Community Health Needs in the Upper Valley

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The Community Health Team

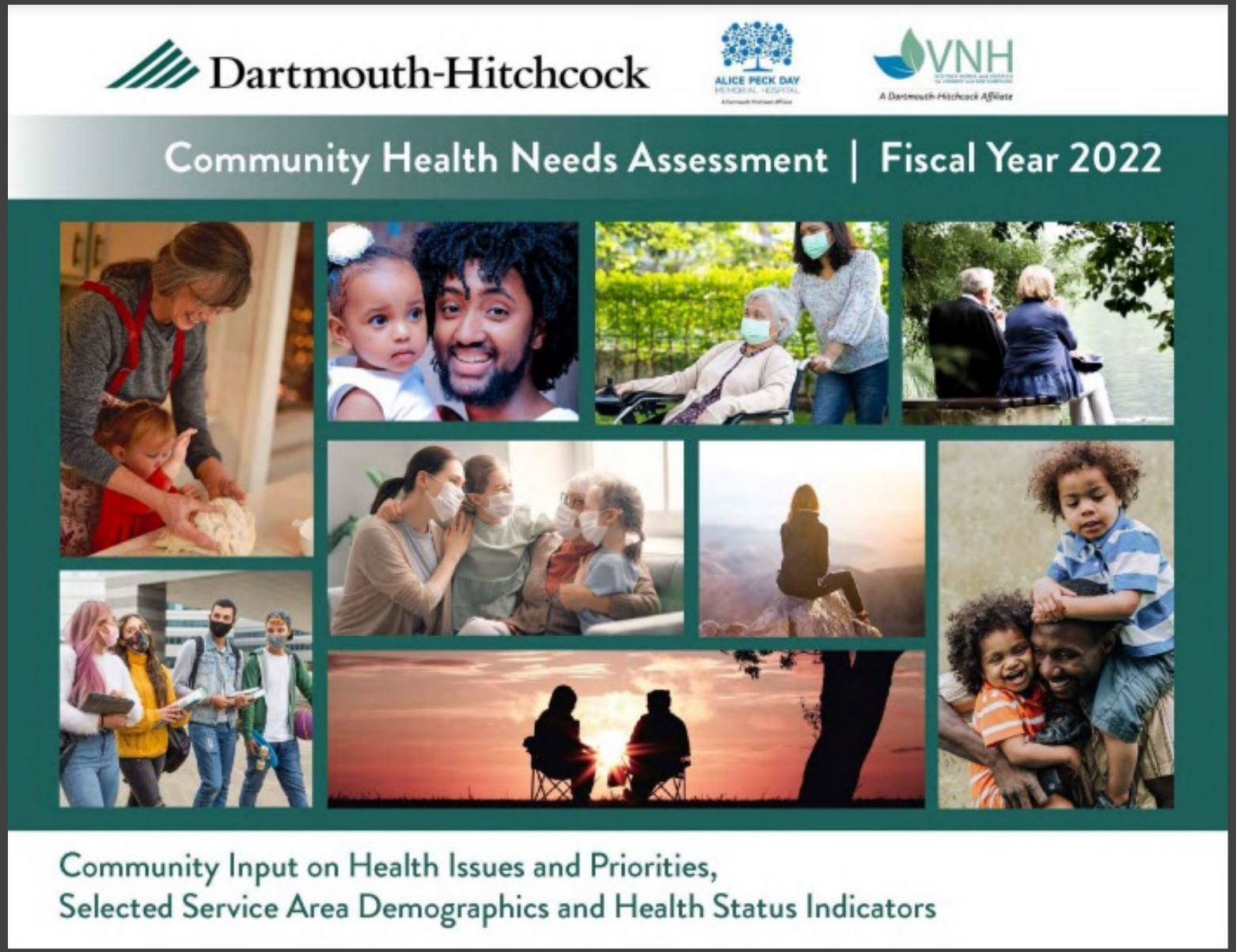
The Dartmouth Health Community Health team sits within the DH Department of Population Health.

The Community Health team works as a trusted **partner** in communities to measurably improve health through the intentional alignment and coordination of medical and community strategies to achieve shared goals.

We focus on improving the **social determinants of health**, with a specific focus on **health equity**.

What makes a *great* community health project?

https://www.dartmouth-hitchcock.org/about/community-health



Methods

1. Survey of area residents
   - Via email, social media, website links and paper copies with collection stations throughout the region
   - n=1,642 community respondents associated with APD, DH and VNH collection activities
2. Survey of community leaders
   - Via email to 352 individual stakeholders
   - n=207 respondents total (50% response rate);

