sent by direct email to key stakeholders and community leaders from around the region. This activity occurred in conjunction with all the Community Health Needs Assessment partners with the survey going to 265 individuals across the greater Upper Valley region of NH and VT including the Greater Windsor region. A total of 153 completed responses were received (58%), of which 39 respondents indicated serving or being most familiar with the Greater Windsor area.

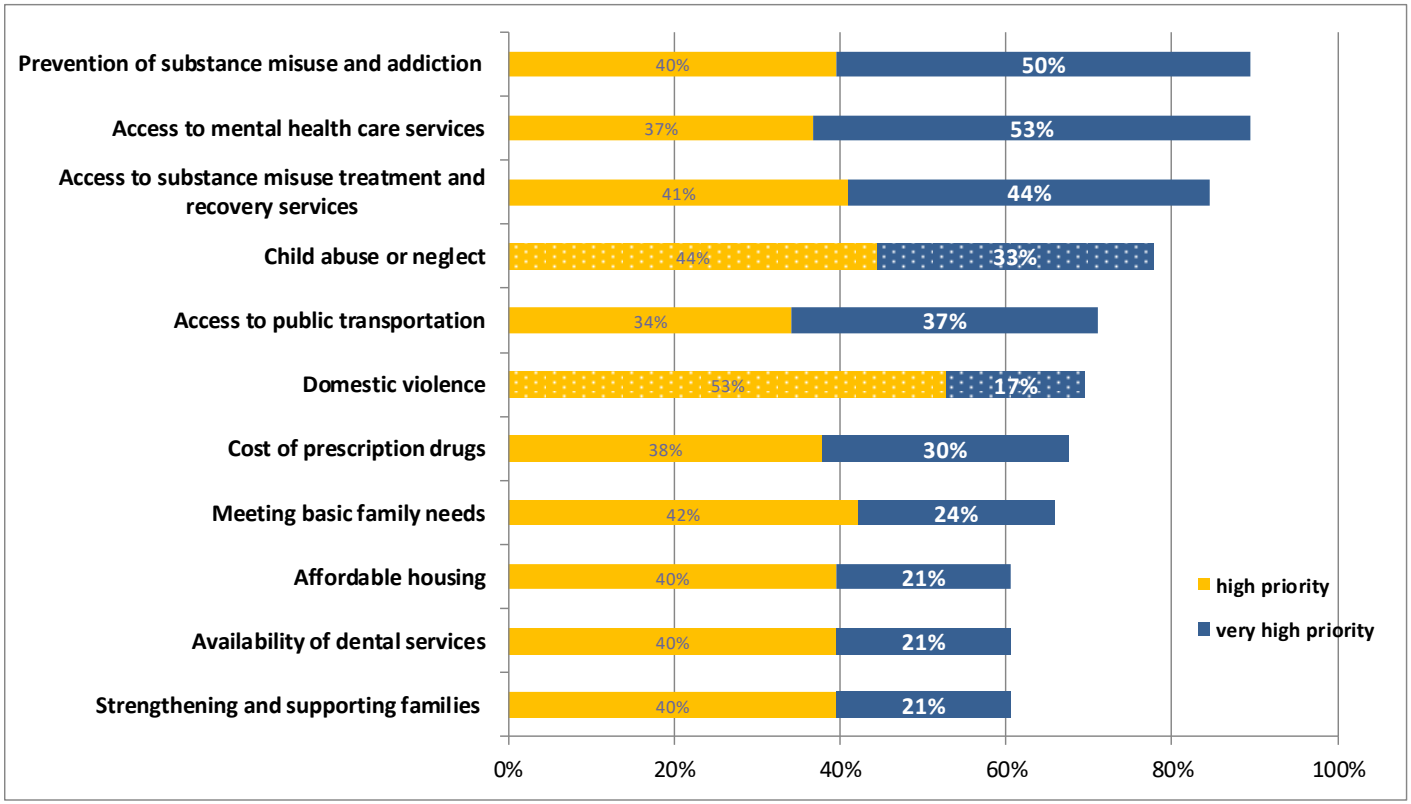
Table 5: Key Stakeholder Survey Respondents, Greater Windsor region

Percent of Respondents	Community Sector
23.1%	Community member / volunteer (9 respondents)
20.5%	Human Service / Social Service (8)
17.9%	Education / Youth Services (7)
17.9%	Municipal / County / State Government (7)
12.8%	Primary Health Care (5)
12.8%	Medical Sub-Specialty (5)
10.3%	Mental Health / Behavioral Health (4)
7.7%	Business (3)
5.1%	Home Health Care (2)
5.1%	Public Health (2)
5.1%	Faith organization (2)
5.1%	Public Safety / Law / Justice (2)
2.6%	Long Term Care (1)
2.6%	Civic / Cultural Organization (1)
2.6%	Recovery services (1)
2.6%	Substance abuse prevention, community based (1)

Respondents to the key stakeholder survey were presented with the same two lists of health-related topics: the list of topics identified as priorities in previous community health assessments in the region and a second list of topics (including 'other') that could be considered priorities for health improvement efforts in the region. The chart on the next page displays the results of these questions from key stakeholder responses. The median percentage for all 28 items (half above, half below) with respect to the

combined percentage of high and very high priority responses is 55%, ranging from 11% (preventing accidents and injuries) to 90% (prevention of substance misuse and addiction). Similar to community respondents, substance misuse and mental health were among the top priority issues identified by key stakeholders. However, key stakeholders were more likely to identify access to public transportation as a high priority compared to community survey respondents and less likely to identify affordable health insurance (59% of key stakeholders selected affordable health insurance as a high or very high priority; not displayed on the chart).

Chart 2: Community Health Improvement Priorities
Key Stakeholder Survey Respondents

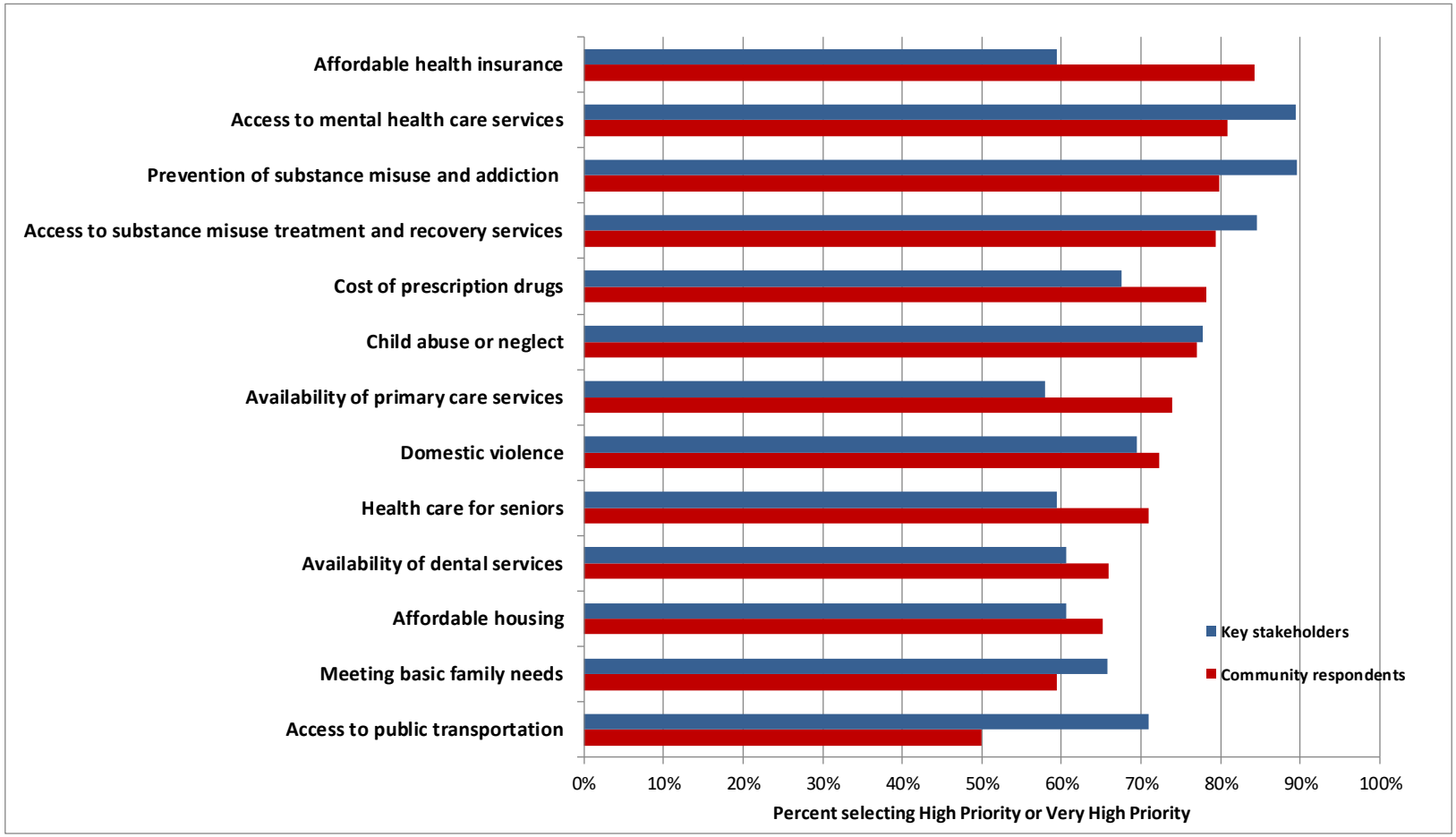


The chart displays the percentage of respondents indicating the topic is a high priority (yellow) or very high priority (needs are mostly unmet; blue). Other response choices were moderate priority, somewhat low priority and low priority (needs are mostly met).

3. Comparison of Most Important Community Health Issues; Community and Key Stakeholder Respondents

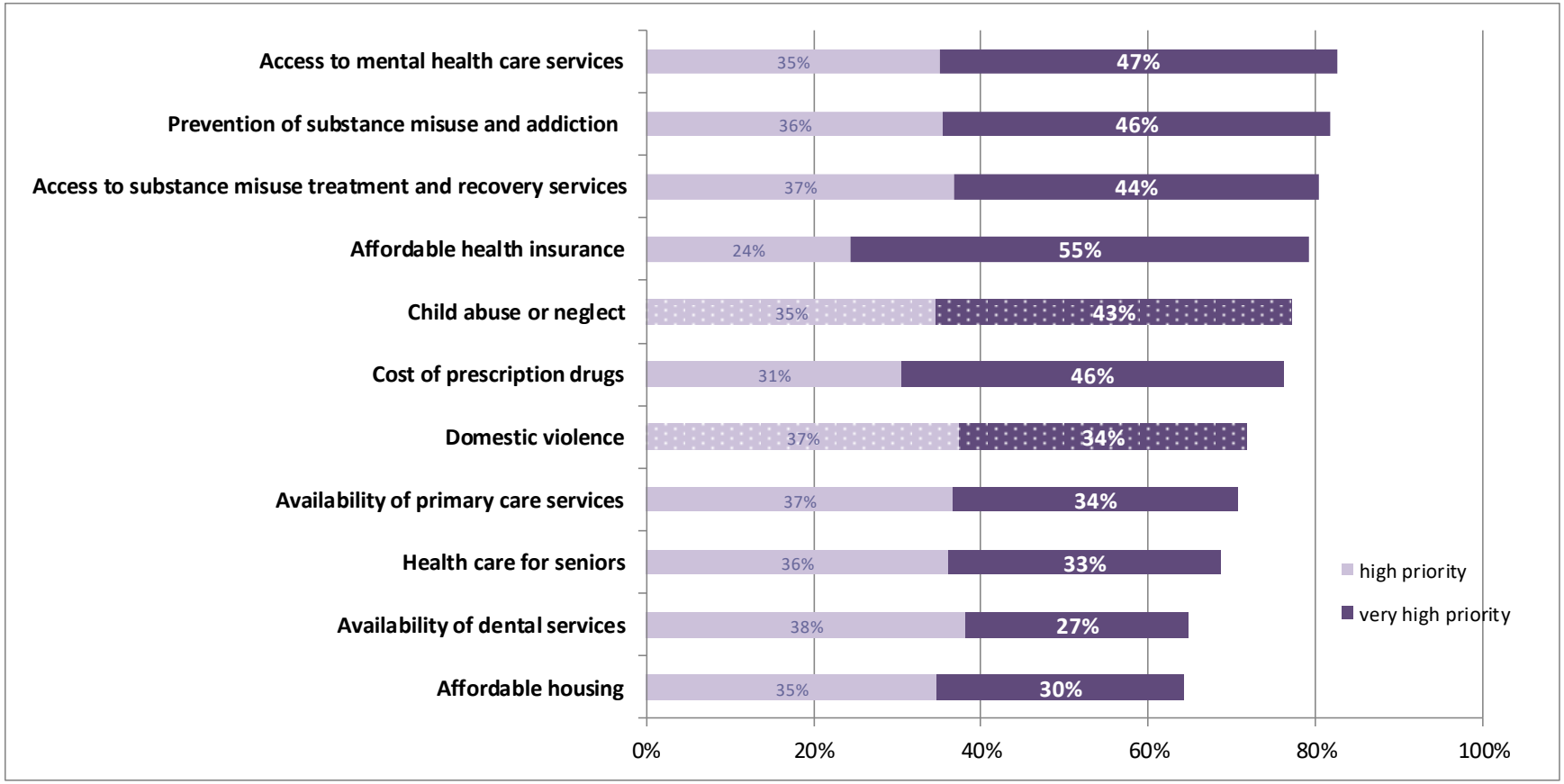
The chart below displays a comparison of the responses between community and key stakeholder surveys for the highest priority community health issues. Blue bars on the chart display the percentage of key stakeholders selecting the topic as high priority or very priority and red bars display the results from community respondents (topics are arrayed overall high to low according to the community respondent percentages).