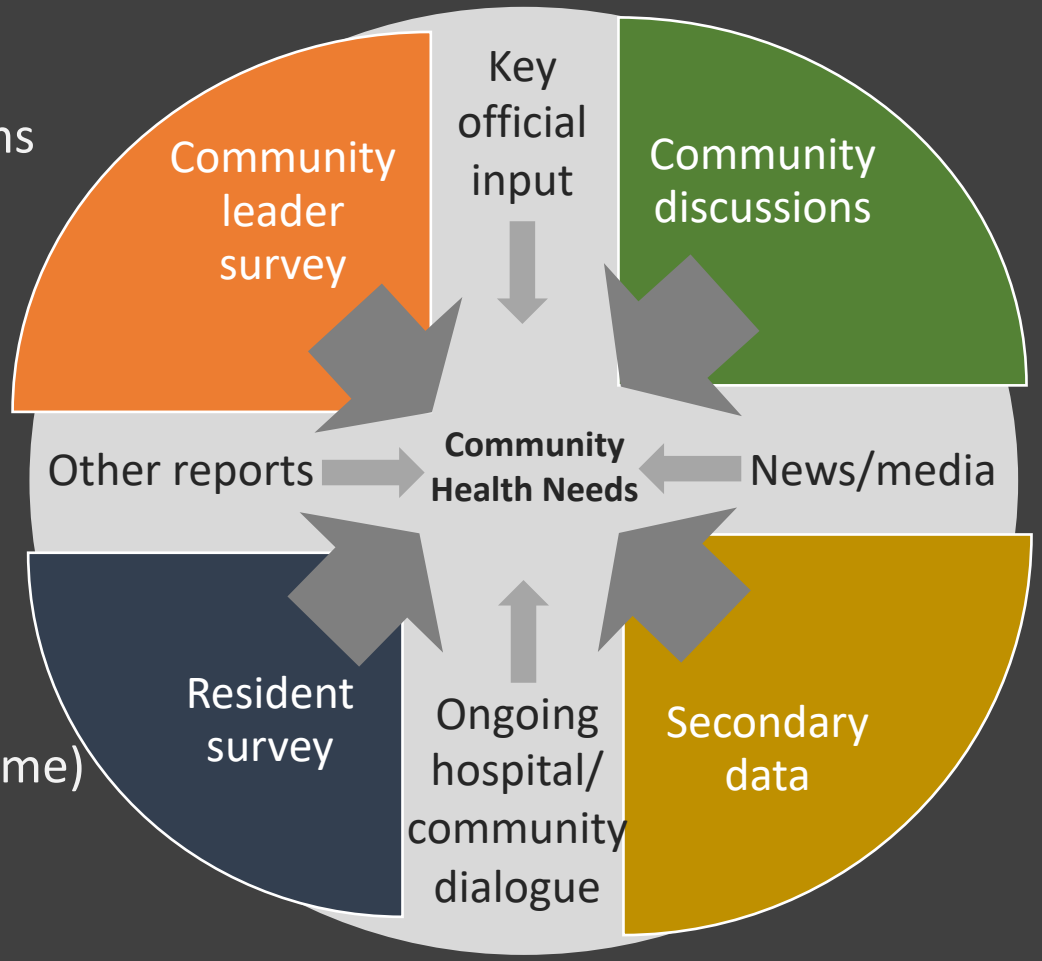
Methods

3. Facilitated community discussion groups (11)
    - Behavioral Health Coordinators (6 participants)
    - Community Health Workers (4 participants)
    - Food Insecurity (2 participants)
    - Regional Public Health (2 participants)
    - Substance Use Recovery Coaches (7 participants)
    - Medication Assisted Treatment (5 participants)
    - Chamber of Commerce Directors (5 participants)
    - Rural Community Residents (6 participants)
    - Individuals with Complex Health Needs (4 participants)
    - Seniors (6 participants)
    - Prevention Network Grantees (3 participants)

4. Secondary data review
    - Collection of available population demographics and health status indicators

CHNA: Four Primary Methods

+ Informed views
+ Informed by formal systems
- Selection Bias (critical)
- Potential conflicts
- Can lean to crisis



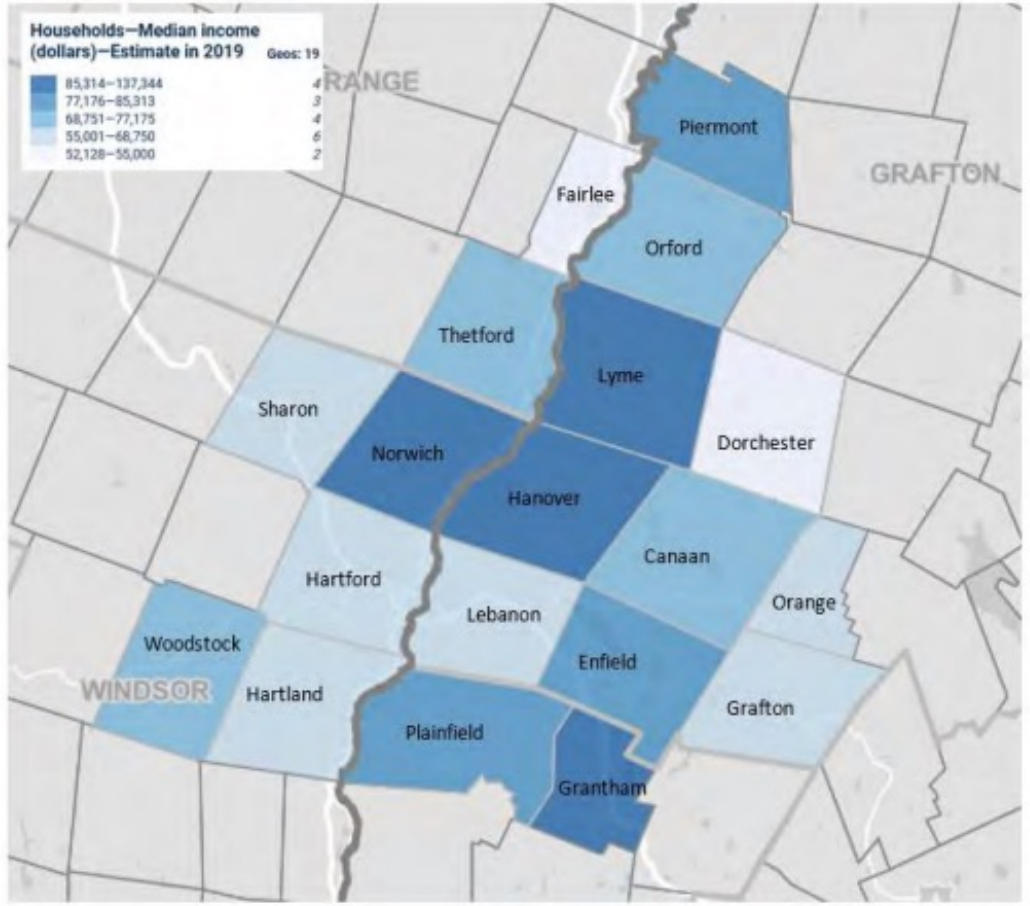
+ Deep context
+ Sub-population views
+ Direct listening
- Selection bias
- Tokenism
- Resource intensive / not enough

+ Wide range of input
+ Engagement
+ Some comparability (income)
- Convenience sample/participation bias
- May not be representative

+ Consistent definition
+ Regular data collection
+ Comparable
- Time lag
- Geographic limitations

DH and APD service area: median household income

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates



Median household income ranges from $52,128 in Fairlee to $137,344 in Hanover.

What does the data tell us?