Chart 3: Community Health Improvement Priorities
Comparison of Community and Key Stakeholder Respondents



The chart below displays the combined results from the questions on community health improvement priorities from the perspective of community and key stakeholder survey respondents. The response percentages from community respondents were given 80% weight in the computation of combined responses and the key stakeholder / community leader responses were given 20% weight. The top 11 community health priorities are displayed (from 28 total topics included on the surveys). As in previous charts, bars depicted with solid color are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring (child abuse or neglect, domestic violence) are topics that rose to a high priority from the second set of potential topics.

Chart 4: Community Health Improvement Priorities
Community and Key Stakeholder Responses Combined



4. Barriers to Services Identified by Community Survey Respondents

Respondents to the FY2018 Community Needs Assessment Survey were asked, "In the past year, have you or someone in your household had difficulty getting the health care or human services you needed?" Overall, 28.6% of survey respondents indicated having such difficulty. As Chart 5 displays, there is a significant relationship between reported household income and the likelihood that respondents reported having difficulty accessing services. In particular, respondents in the middle income category of $25,000 up to $49,999 were most likely to report difficulty accessing services and three times as likely compared to respondents with household income of $100,000 or more.

Chart 5: Access to Services
Community Survey Responses

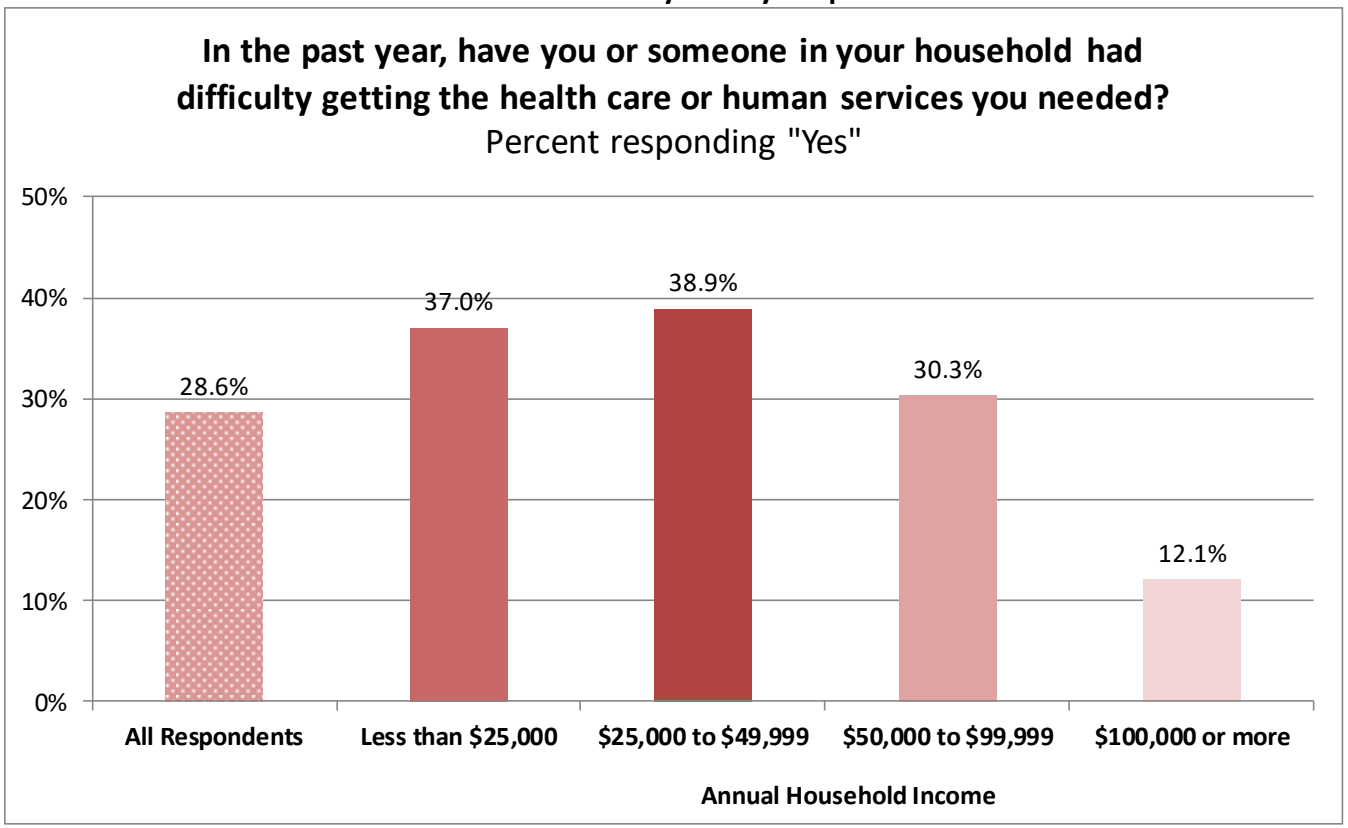
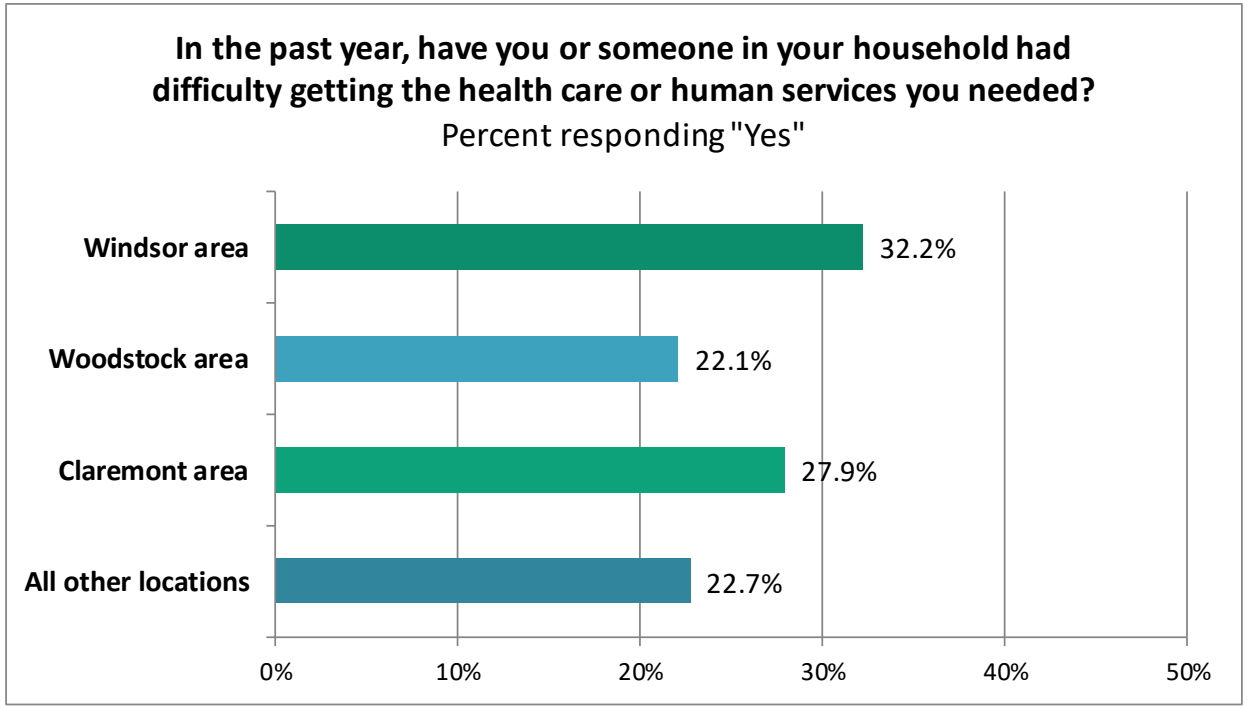


Chart 6 examines responses to this question by sub-region within the MAHHC service area. Respondents from the Windsor and Claremont areas were more likely to report difficulty accessing compared to respondents from the Woodstock area or from communities outside the primary service area.

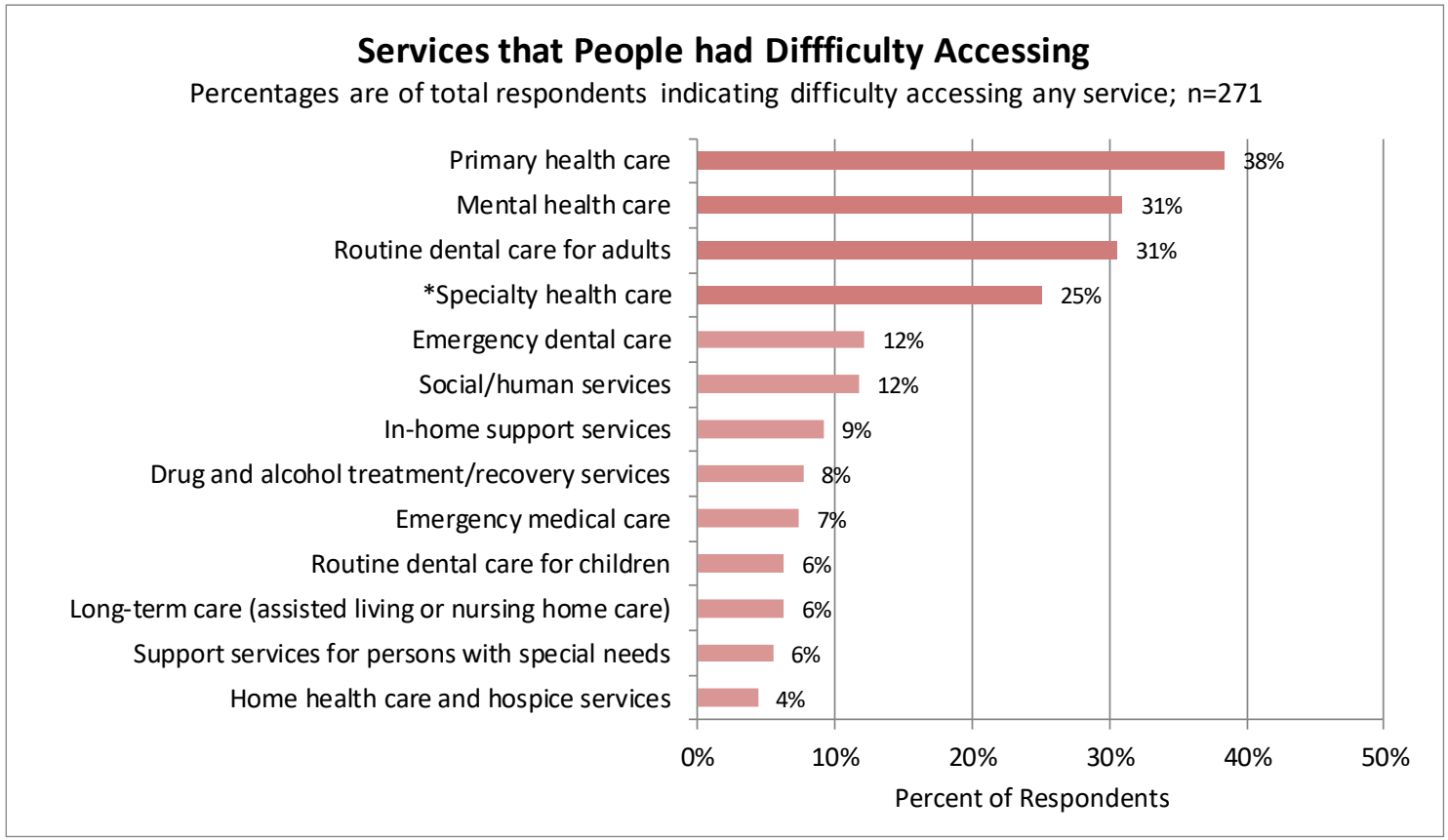
Chart 6: Access to Services by Sub-region



Windsor area includes Windsor, West Windsor, Reading, Weathersfield and Hartland. Woodstock area includes Woodstock, Hartford, Pomfret, Bridgewater and Barnard. Claremont Area includes Claremont NH, Plainfield NH and Cornish NH.