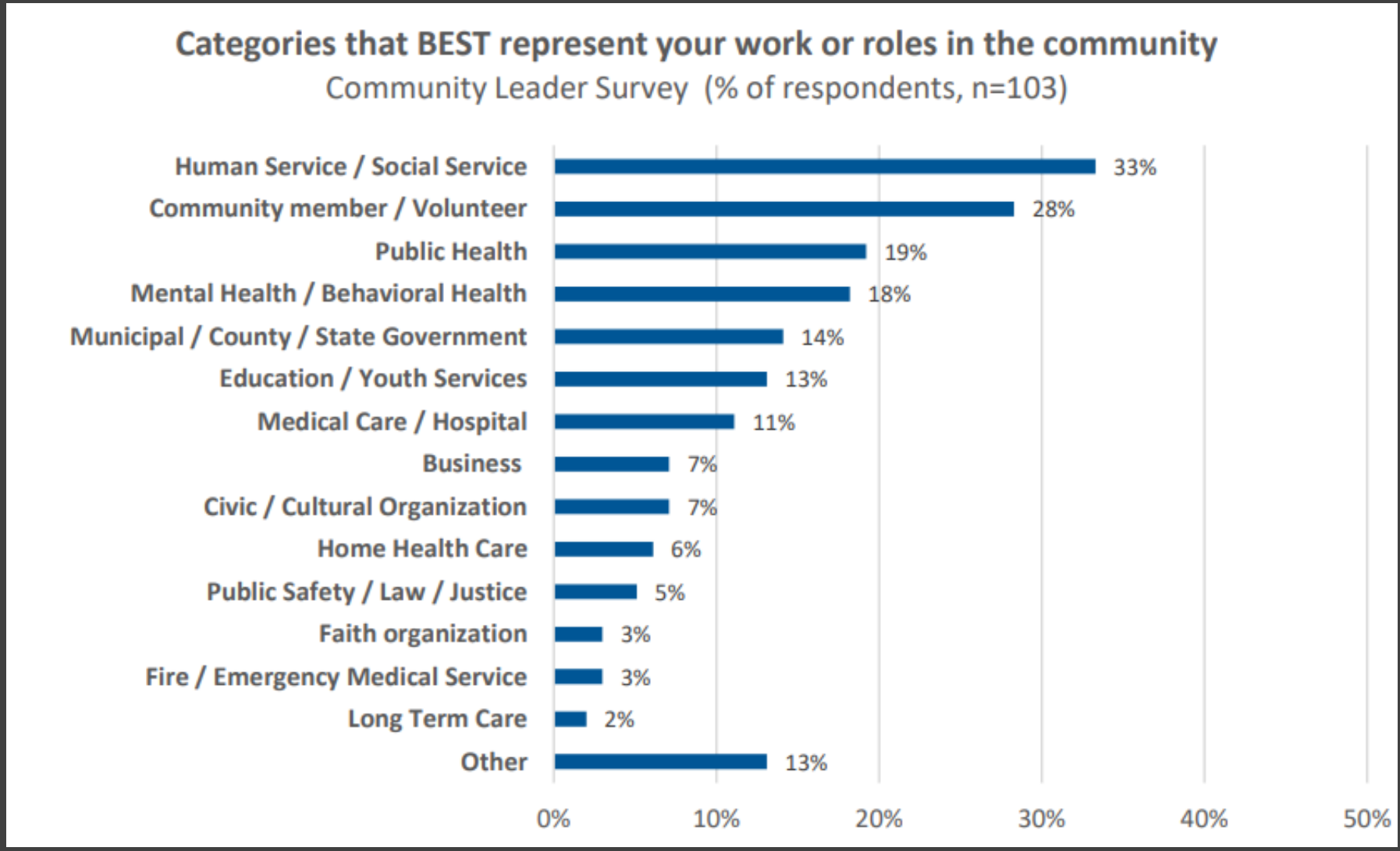
Demographics

Age < 65 years	Female	Black, Indigenous and People of Color	Current military service or veteran
84%	66%	11%	9%
Household Income < $50K	**Currently Uninsured**	**Currently has Medicaid coverage**	**Hard to do some Daily Tasks without help**
23%	3%	11%	9%

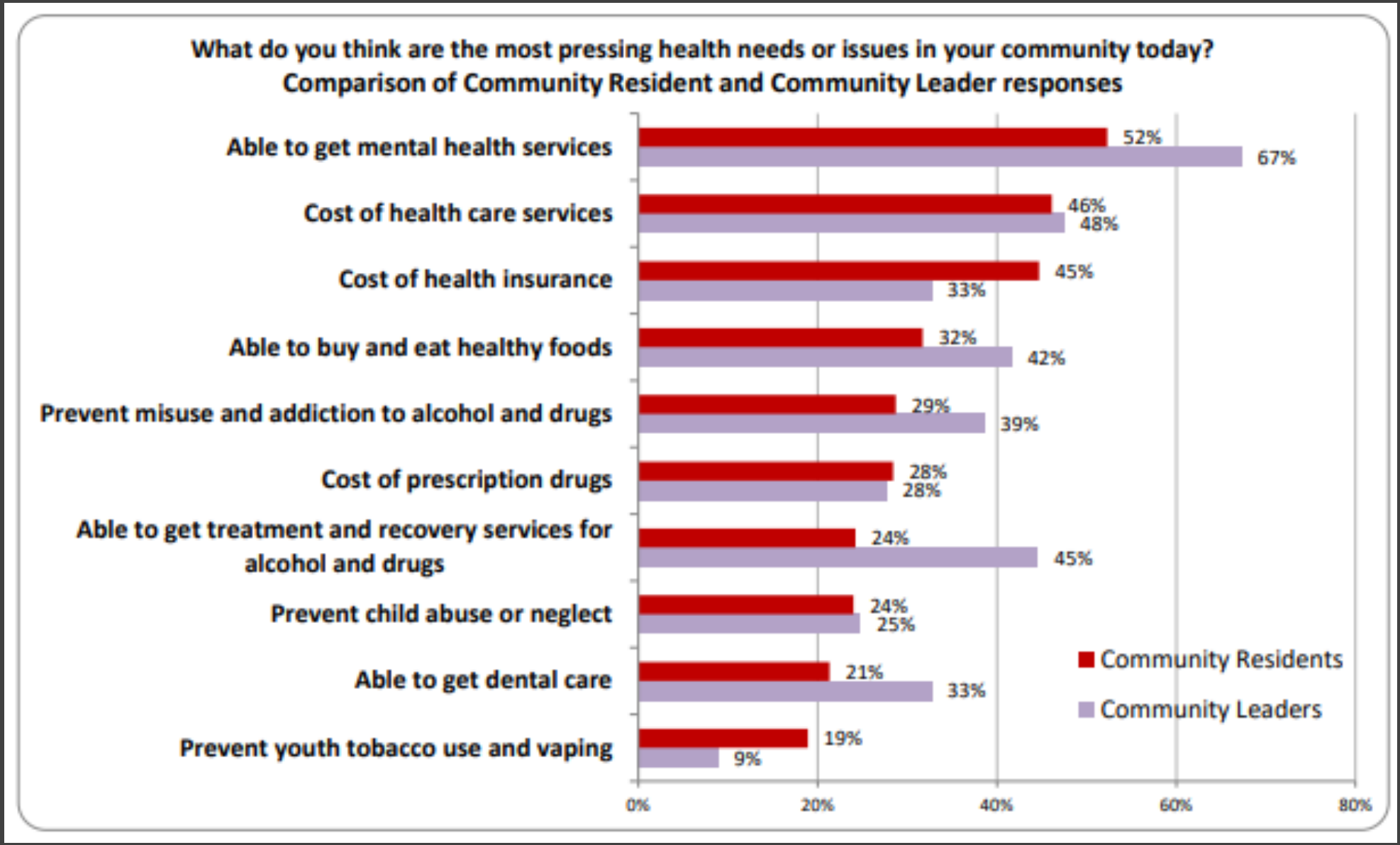
Demographics

Race / Ethnicity	Community Survey Respondents, % (n)	Region: 48 NH and VT Municipalities, % (n)
Hispanic	2.1% (90)	2.4% (3,393)
Not Hispanic or Latino		
Black or African American alone	0.9% (40)	0.8% (1,112)
American Indian and Alaska Native alone	0.3% (14)	0.2% (341)
Asian alone	1.8% (78)	2.3% (3,229)
Native Hawaiian and Other Pacific Islander alone	0.2% (8)	<0.1% (36)
White alone	85.0% (3,702)	89.0% (124,001)
Middle Eastern or North African	0.2% (8)	
Some Other Race alone		0.4% (605)
Two or more races	1.1% (48)	4.7% (6,542)
Prefer to self-describe	1.9% (81)	
Prefer not to answer	6.6% (287)	
TOTAL	100% (4,356)*	100% (139,259)

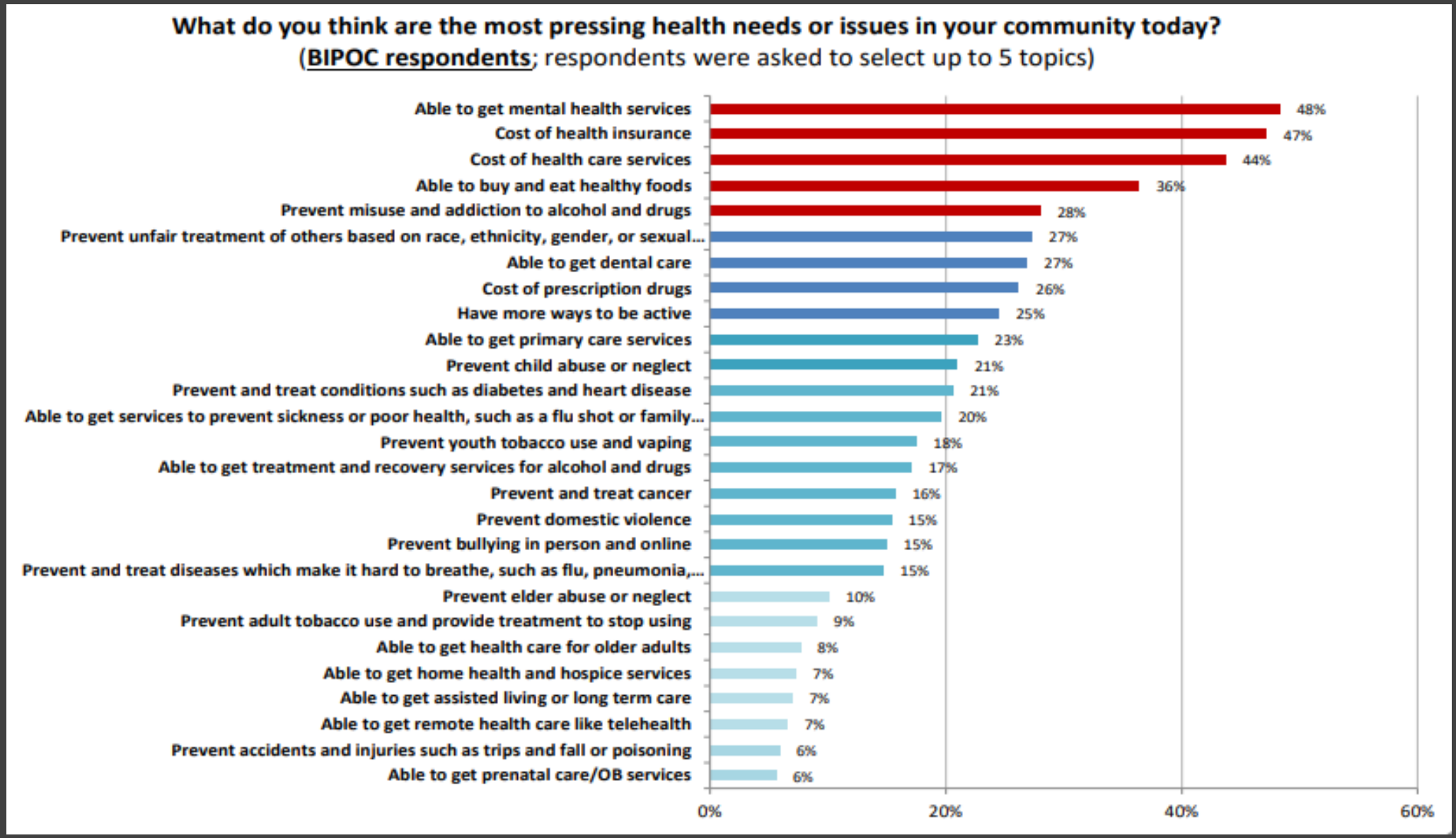
Demographics



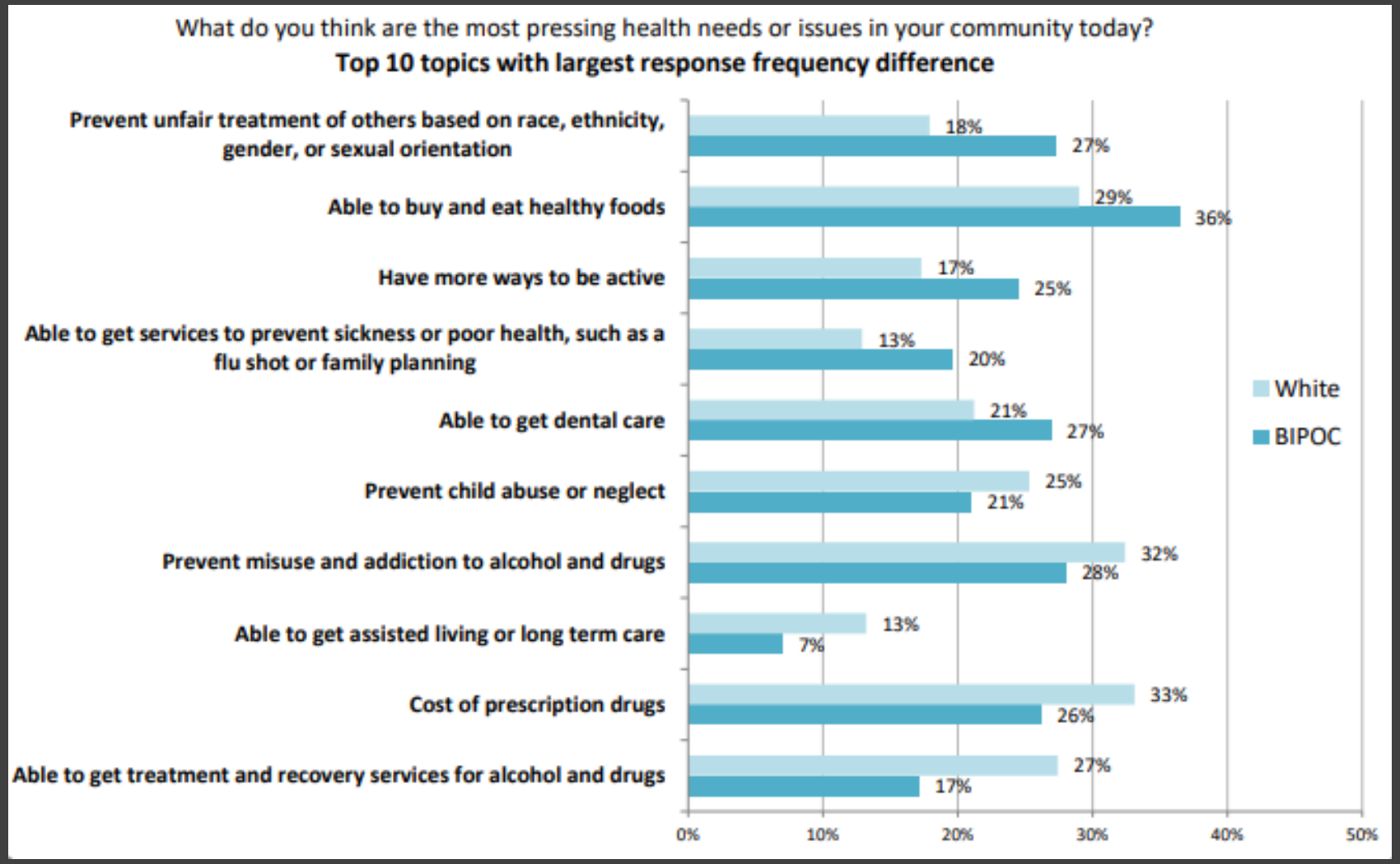
Community Health Improvement Priorities: Comparison of Community and Key Stakeholder Respondents