The community survey also asked people to indicate the areas in which they had difficulty getting services or assistance. As displayed by Chart 7, the most common service types that people had difficulty accessing were primary health care (38% of those respondents indicating difficulty accessing any services; mental health care (31%); routine dental care for adults (31%); and specialty health care (25%). Note that percentages on this chart are of the subset of respondents who indicated any difficulty accessing services (28.6% of all respondents; n=271).

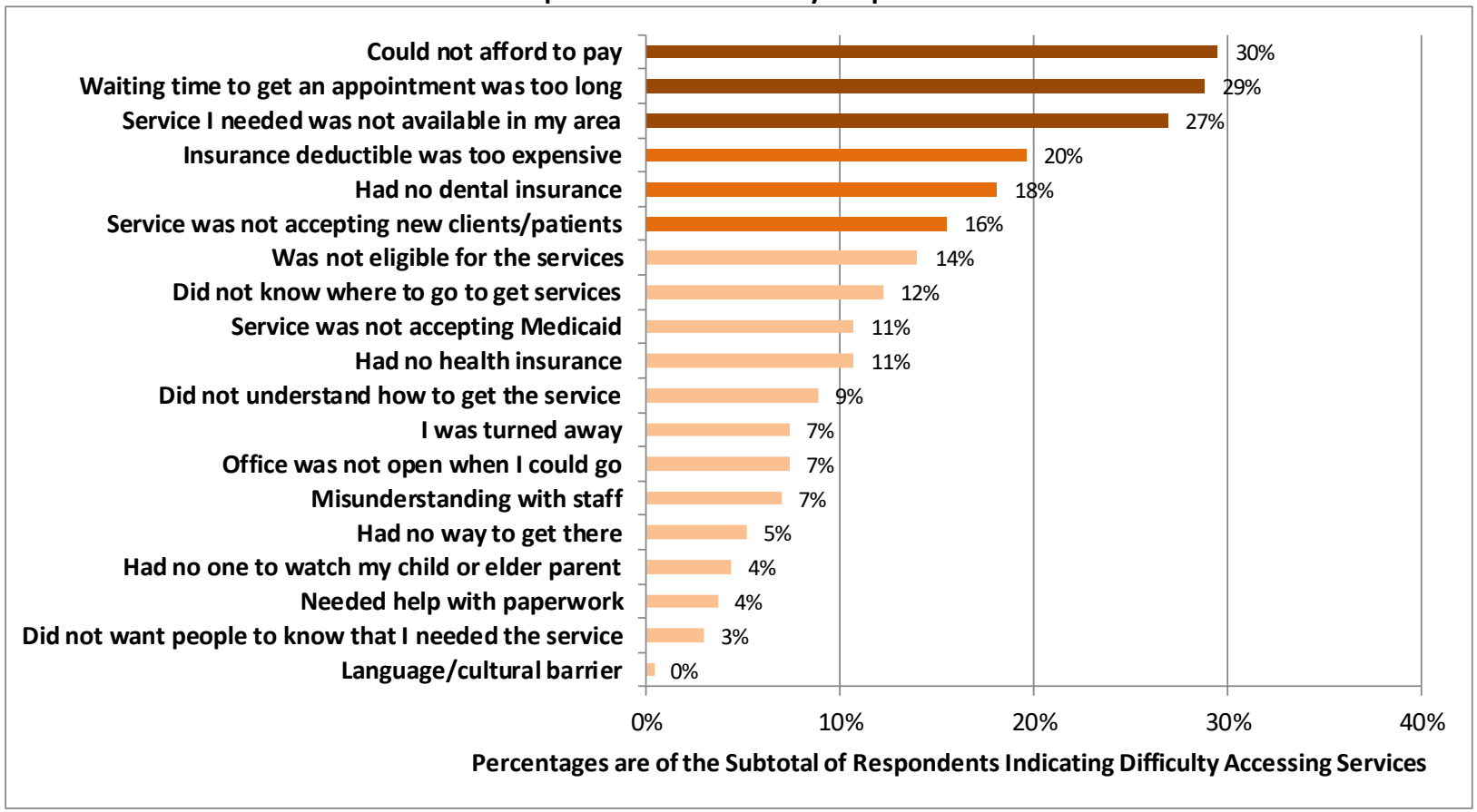
Chart 7



*Survey respondents selecting Specialty health care were asked to specify further. The most frequently cited specialty health care services were Orthopedics, Dermatology, and Prenatal Care/ObGyn.

Respondents who reported difficulty accessing services in the past year for themselves or a family member were also asked to indicate the reasons why they had difficulty. As shown on Chart 8, the top reasons cited were could not afford to pay' for the service (30%); 'waiting time to get an appointment was too long' (29%); 'service I needed was not available in my area' (27%); and 'insurance deductible was too expensive' (20%). Percentages are again calculated from the subset of respondents who indicated difficulty accessing services.

Chart 8: Access Barriers
Perspectives of Community Respondents



Further analysis of these two questions addressing access to specific types of services is shown by Table 6. Among respondents indicating difficulty accessing primary health care or specialty health care, the top reason indicated for difficulty accessing (any) services was 'waiting time to get an appointment too long'. Among respondents indicating difficulty accessing mental health care, the top reason cited was 'could not afford to pay'. Among respondents indicating difficulty accessing adult dental care, the top reason cited for access difficulties was 'had no dental insurance'.

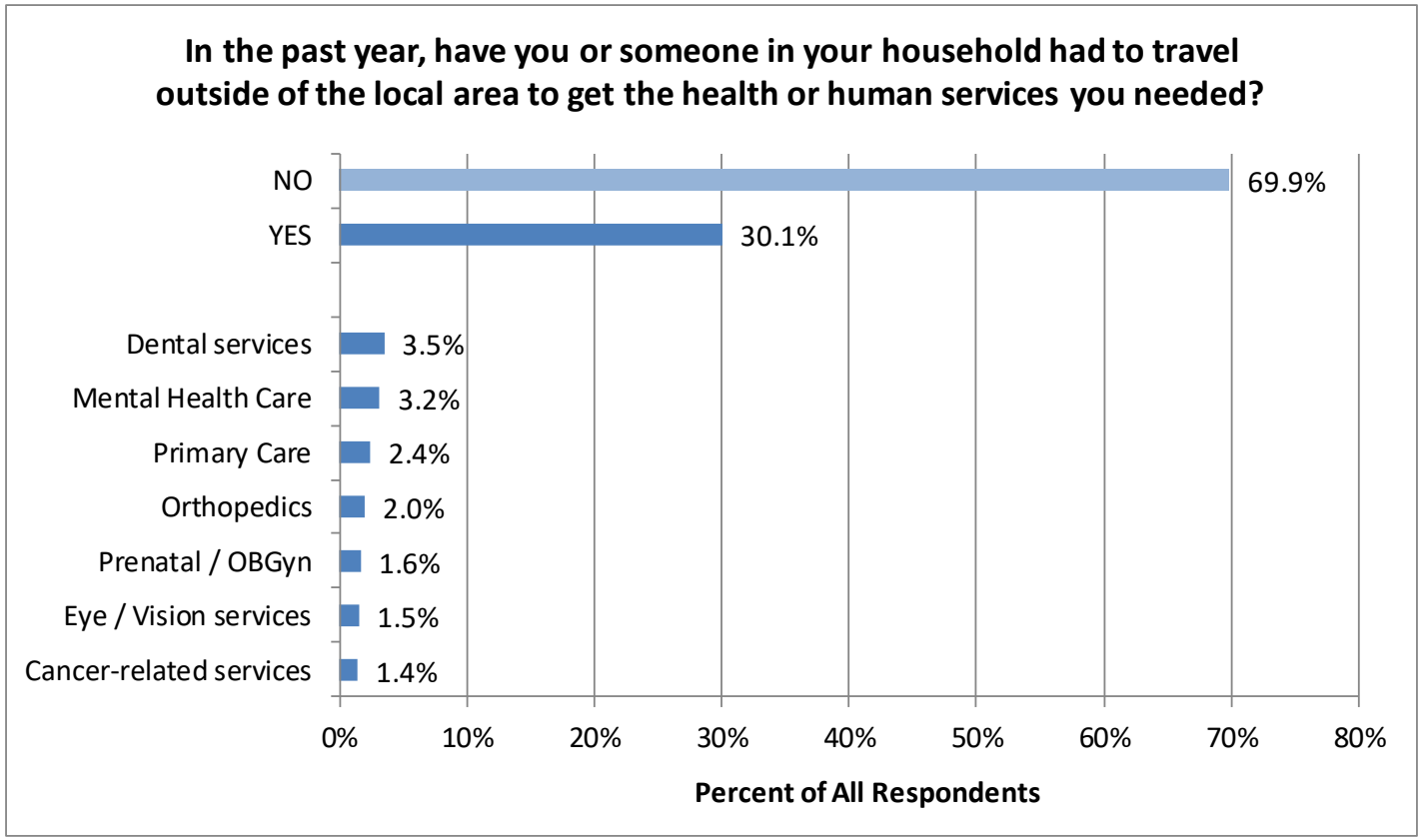
TABLE 6: TOP REASONS RESPONDENTS HAD DIFFICULTY ACCESSING SERVICES BY TYPE OF SERVICE

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

Primary Health Care (n=104, 11% of all respondents)	Mental Health Care (n=86, 9.1% of all respondents)	Routine Dental Care for Adults (n=86, 9.1% of all respondents)	Specialty Health Care (n=70, 7.4% of all respondents)
35.6% of respondents who had difficulty accessing primary health care also reported ***Waiting time to get an appointment was too long***	**45.3%** of respondents who had difficulty accessing mental health care also reported ***Could not afford to pay***	**48.8%** of respondents who had difficulty accessing routine adult dental care also reported ***Had no dental insurance***	**40.0%** of respondents who had difficulty accessing specialty health care also reported ***Waiting time to get an appointment was too long***
29.8% ***Could not afford to pay***	**41.9%** ***Waiting time to get an appointment was too long***	**47.7%** ***Could not afford to pay***	**28.6%** ***Insurance deductible was too expensive***
25.0% ***Insurance deductible was too expensive***	**38.4%** ***Service I needed was not available in my area***	**33.7%** ***Insurance deductible was too expensive***	**27.1%** ***Service I needed was not available in my area***
22.1% ***Service I needed was not available in my area***	**25.6%** ***Service was not accepting new clients / patients***	**30.2%** ***Service I needed was not available in my area***	**27.1%** ***Could not afford to pay***
20.2% ***Had no health insurance***	**20.9%** ***Insurance deductible was too expensive***	**27.9%** ***Waiting time to get an appointment was too long***	**15.7%** ***Service was not accepting new clients / patients***

In a separate question, survey respondents were asked, “In the past year, have you or someone in your household had to travel outside of the local area to get the health or human services you needed?” About 30% of all survey respondents indicated traveling outside of the ‘local area’ for health and human services in the past year. In an open-ended follow-up question, respondents were asked what type of services they had traveled outside of the area to get. Dental care, mental health care, primary care, and orthopedics were the most frequently mentioned types of services.