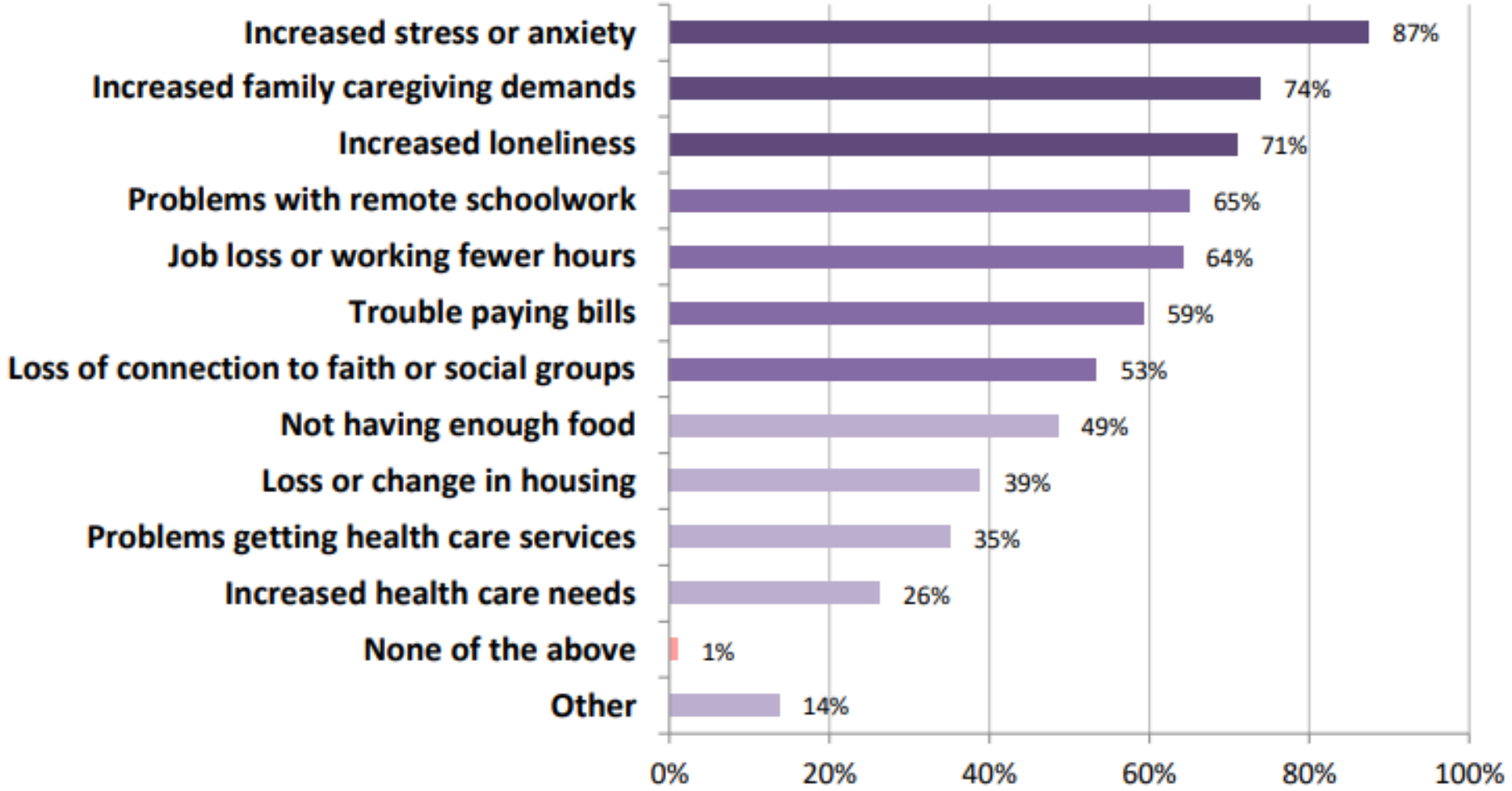
Community Health Improvement Priorities: BIPOC respondents