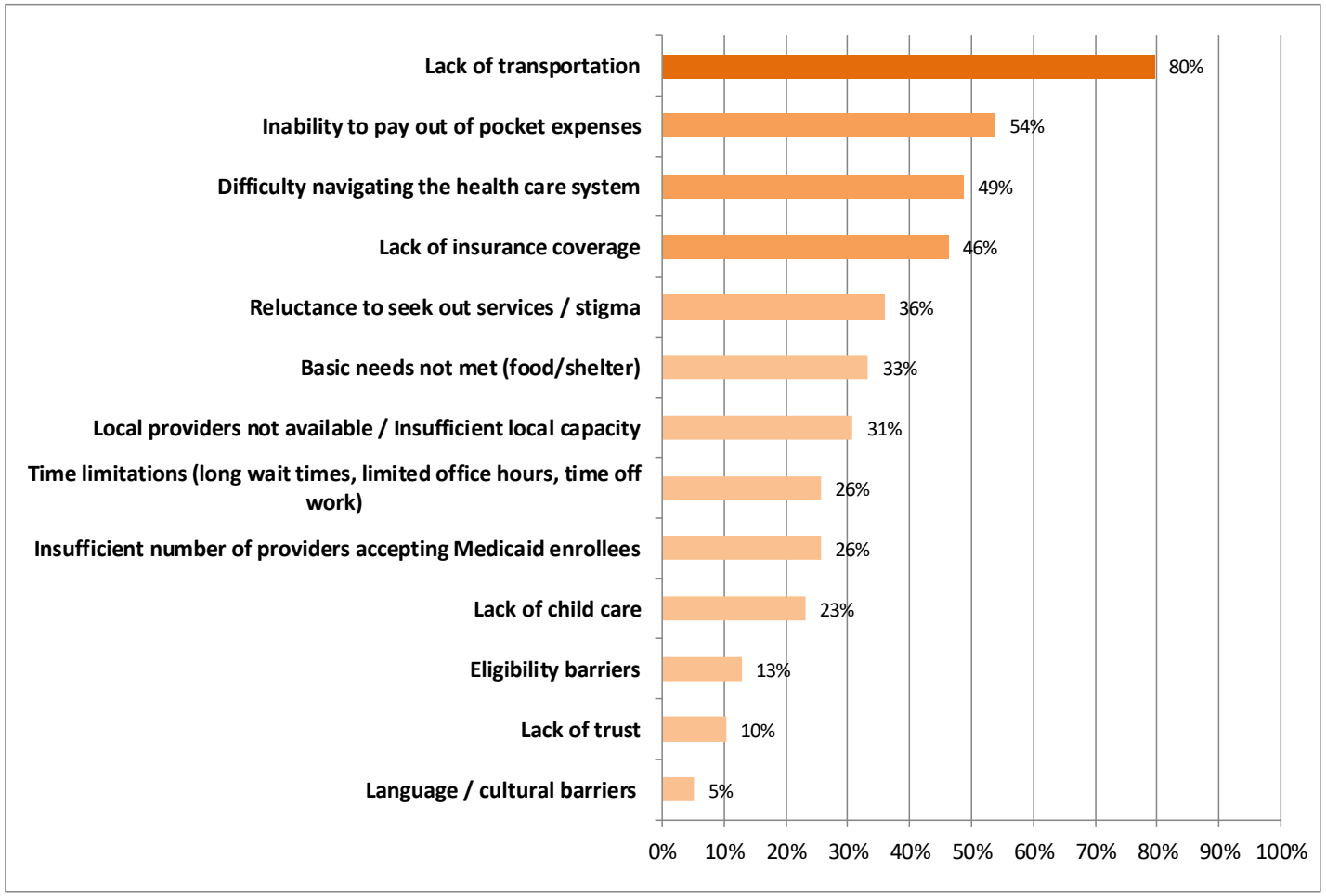
Chart 9



5. Barriers to Services Identified by Key Stakeholder Survey Respondents

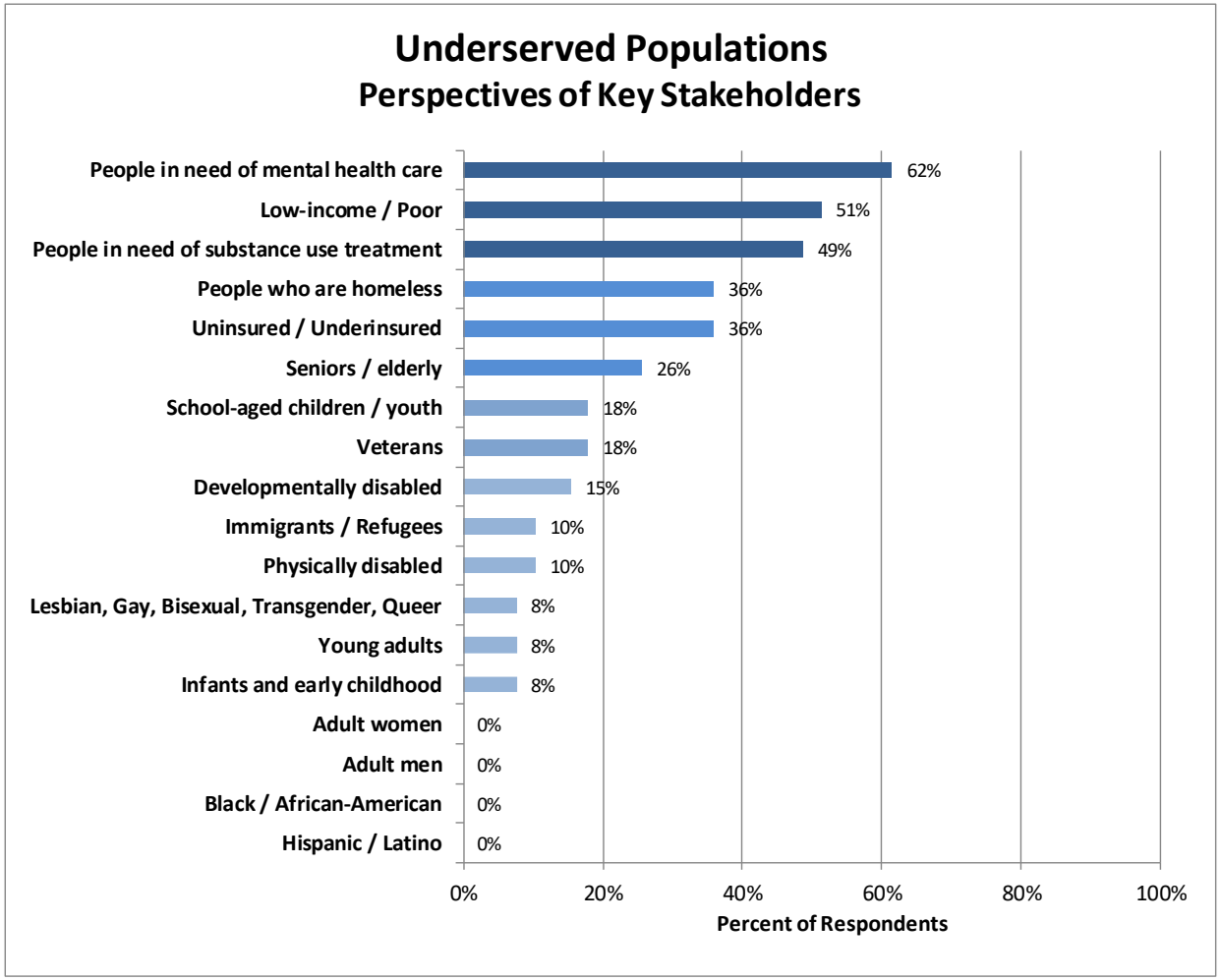
Respondents to the key stakeholder survey were also asked to identify the most significant barriers that prevent people in the community from accessing needed health care services. The top issue identified by this group was lack of transportation, followed by inability to pay out of pocket expenses, difficulty navigating the health care system, and lack of insurance coverage.

Chart 10: Most Significant Barriers to Accessing Services
Perspectives of Key Stakeholders



Key stakeholders were also asked if there are specific populations in the community that are not being adequately served by local health services. Chart 11 displays results from key stakeholder responses on specific populations thought to be currently underserved. 'People in need of Mental Health Care', 'Low Income/Poor', and 'People in need of substance abuse treatment' and were the most frequently indicated populations perceived to be currently underserved.

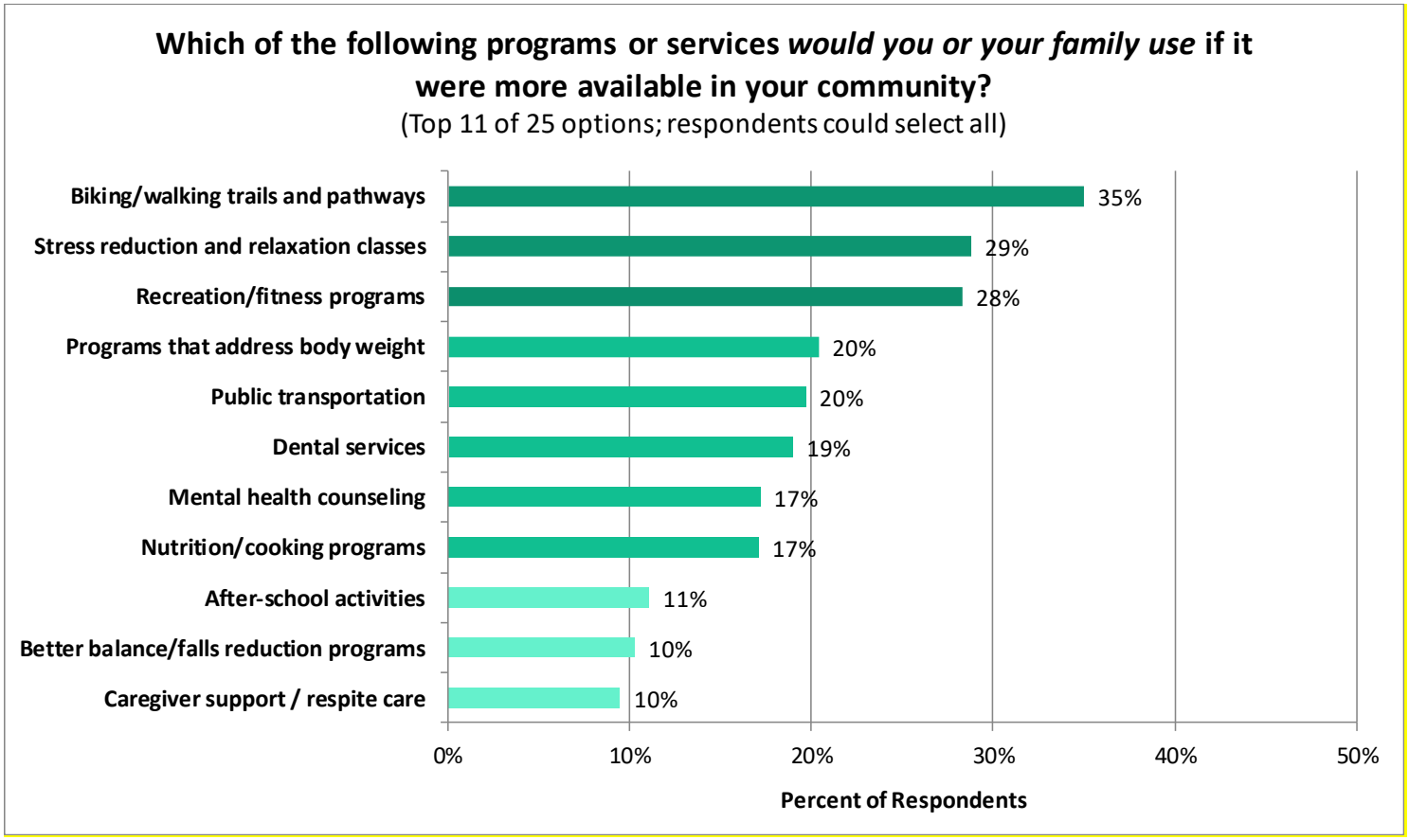
Chart 11



6. Community Health Resources and Suggestions for Improvement

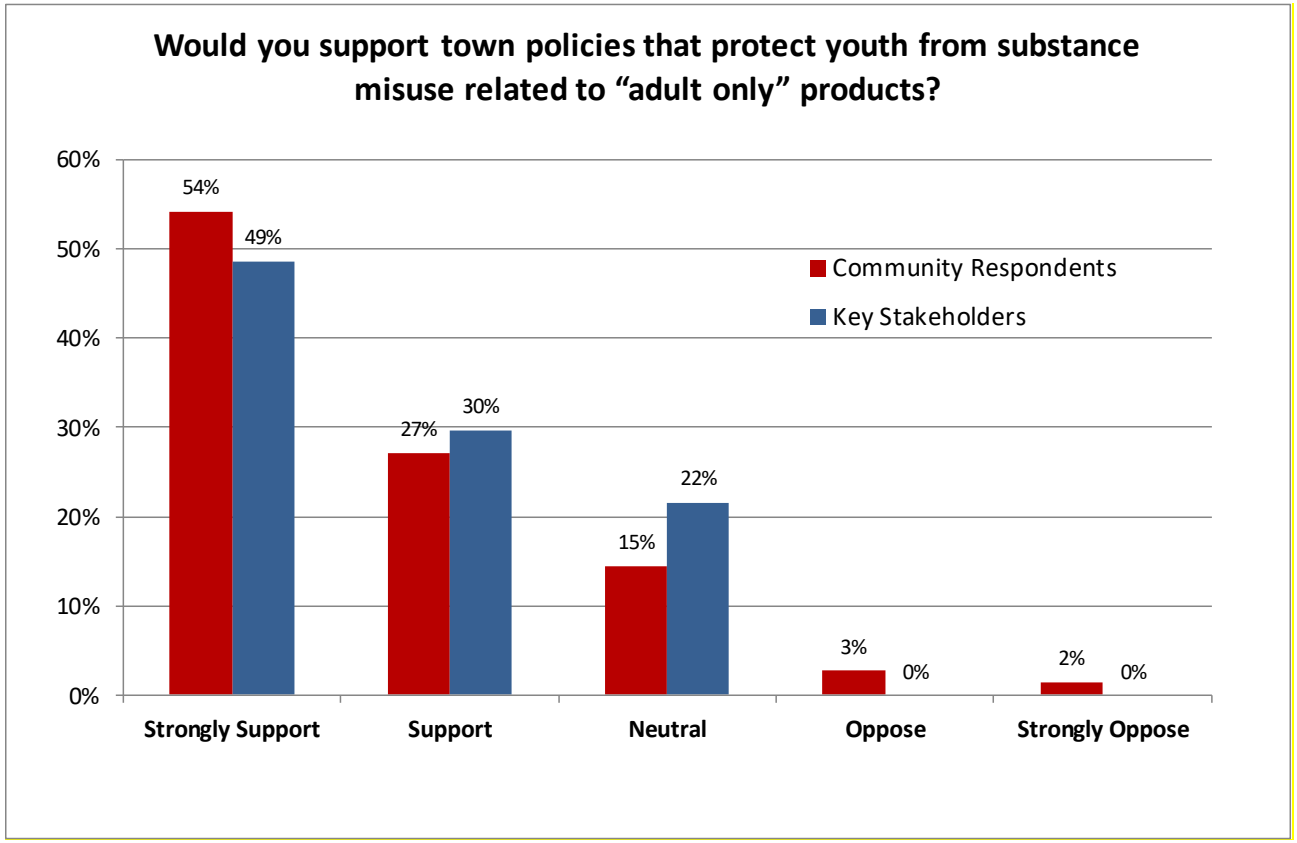
The 2018 MAHHC Community Health Needs Assessment Survey asked people to indicate community health-related programs or services they would use if more available in the community. Biking/walking trails (35%), stress reduction and relaxation classes (29%), and recreation/fitness programs (28%) were the programs or services most frequently selected.

Chart 12



Respondents to the community survey and the key stakeholder survey were asked the question, “Would you support town policies that protect youth from substance misuse related to “adult only” products?” Examples of such policies could include policies that limit advertising, limit retail locations, or restrict use at community events of alcohol, tobacco, ‘vaping’, marijuana and related paraphernalia. Support for these types of town policies was similar on the two surveys with about 80% of community and key stakeholder respondents indicating support or strong support.

Chart 13



The 2018 Community Health Needs Assessment Survey asked people to respond to the question, ***"If you could change one thing that you believe would contribute to better health in your community, what would you change?"*** A total of 572 survey respondents (53%) provided written responses to this question. Table 7 provides a summary of the most common responses by topic theme.

TABLE 7

"If you could change one thing that you believe would contribute to better health in your community, what would you change?"	
Affordability of health care/low cost or subsidized services; health insurance; health care payment reform	**15.4% of all comments**
Health care provider availability including certain specialties; hours and wait time; health care delivery system improvements, quality and options	**15.1%**
Accessibility / availability of substance use treatment services; substance misuse prevention including tobacco	**10.0%**
Improved resources, programs or environment for healthy eating / nutrition / food affordability	**9.8%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**9.3%**
Accessibility/availability of mental health services; awareness, outreach and stigma	**6.8%**
Caring community / culture; community connections and supports; role of government	**6.8%**
Programs/services for youth and families; healthy lifestyle education	**6.6%**
Overall wellness; health and wellness education; alternative health information and services	**6.3%**
Senior services / assisted living / concerns of aging; physical disability concerns	**3.1%**
Improved transportation services / public transportation; medical transportation	**3.1%**

"If you could change one thing that you believe would contribute to better health in your community, what would you change?" (continued)	
Improved job opportunities; affordable housing; child care; economy	**2.9% of all comments**
Affordability / availability of dental services	**2.0%**
Public safety, violence, crime; gun control	**0.7%**
Environmental health concerns	**0.7%**
Satisfied with services / community	**0.5%**

B. COMMUNITY HEALTH DISCUSSION GROUPS

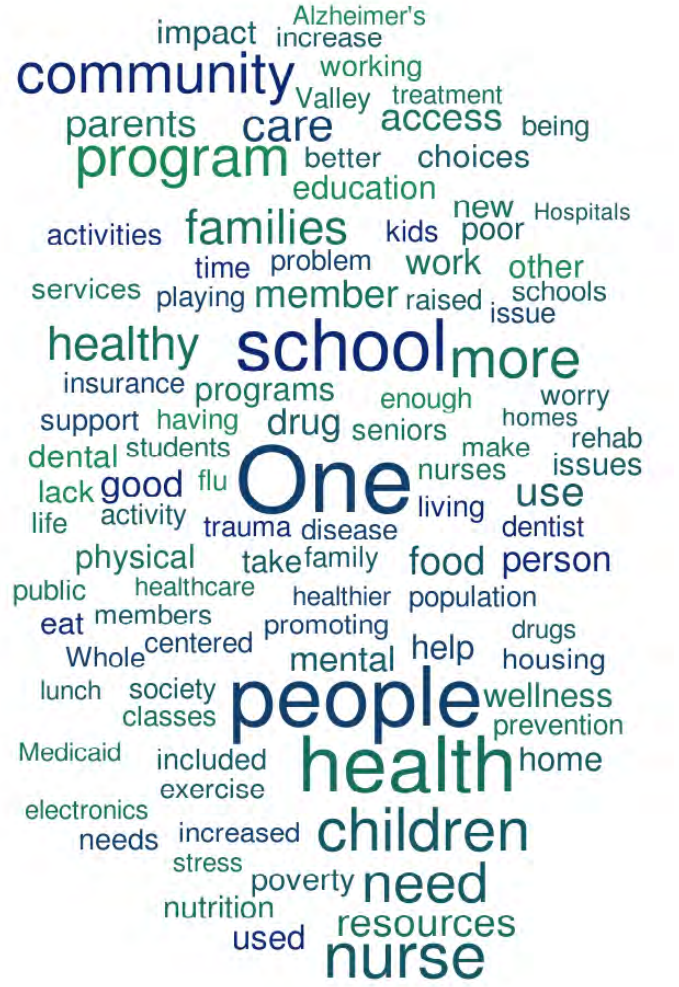
A set of three discussion groups were convened in the spring of 2018 as part of the effort by Mt. Ascutney Hospital and Health Center to understand the health-related needs of the community and to plan programs and services that address those needs. The purpose of the discussion groups was to get input on health issues that matter to the community and thoughts and perceptions about the health of the community. Discussion groups were convened representing important community sectors and perspectives, specifically the following:

- Medication Assisted Therapy (4 participants)
- Regional school nurses (8 participants, 7 nurses and 1 Pediatrician)
- Business sector representative (7 participants)

1. Community Discussion Group Themes

The following paragraphs and table summarize the findings from the community discussion groups.

- Discussion group participants described a relationship between individual health and community health: “Individual health reflects the health of the community and the health of the community contributes to health of the individual”. Discussion group participants also had mixed perspectives about the current health status of the overall community. There was consensus that “the majority of people in the community are healthy” with increased focus on healthy foods, physical activity and decreased prevalence of cigarette smoking -“It is rare to see anyone smoking”. However, it was also observed across groups that there are disparities within the community that contribute to poor health such as poverty, lack of transportation and lack of dental care. Other factors noted by discussion group participants that contribute to increased health risks included the opiate epidemic, an aging population (“resources are limited especially for seniors”), and



limited infrastructure and education to support healthy choices such as exercise and good nutrition. Discussion also described increased family stress and related issues of adverse childhood experiences and negative impacts of electronic devices such as cell phones and computers on the mental and physical health of children and families.

> *"Our community is heading in the right direction with health and exercise. There is a movement to eat right and be healthier." Business* Group Participant

- Participants identified a wide variety of community strengths and resources that promote health including schools, hospitals, the Good Beginnings program, recreation departments, hiking and biking trail systems, community events involving physical activity, farmers markets and organic food sections in stores. Specific examples from schools included Farm to Table programs, getting rid of soda machines, and promoting physical activities. Participants in two discussion groups also discussed reductions in tobacco use, cessation classes, and health promotion messages focused on youth tobacco prevention. The business group also discussed the effectiveness of wellness programs in larger business settings and that it would be good to develop capacity for offering similar options to smaller businesses.

> *"Children and families have changed significantly . . . . Chaos, stress, trauma and fragmentation in families is staggering."* School Nurse Group Participant

- Participants identified a range of barriers to promoting good health in the community, especially factors influenced by individual and family finances and poverty. Such factors included affordability of care, access to care including dental care and related transportation challenges, and the expense of eating healthy. Other aspects of the discussions focused on the effects of substance misuse, concerns about adolescent mental health and cyberbullying, and cultural changes that have led to decreased participation in physical outdoor activities and increased 'screen time'.

> *"There is a pervasive worry about drugs. All it takes is one wrong person to influence a young person's life. There is a lot of peer pressure for kids."* MAT Group Participant

- With respect to what organizations could be doing better to support or improve community health, there was significant discussion around needs for increased community health teams and family supports. Examples included more case management similar to the community health team working out of the Ottauquechee Health Center, more interdisciplinary mental health conversations between school and community partners, mentoring programs or wellness coaches for parents, and the value of the family wellness program embedded in pediatrics. Related discussions included more support for agencies and healthcare professionals to be trauma sensitive in their approach to overcome the impact of adverse childhood

experiences and to reduce perceived shame, stigma or judgement associated with seeking help from health and human service agencies. Discussion group participants also addressed the need for improved approaches to substance use disorder treatment such as better and longer inpatient rehabilitation.

> *"Moms will send children to school sick and then have the school nurse call so they can come and pick them up. They state that their jobs are tenuous and they fear punishment if they just call in because their children are sick. They report that if the school calls them at work there are not the same repercussions."* School Nurse Group Participant

2. High Priority Issues from Community Discussion Groups

In each of the community discussion groups convened in 2018, the discussion group facilitator read top priority areas identified in previous Community Health Needs Assessments in the region. The priorities named in the discussion groups were:

- Access to mental health care
- Alcohol and drug use prevention, treatment and recovery
- Affordability of health insurance and the cost of prescription drugs
- Lack of physical activity and the need for more recreational opportunities
- Health care services for seniors
- Support for families with low income; addressing poverty

> *"Just plain detox doesn't work. . . . (There needs to be) inpatient rehab set up with a transition in an aftercare plan that includes addressing issues such as housing, insurance, medical care, and employment."* MAT Group Participant

Participants were then asked if they were: a) aware of any programs or activities that have focused on any of these areas; b) if they had noticed any improvements in these areas; and c) if they thought these are still the most important issues for the community to address for improving health or if there are new, different priorities. With some additions (see table on the next page), most participants in each group expressed the overall opinion that the priorities identified previously were still the most important issues to focus attention on for community health improvement.

> *"(We need to address) the impact of stigma and shame around asking for help. (For example), the local food shelf offered smoke detectors with assistance from the fire department to install them. No one in the community took advantage of this because they didn't want people to go into their homes." Business* Group Participant

The table below displays overall priorities, concerns and areas of improvement identified by each set of discussion groups. As noted on the previous page, the community discussion groups convened in 2018 generally endorsed the same set of priorities as identified in 2015. Some additional themes emerged in these discussions and are noted in this table as well.

TABLE 8 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

	Regional school nurses	Medication Assisted Therapy Group	Business sector representatives
High priority health issues from previous assessments*	"Mental health is at the top of the list." "Addressing drug use is good but we need to be looking at what is happening to the children. There is a significant impact of trauma for the children, which is going to affect their later life and health." "We should pay attention to the elderly. The number of seniors is growing" and there will be increasing challenges taking care of frail elders. "Access to all services is big." Physical activity and poor nutrition need to be a focus, but it needs to be addressed "in a way that is engaging and impactful for the population to change behavior." The group discussed children playing with video games and not playing outside. Lack of transportation is also a problem. Other issues include safety of children who are either alone at home or live in homes that are unsafe. There needs to be more low income housing. There is an increasing homeless population or families living in temporary places like the Haven.	The consensus of the group was that these are still the most important issues overall with substance misuse having the biggest impact. Other aspects of the discussion included economic instability, difficulties of getting a good paying job, and concerns about people 'gaming the system' for public assistance including subsidized housing. One member of the group stated that the influenza should be added to the list of priorities.	Access to affordable health care is the highest priority including the need for more urgent care options. The second issue raised was mental illness including Alzheimer's disease. There was discussion about the difficulty of dealing with patients with dementia in the ED and the need for more education of healthcare providers. The third issue concentrated on nutrition. The example was given that other cultures have less disease and the association with improved diets. The group also discussed the overall need for more health education and promotion "to transform the culture to more healthy lifestyles."
***Access to mental health care; Alcohol / drug use prevention, treatment and recovery; Affordability of health insurance and cost of prescription drugs; Lack of physical activity / more recreational opportunities; Health care services for seniors; Support for families with low income; addressing poverty**			

	Regional school nurses	Medication Assisted Therapy Group	Business sector representatives
What people are concerned about	"People worry most about finances. We see many people living on the edge and if anything happens, there is no backup or support. People do not have extended families or help when crisis occurs." Access to services the biggest problem. The closest dentist to Woodstock that accepts Medicaid is in Norwich and Lebanon; and some families have no cars. There are some fixed route transportation options, but "these rides take kids out of school longer because of the time in transport and that affects their learning time."	"I worry about nutrition. It is expensive to eat healthy and the American public is obese" "We worry about cancer, additives and preservatives in food" "There is a pervasive worry about drugs. All it takes is one wrong person to influence a young person's life. There is a lot of peer pressure for kids." "We worry about cyber bullying. As a parent I try to monitor but I can't see everything that is going on." There is a significant amount of cyber bullying.	"People worry about not having enough money to pay for healthcare." The focus of the discussion was around poverty and its effects on health. Other issues raised included the epidemic of drug use and the challenges of caring for people with Alzheimer's disease.
Areas where there has been improvement	There are increased dental resources and dentists that take Medicaid. There is an increase in school counselors and mental health counselors helping children directly in the school and more community resources in the school. The Windsor Whole School Whole Community Whole Child Committee (WSCCC) at the supervisory Union was described as a model that brings together multidisciplinary teams to promote health. The Good Neighbor Health Clinic was noted for its Needle exchange program. Valley Vista is making a telehealth evaluation for substance misuse available at the same time as the needle exchange to try to improve access to treatment.	The consensus of the group was they have not seen improvements in the areas. Examples included seniors having to go to Canada for medications due to the cost of prescription drugs and medical care being beyond the means of most people. "The poor stay poor. There is no middle class anymore." "(The poor) stay stuck. It is a vicious cycle. Rent is the same amount as a mortgage. There needs to be a way to help poor people buy homes and afford to keep them."	Improvement in drug treatment efforts was noted, specifically access to Medication Assisted Treatment. There was also a perception that doctors have tightened up on over-prescribing. However, the discussion participants also noted continuing lack of access to psychological and rehab services, as well as related issues of finding housing, particularly for individuals with criminal records. The group also discussed the need for a cultural shift away from focusing on pharmacological solutions for health issues toward more focus on prevention and wellness.

C. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2018 Community Health Needs Assessment report provides information on key indicators and measures of community health status. Some measures associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 13 town service area identified as the Mt. Ascutney Hospital and Health Center Service Area (identified in the following tables as MAHHC Service Area). In some instances, population health data are only available at the county or health district / regional level. For example, some indicators included here report statistics for Windsor County, Vermont. All 10 Vermont municipalities are within Windsor County and comprise about 48% of the total population of Windsor County. In a few instances, Vermont health data are reported for the White River Junction and Springfield Health Districts, which are larger geographic areas that incorporate the northern and southern Vermont municipalities of the MAHHC service area. For New Hampshire municipalities in the MAHHC service area, some population health information is reported for the Greater Sullivan County Public Health Region, which includes Claremont and Cornish, which comprise about 32% of the total population of the public health region. The following tables identify the different geographic regions and data sources from which the different statistics are derived.

1. Demographics and Social Determinants of Health

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

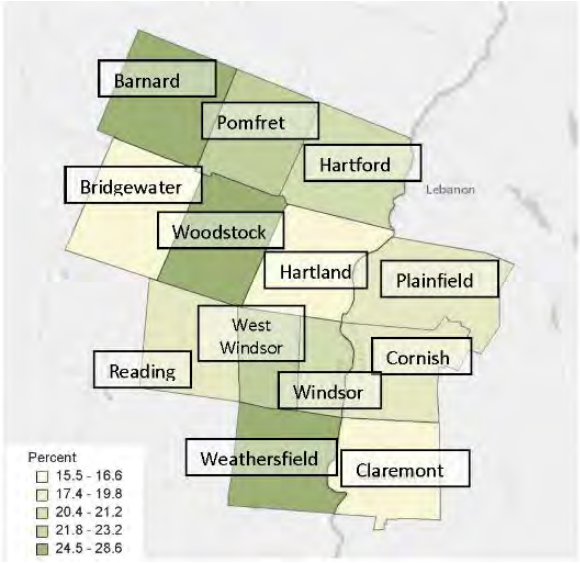
a. General Population Characteristics

According to the 2016 American Community Survey (US Census Bureau), the population of the MAHHC Service Area is older on average than in Vermont or New Hampshire overall. The service area map on the next page displays the percent of the population 65 years of age and older by town. Between 2010 and 2016, the population of the MAHHC Service Area decreased by over 1%.

Population Overview	MAHHC Service Area	Vermont	New Hampshire
Total Population	**44,035**	626,249	1,327,503
Age 65 and older	**19.5%**	17.0%	15.8%
Under age 18	**19.6%**	19.4%	20.1%
Change in population compared to 2010 census	**-1.4%**	+0.05%	+0.8%

Data Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates and 2010 US Census.

Figure 2 - Percent of Population 65 years of age and older MAHHC Service Area Towns



The proportion of the population age 65 years or more ranges from 15.5% in Bridgewater to 28.6% in Woodstock.

b. Poverty

The correlation between economic prosperity and good health status is well established. Inversely, the lack of economic prosperity, or poverty, can be associated with barriers to accessing health services, healthy food, and healthy physical environments that contribute to good health. Information describing household income and poverty status was included in the first section of this report. The table below presents the proportion of children under age 18 living below 100% and 200% of the Federal Poverty Level in the MAHHC Service Area compared with percentages for Vermont and New Hampshire. Child poverty rates in the service area are similar to Vermont statewide proportions of children living in or near poverty and higher compared to New Hampshire overall.

Area	Percent of Children in Poverty Income < 100% FPL	Percent of Children in or near Poverty Income < 200% FPL
MAHHC Service Area	**13.4%**	**34.6%**
Vermont	15.1%	35.3
New Hampshire	11.0%	26.8%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

c. Education

Educational attainment is also considered a key driver of health status with lower levels of education linked to both poverty and poor health. A similar proportion of the population of the MAHHC Service Area have earned at least a high school diploma or equivalent compared to the overall statewide proportions on this measure. The table below presents data on the percentage of the population aged 25 and older without a high school diploma (or equivalent).

Area	Percent of Population Aged 25+ with No High School Diploma
MAHHC Service Area	**7.6%**
Vermont	8.1%
New Hampshire	7.4%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

d. Language

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

Area	Percent of Population Aged 5+ Who Speak English Less Than "Very Well"
MAHHC Service Area	**0.4%**
Vermont	0.7%
New Hampshire	1.5%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

e. Housing

Housing characteristics, including housing quality and cost burden as a proportion of income, can influence the health of families and communities. The table below presents data on the percentage of housing units that are considered substandard housing and housing cost burden.

"Substandard" housing units are housing units that have at least one of the following characteristics 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) an average of more than one occupant per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent.

A component of the substandard housing index is the proportion of income that is spent on housing costs. According to research by the U.S. Department of Housing and Urban development, households that spend more than 30 percent of income on housing costs are less likely to have adequate resources for food, clothing, medical care, or other needs. The table below shows the proportion of households in the region for which the mortgage or rental costs exceed 30% of household income.

Area	Percent of Housing Units Categorized As "Substandard"	Percent of Households with Housing Costs >30% of Household Income
MAHHC Service Area	**33.0%**	**34.4%**
Vermont	35.3%	35.4%
New Hampshire	32.8%	33.3%

Data Source: 2012 – 2016 American Community Survey 5-Year Estimates; Sub-standard Housing and Housing Cost Burden data accessed from Community Commons.

f. Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. The next table presents data on the percent of households that have no vehicle available. Nearly 7% of households in the MAHHC service area report not having access to a vehicle, the same proportion as for the State of Vermont overall.

Area	Percent of Households with No Vehicle Available
MAHHC Service Area	**6.7%**
Vermont	6.7%
New Hampshire	5.3%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

g. Disability Status

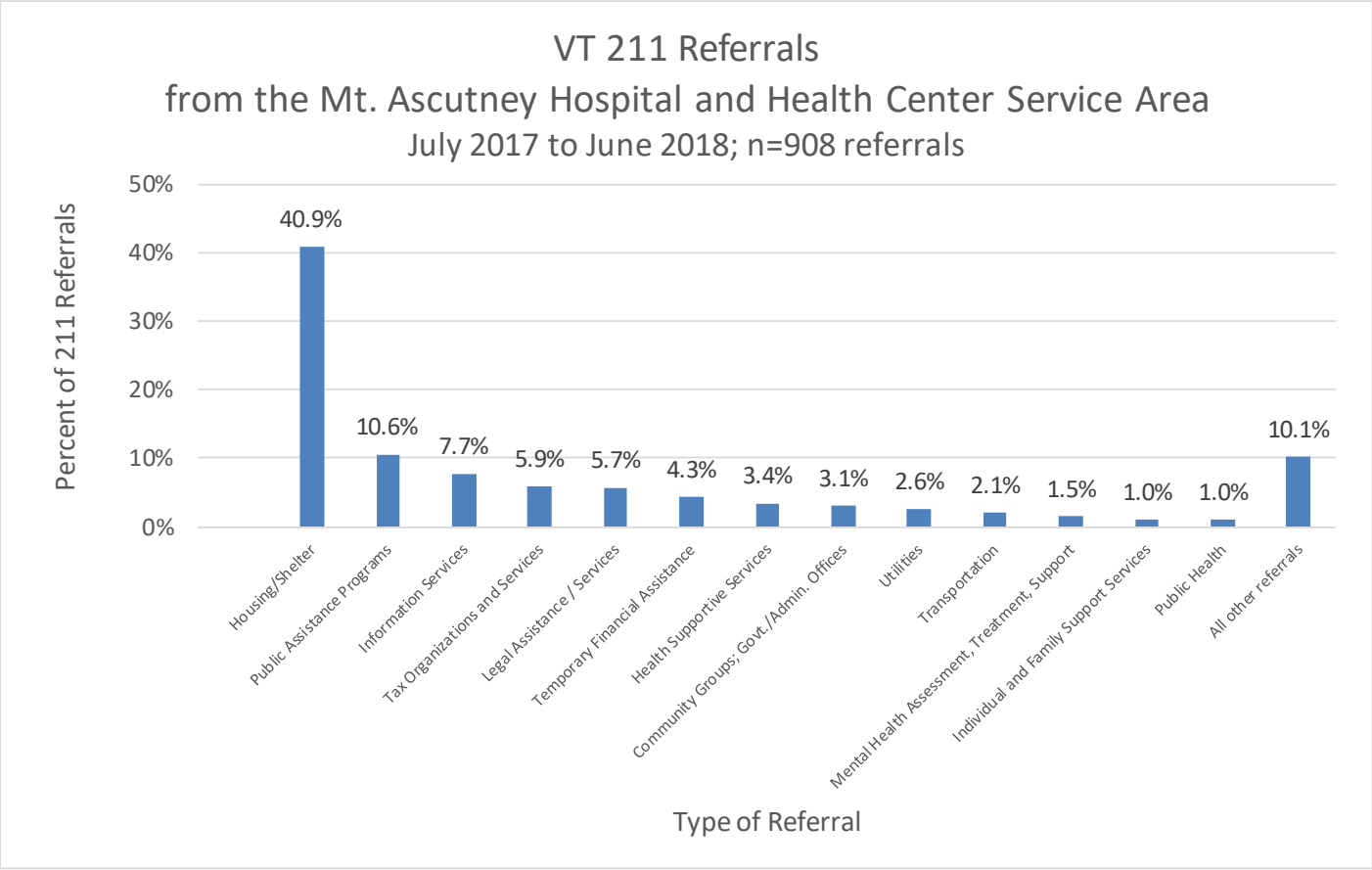
Disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. The US Census Bureau (American Community Survey) identifies people reporting serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation. According to the 2016 American Community Survey, 15.2% of MAHHC Service Area residents report having at least one disability, a percentage that is slightly higher than the statewide proportions, most likely a reflection of the proportionally older population.

Area	Percent of Population Reporting Serious Difficulty With Hearing, Vision, Cognition and/or Ambulation
MAHHC Service Area	**15.2%**
Vermont	14.0%
New Hampshire	12.3%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

h. Community Referral Needs

An additional barometer of community needs is referral activity through Vermont 2-1-1. During the period July 2017 through June 2018, Vermont 2-1-1 made 908 referrals for services for residents of towns in the MAHHC service area. The chart below displays the distribution of these referrals by referral type. By far, the most common type of referral was for Housing/Shelter (41% of referrals) followed by referrals to public assistance programs (11%).



2. Access to Care

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

a. Insurance Coverage

Table 9 displays estimates of the proportion of residents who do not have any form of health insurance coverage by municipality, as well as the proportion of residents covered by Medicare or Medicaid. It is important to note that the data source for these municipal level estimates is a 5 year span of the American Community Survey. A combination of five years of data is required to produce reasonably stable estimates on these and other measures from the survey samples. This particular time period spans a period of significant change in the health insurance market with the implementation of the federal Affordable Care Act and the beginning of Medicaid expansion. The overall proportion of the population without health insurance is estimated to be 7.5%. In the 2015 Community Health Needs Assessment, the estimated percentage of the service area population without health insurance was 10.8%.

TABLE 9

Area	Percent of the Total Population with No Health Insurance Coverage	Percent with Medicare Coverage Alone or in Combination	Percent with Medicaid Coverage Alone or in Combination
Pomfret VT	2.1%	22.4%	14.3%
Barnard VT	2.1%	25.6%	18.6%
West Windsor VT	2.4%	23.2%	22.7%
Plainfield NH	3.0%	18.0%	8.9%
Vermont	**5.3%**	**19.3%**	**24.9%**
Cornish NH	5.6%	17.7%	9.7%
Windsor VT	5.9%	23.8%	29.1%
Woodstock VT	6.6%	29.7%	13.9%
Bridgewater VT	6.7%	19.1%	27.4%
MAHHC Service Area	**7.5%**	**22.0%**	**21.5%**
Weathersfield VT	7.6%	29.1%	22.4%
Hartland VT	7.7%	20.3%	23.3%
Hartford VT	**7.8%**	**21.7%**	**21.8%**
New Hampshire	**8.4%**	**17.5%**	**11.8%**
Claremont NH	9.9%	20.3%	24.1%
Reading VT	11.2%	21.0%	32.1%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates

b. Adults with a Personal Health Care Provider

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

Area	Percent of adults who report having a personal doctor or health care provider
Windsor County	**86%**
Greater Sullivan County PHR	**86.1%**
Vermont	88%
New Hampshire	86.8%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

c. Preventable Hospital Stays

Preventable Hospital Stays is the hospital discharge rate for diagnoses potentially treatable in outpatient setting, also known as ambulatory care sensitive conditions, such as diabetes, hypertension, asthma and chronic obstructive pulmonary disease. This measure is reported for Medicare enrollees. A high rate of inpatient stays for ambulatory care sensitive conditions may indicate limited access, availability or quality of primary and outpatient specialty care in a community. The rate of preventable hospital stays in the MAHHC service area is similar to the overall NH state rate and somewhat higher than overall VT state rate.

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
MAHHC Service Area	**45.5**
Vermont	38.8
New Hampshire	44.8

Data Source: Dartmouth Atlas of Health Care, 2014; accessed through Community Commons.

d. Behavioral Health

Overall health depends on both physical and mental well-being. The table below shows proportion of adults who self-report that their mental health was not good for 14 or more days in the past 30 days, a measure that is correlated with depression and other chronic mental health concerns as well as overall health-related quality of life. The proportion of adults in the service area reporting 14 or more days in the past 30 days when their mental health was not good ranges from about 10% in the Sullivan County Public Health Network (includes Claremont NH) to 16% in the Springfield Health District (includes Windsor).

Area	Percent of adults reporting 14 or more days in the past 30 days during which their mental health was not good
White River Jct Health District	**10%**
Springfield Health District	**16%**
Greater Sullivan County PHR	**9.9%**
Vermont	12%
New Hampshire	11.0%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-1016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

e. Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past five years. The proportion of adults in the MAHHC service area who report not having seen a dentist in the past year is higher compared to the overall state rates, although the observed differences are not statistically significant.

Area	Percent of adults who have not visited a dentist or dental clinic in the past year
Windsor County	**31%**
Greater Sullivan County PHR	**33.6%**
Vermont	29%
New Hampshire	30.3%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2014, 2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

f. Poor Dental Health

This indicator reports the percentage of adults (ages 45-64 for Vermont; ages 18-64 for New Hampshire) who self-report having any of their permanent teeth removed due to tooth decay, gum disease, or infection. In addition to highlighting needed improvements in preventive oral health care, this indicator can also highlight a lack of access to care, a lack of health knowledge, or social and economic barriers preventing utilization of services.

Area	Percent of adults who report having any of their permanent teeth removed
Windsor County	**46%** (ages 45-64)
Greater Sullivan County PHR	**38.2%** (ages 18-64)
Vermont	49% (ages 45-64)
New Hampshire	34.7% (ages 18-64)

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2014, 2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

3. Health Promotion and Disease Prevention Practices

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

a. Fruit and Vegetable Consumption (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day. Unhealthy eating habits contribute to significant health issues such as obesity and diabetes.

Area	Percent of Adults Consuming Less than 5 Fruit or Vegetable Servings per Day
White River Jct Health District	**77%**
Springfield Health District	**83%**
Greater Sullivan County PHR	**69.5%**
Vermont	80%
New Hampshire	71.5%

b. Physical Inactivity (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. About 3 of every 5 adults in Vermont and in the region self-reported meeting guidelines for regular physical activity.

Area	No physical activity or exercise in past 30 days, % of adults
Windsor County	**23%**
Greater Sullivan County PHR	**25.3%**
Vermont	18%
New Hampshire	20.8%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

c. Pneumonia and Influenza Vaccinations (Adults)

This indicator reports the percentage of adults who self-report that they have ever received a pneumonia vaccine or received influenza vaccine in the past year. In addition to measuring the population proportion receiving preventive vaccines, this indicator can also highlight a lack of access to preventive care, opportunities for health education, or other barriers preventing utilization of services.

Area	Adults who have received a flu shot in past 12 months and those who have ever received a pneumococcal vaccination		
	Influenza Vaccination 18 years of age or older	Influenza Vaccination 65 years of age or older	Pneumococcal Vaccination 65 year of age or older
Windsor County		**62%**	**74%**
Greater Sullivan County PHR	**45.9%**		**76.7%**
Vermont		59%	77%
New Hampshire	43.7%		77.2%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-1016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

d. Substance Misuse

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

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking more than two drinks per day on average for men or more than one drink per day on average for women), or binge drinking (drinking 5 or more drinks on an occasion for

men or 4 or more drinks on an occasion for women), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Area	Engaged in Binge Drinking in Past 30 days, Percent of Adults		
	Male	Female	Total
Windsor County			**16%**
Greater Sullivan County PHR	**21.0%**	**11.6%**	**16.1%**
Vermont			18%
New Hampshire	21.7%	12.3%	16.8%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-1016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Area	Heavy Alcohol Use, Percent of Adults		
	Male	Female	Total
White River Jct Health District			**11%**
Springfield Health District			**8%**
Greater Sullivan County PHR	**14.7%**	**6.2%**	**10.4%**
Vermont			9%
New Hampshire	6.4%	6.8%	6.6%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth. On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers. In the Greater Sullivan County Public Health Region, the proportion of high school aged youth reporting binge drinking behavior is slightly higher than the overall state percentage, although the difference is not statistically significant.

Area	Engaged in Binge Drinking in Past 30 days, Percent of High School Youth
Windsor County	15%
Greater Sullivan County PHR	**19.1%**
Vermont	17%
New Hampshire	15.9%

Data Source: Youth Risk Behavior Survey, VDH, 2017, NHDHHS, 2017

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

The misuse of prescription drugs, particularly prescription pain relievers, poses significant risk to individual health and can be a contributing factor leading to misuse of other drugs and a cause of unintentional overdose and mortality. About 11% of high school youth in the Greater Sullivan County Public Health Region report having ever used a prescription drug that was not prescribed to them, a proportion similar to the state overall.

Area	Ever used prescription drugs without a doctor's prescription, Percent of High School Youth	Ever misused prescription pain medicine, Percent of High School Youth	Ever misused prescription stimulants, Percent of High School Youth
Greater Sullivan County Public Health Region	10.8%		
New Hampshire	11.5%		
Windsor County		7%	6%
Vermont		8%	8%

Data Source: NH Youth Risk Behavior Survey, 2017; VT Youth Risk Behavior Survey 2017

Regional rate is not significantly different than the overall NH rate

Note: The NH YRBS asked one question, “During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?” The VT YRBS separated this into two questions, one instructing respondents to “count drugs such as such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet” and one instructing respondents to “count drugs such as Adderall or Ritalin”.

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. Nearly 1 in 5 adults in the communities of the MAHHC service area are estimated to be current smokers, a proportion similar to the overall statewide rates.

Area	Percent of Adults who are Current Smokers
Windsor County	**19%**
Greater Sullivan County PHR	**20.6%**
Vermont	18%
New Hampshire	17.0%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

f. Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rates in the MAHHC service area, as represented by Windsor County (VT) and the Greater Sullivan Public Health Region (NH) are higher than the respective state comparison rates, although the differences are not statistically significant.

Area	Teen Birth Rate per 1,000 Women Age 15-19
Windsor County	**22.6**
Greater Sullivan County PHR	**13.9**
Vermont	16.8
New Hampshire	11.0

Data source: NH Division of Vital Records Administration birth certificate data; 2012-2016. VT Dept of Health, 2016
Regional rates are not significantly different statistically from the overall state rates.

g. Children in Foster Care

One measure of child safety, abuse and neglect in a community is the number of children placed in temporary out-of-home care. As displayed by the table below, the rate of such placements in Windsor County during 2016 was 16.5 children per 1,000, rate statistically similar to the overall rate in Vermont. (Similar information for NH not currently available.)

Area	Children under age 18 in DCF Custody Rate per 1,000 Children
Windsor County	**16.5**
Vermont	14.2

Data source: Vermont Agency of Human Services, Adoption and Foster Care Analysis and Reporting System, April – September 2016
Regional rate is not significantly different statistically from the overall state rate.

4. Selected Health Outcomes

Traditional measures of population health status focus on rates of illness or disease (morbidity) and death (mortality) from specific causes. Advances in public health and medicine through the 20th Century have reduced infectious disease and complications of child birth as major contributors to or causes of death and disease. Chronic diseases, such as heart disease, cancer, respiratory disease and diabetes, along with injury and violence, are now the primary burdens on the health and wellbeing of individuals, families and communities. In addition to considering the absolute magnitude of specific disease burdens in a population, examination of disparities in disease rates can help to identify areas of need and opportunities for intervention.

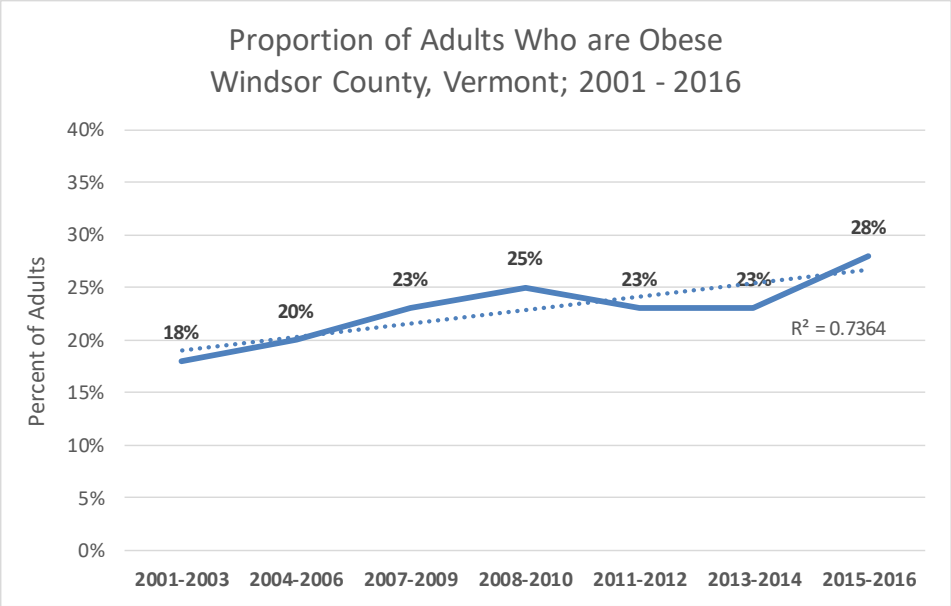
a. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) or greater than 25.0 (overweight or obese). The chart on the next page displays the trend in Windsor County since 2001 toward increasing prevalence of obesity in the adult population.

Area	Percent of Adults Who Are Obese	Percent of Adults Who Are Overweight or Obese
Windsor County	**28%**	
Greater Sullivan County PHR	**31.2%**	**66.5%**
Vermont	28%	
New Hampshire	27.0%	63.6%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Chart 14



Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2015

b. Heart Disease

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

Cardiovascular and Heart Disease Prevalence: This indicator reports the percentage of adults aged 18 and older who have ever been told by a doctor that they have coronary heart disease or angina (NH) or the percentage of adults who have been told they have coronary heart disease, or have had a heart attack or stroke (VT).

Area	Percent of Adults with Heart Disease (self-reported)	Percent of Adults with Cardiovascular Disease (self-reported)
Windsor County		**10%**
Greater Sullivan County PHR	**4.7%**	
Vermont		8%
New Hampshire	4.0%	

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Cholesterol Screening: High levels of total cholesterol and low density lipoprotein-cholesterol (LDL-C) and low levels of high density lipoprotein-cholesterol (HDL-C) are important risk factors for coronary heart disease. Periodic cholesterol screening for adults, particularly those with other risk factors, is a beneficial procedure for early identification of heart disease that can be treated with preventive therapy. The table below displays the proportion of adults who report that they have had their cholesterol levels checked at some point within the past 5 years.

Area	Percent of adults who have had their cholesterol levels checked within the past 5 years
Windsor County	**74%**
Greater Sullivan County PHR	**85.5%**
Vermont	76%
New Hampshire	83.0%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2013, 2015, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Heart Disease and Stroke Mortality: Coronary Heart Disease, a narrowing of the small blood vessels that supply blood and oxygen to the heart, is the largest component of heart disease mortality. The rate of death due to coronary heart disease among Windsor County residents was significantly lower than the overall rate for Vermont in 2014 (most current information available). Cerebrovascular disease (stroke), which happens when blood flow to a part of the brain stops, is the fifth leading cause of death in New Hampshire and in the MAHHC service area.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Windsor County	**89.1***	**33.0**
Greater Sullivan County PHR	**95.2**	**27.1**
Vermont	105.4	27.7
New Hampshire	94.6	27.9

Data Source: NH Division of Vital Records death certificate data, 2012-2016; VDH, 2012-2014

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

Other regional rates are not significantly different statistically from the overall state rates.

c. Diabetes

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

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. Nearly 11% of adults in the MAHHC service area report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes
Windsor County	**10%**
Greater Sullivan County PHR	**11.9%**
Vermont	8%
New Hampshire	8.6%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

Diabetes Management: This indicator reports the percentage of Medicare beneficiaries with diabetes a who have had a hemoglobin A1c (HbA1c) test, a blood test which measures blood glucose levels, administered by a health care professional in the past year. Regular HbA1C testing is important for diabetes management and prevention of diabetes-related health complications.

Area	Percent of Medicare Beneficiaries with Diabetes with Annual Hemoglobin A1c Test
MAHHC Service Area	**90.0%**
Vermont	89.9%
New Hampshire	90.3%

Data Source: Dartmouth Atlas of Health Care, 2014; accessed through Community Commons
Regional rate is not significantly different from the overall NH rate

Diabetes-related Mortality: Diabetes is the seventh leading cause of death in both Vermont and New Hampshire. The rate of death due to Diabetes Mellitus among MAHHC area residents is similar to the overall rates for New Hampshire and Vermont.

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Windsor County	**18.3**
Greater Sullivan County PHR	**21.1**
Vermont	20.5
New Hampshire	18.2

Data Source: NH Division of Vital Records death certificate data, 2012-2016
CDC Wonder, 2015-2016

d. Cancer

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

Cancer Screening: The table below displays screening rates for colorectal cancer, breast cancer and cervical cancer. The United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The proportion of adults age 50 to 75 who are in compliance with the USPSTF recommendations (self-report) in the region is similar to the overall state rates. The proportion of women who report being in compliance with breast and cervical cancer screening recommendations are also similar to the overall state rates.

Cancer Screening Type	Windsor County	Greater Sullivan County PHR	Vermont	New Hampshire
Percent of adults who are aged 50+ that met USPSTF colorectal cancer screening recommendations*	69%	76.1%	72%	74.9%
Percent of females aged 50+ who have had a mammogram in the past two years**	75%	74.7%	79%	80.8%
Percent of females aged 18-64 who have had a pap test in the past 3 years**	90%	81.7%	86%	80.0%

*Data Source: Behavioral Risk Factor Surveillance System; NHDHHS 2015; VDH 2014 and 2016 (County), 2016 (State), ages 50-75

**Data Source: Behavioral Risk Factor Surveillance System; NHDHHS 2014; VDH 2014 and 2016 (County), 2016 (State), ages 50-74

***Data Source: Behavioral Risk Factor Surveillance System; NHDHHS 2014; VDH 2012 and 2014, ages 21-65

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

Cancer Incidence and Cancer Mortality: The table below shows cancer incidence rates by site group for the cancer types that account for the majority of new cancer cases (incidence). The incidence rates for the most common cancers are similar to the state rates, although incidence of Melanoma of the Skin is somewhat elevated in Windsor County and incidence of Prostate cancer is lower in the region compared to the overall rate in NH.

Cancer Incidence per 100,000 people, age adjusted				
	Windsor County	Greater Sullivan County PHR	Vermont	New Hampshire
Overall cancer incidence (All Invasive Cancers)	456.4	470.8	454.9	497.7
Cancer Incidence by Type				
Breast (female)	141.2	159.4	130.4	145.3
Prostate (male)	90.8	73.2	92.0	120.9
Lung and bronchus	61.9	62.1	63.3	67.3
Colorectal	34.8	38.5	36.1	38.8
Melanoma of Skin	41.5	36.7	33.1	29.7
Bladder	22.5	20.8	22.8	28.3

Data Source: VT Cancer Registry, 2011-2015; NH State Cancer Registry, 2011 - 2015
Data Source for Windsor County: National Cancer Institute, State Cancer Profiles, 2011 - 2015

Cancer Mortality: The table below shows the overall cancer mortality rate and for the cancer types that account for the majority of cancer deaths. The overall cancer mortality rate and mortality rate from specific cancer types are similar to the state overall.

Cancer Mortality per 100,000 people, age adjusted				
	Windsor County	Greater Sullivan County PHR	Vermont	New Hampshire
Overall cancer mortality (All Invasive Cancers)	161.0	150.2	168.6	162.3
Cancer Mortality by Type				
Lung and bronchus	45.4	41.2	45.2	44.4
Pancreas	11.9	12.0	11.1	10.7
Prostate (male)	26.4	14.2	20.2	20.1
Breast (female)	18.1	15.4	19.2	19.4
Colorectal	9.5	7.0	14.1	12.8

Data Source: NH State Cancer Registry, 2012 – 2016; *VT Vital Statistics, 2011-2015.*

Data Source for Windsor County: National Cancer Institute, State Cancer Profiles

e. Asthma

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

Asthma Prevalence: This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma; also displayed is the percentage of children with current asthma as reported by a parent or guardian. The reported asthma rate in the region for children appears higher than the state overall, although the observed difference is not statistically significant.

Area	Percent of Children (ages 0 to 17) with Current Asthma*	Percent of Adults (18+) with Current Asthma
Windsor County	**7%**	**11%**
Greater Sullivan County Public Health Region	**14.2%**	**10.9%**
Vermont	8%	11%
New Hampshire	7.2%	10.1%

Data Source: Behavioral Risk Factor Surveillance System, VDH, 2015-2016, NHDHHS, 2014-2015.
Regional rates are not significantly different statistically from the overall state rates.

f. Intentional and Unintentional Injury:

Accidents and injury are the third leading cause of death in Vermont and New Hampshire. Deaths due to falls in older adults have been increasing in as the population of each state ages.

Area	Fall related deaths (age 65 and over) Age-adjusted rate
Windsor County	**111.3**
Greater Sullivan County PHR	**81.6**
Vermont	118.7
New Hampshire	97.1

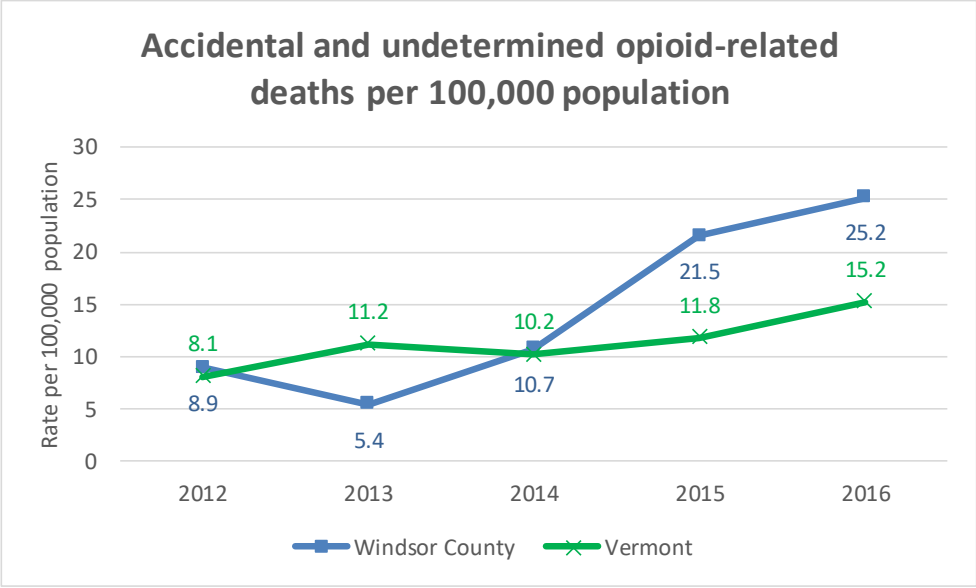
Data Source: NH Division of Vital Records death certificate data, 2012-2016; VDH, 2012-2014

Drug Overdose Mortality: New Hampshire and Vermont have been among the hardest hit states by the epidemic of opioid-related misuse with NH ranking 3rd and Vermont ranking 20th among all states in 2016 for the number of opioid-related deaths per capita. While the rate of drug overdose deaths in the NH portion of the MAHHC service area appears to have remained below the overall rate for NH, the rate of drug-related fatalities including opioids in Windsor County has been increasing at a rate higher than observed in VT overall. In 2016, the rate of all drug-related fatalities in Windsor County was 26.9 per 100,000 population; the second-highest rate among Vermont counties. It is also important to note that the proportion of prescriptions over 90 morphine milligram equivalents (MME) is among the highest in the state at 17% and the total percentage of prescriptions over 50 MME is at 35% which ranks third-highest among Vermont counties.

Area	All drug overdose deaths (prescription , illicit, other & unspecified drugs) Age-adjusted rate per 100,000 population	Accidental and undetermined opioid-related deaths per 100,000 population
Windsor County		**25.2**
Greater Sullivan County PHR	**19.2***	
Vermont		15.2
New Hampshire	31.4	

Data Source: NH Division of Vital Records death certificate data, 2014-2016; Vermont Agency of Human Services, 2016

***Rate is statistically different and lower** than the overall NH rate; Windsor County rate is not significantly different than the VT state rate.



Vermont Agency of Human Services, Vital Records data

Suicide: This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care. During the period 2012 to 2016, the suicide rate in the region was similar to the overall rate of suicide deaths in Vermont and New Hampshire.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
Windsor County, VT	**15.3**
Greater Sullivan County PHR	**17.4**
Vermont	17.2
New Hampshire	15.3

Data Source: NH Division of Vital Records death certificate data, 2012-2016; VDH, 2012-2014

g. Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. During the period 2014 to 2016, 662 deaths in Windsor County and 568 deaths in Sullivan County occurred before the age of 75.

Area	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Windsor County, VT	5,993
Sullivan County, NH	6,557
Vermont	5,732
New Hampshire	5,867

Data source: National Center for Health Statistics, National Vital Statistics System accessed via County Health Rankings, 2014-2016.

5. Comparison of Selected Community Health Indicators between 2015 and 2018

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2018) and the previous assessment conducted in 2015, as well as the most recent statewide statistic for each indicator. This comparison is provided for informational purposes and it is important to note the differences between the 2015 and 2018 estimates for the region and the state comparison estimate are not significantly different for most indicators. Statistics that show improvement from the prior assessment (although not statistically significant) are highlighted in green font and those that suggest declines from the previous assessment are highlighted in red.

Table 10: Comparison of Selected Community Health Indicators between 2015 and 2018 with NH State Comparison

Community Health Indicator	Geographic Area	2015 Community Health Assessment	2018 Community Health Assessment	State Comparisons (most recent statistics available)	
Access to care				VT	NH
Percentage of adult population (age 18+) without health insurance coverage	MAHHC Service Area	10.8%	**7.5%**	5.3%	8.4%
Do not having a personal doctor or health care provider, percent of adults	Windsor County	13%	14%	12%	13%
Have not visited a dentist or dental clinic in the past year, percent of adults	Windsor County	28%	**31%**	29%	30%
Health Promotion and Disease Prevention					
Current smoking, percent of adults	Windsor County	19%	19%	18%	17%
Physically inactive in the past 30 days, % of adults	Windsor County	20%	**23%**	18%	21%
Binge drinking, percent of adults	Windsor County	17%	**15%**	17%	16%
Teen Birth Rate, per 1,000 Women Age 15-19	Windsor County	27.4	**22.6**	16.8	11.0

Community Health Indicator	Geographic Area	2015 Community Health Assessment	2018 Community Health Assessment	State Comparisons (most recent statistics available)	
Health Outcomes				VT	NH
Obese, percent of adults	Windsor County	26%	**28%**	28%	27%
Ever told had diabetes, percent of adults	Windsor County	6%	**10%**	8%	9%
Current asthma, percent of adults	Windsor County	10%	11%	11%	10%
Coronary Heart Disease Mortality, per 100,000 people, age-adjusted	Windsor County	121.3	**89.1**	105.4	94.6
Cancer Incidence, All sites, per 100,000 people, age-adjusted	Windsor County	NA	456.4	454.9	497.4
Cancer Deaths, All Sites, per 100,000 people, age-adjusted	Windsor County	171.0	**161.0**	168.6	162.3