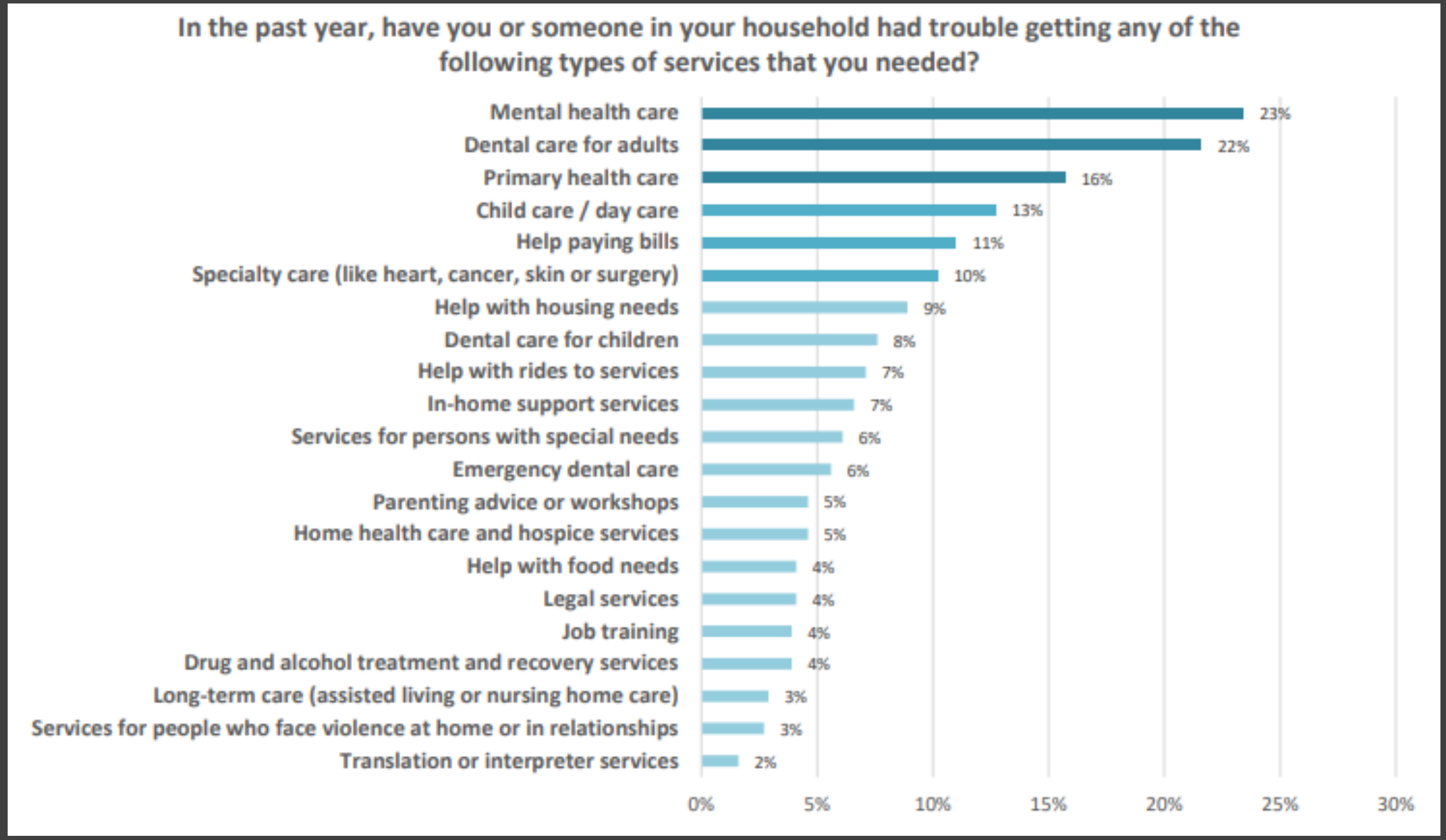


Community Health Needs: Differences between BIPOC and White respondents



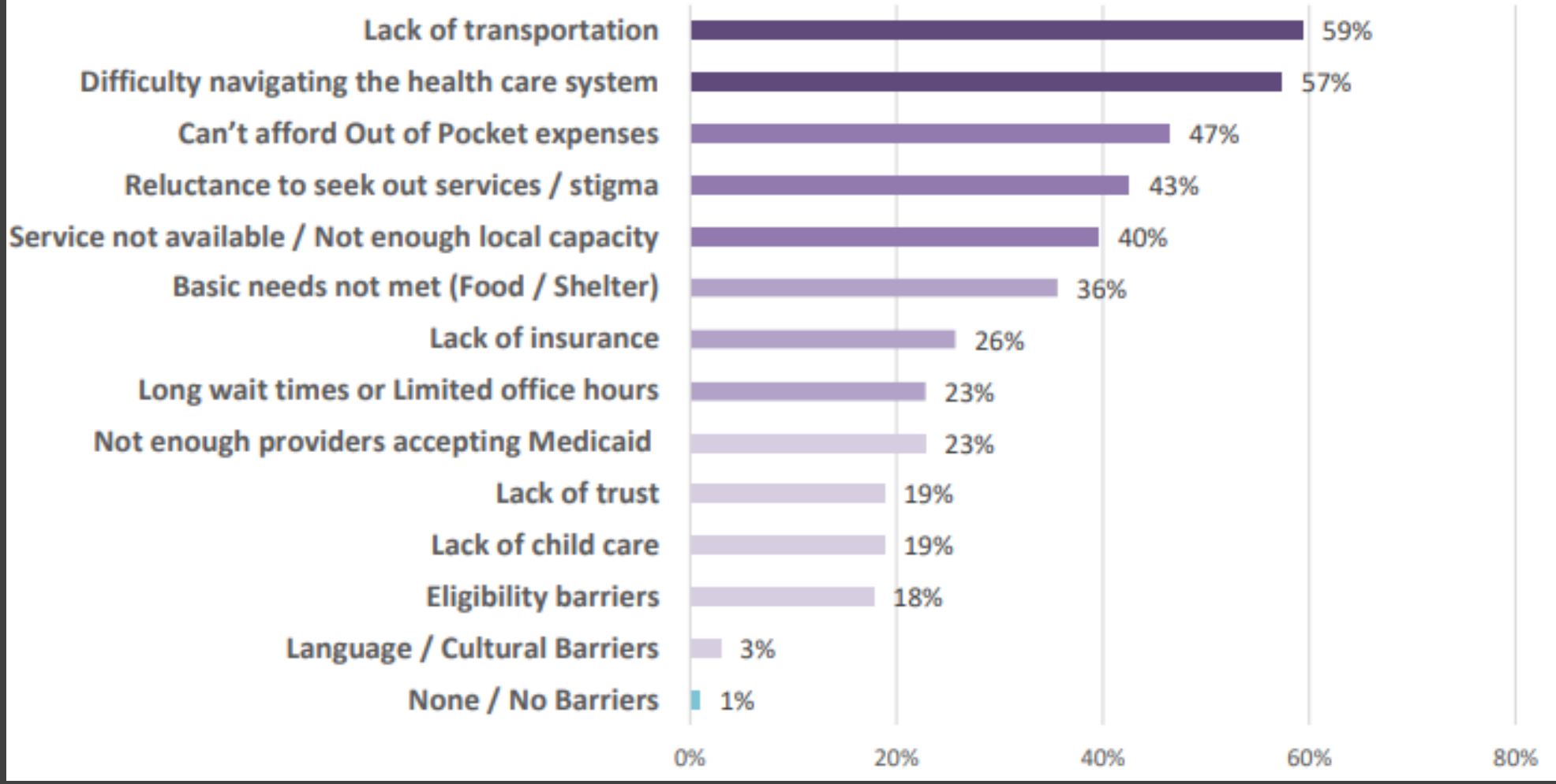
As a result of COVID-19, what do you perceive to be the biggest challenges that people in your community currently have?

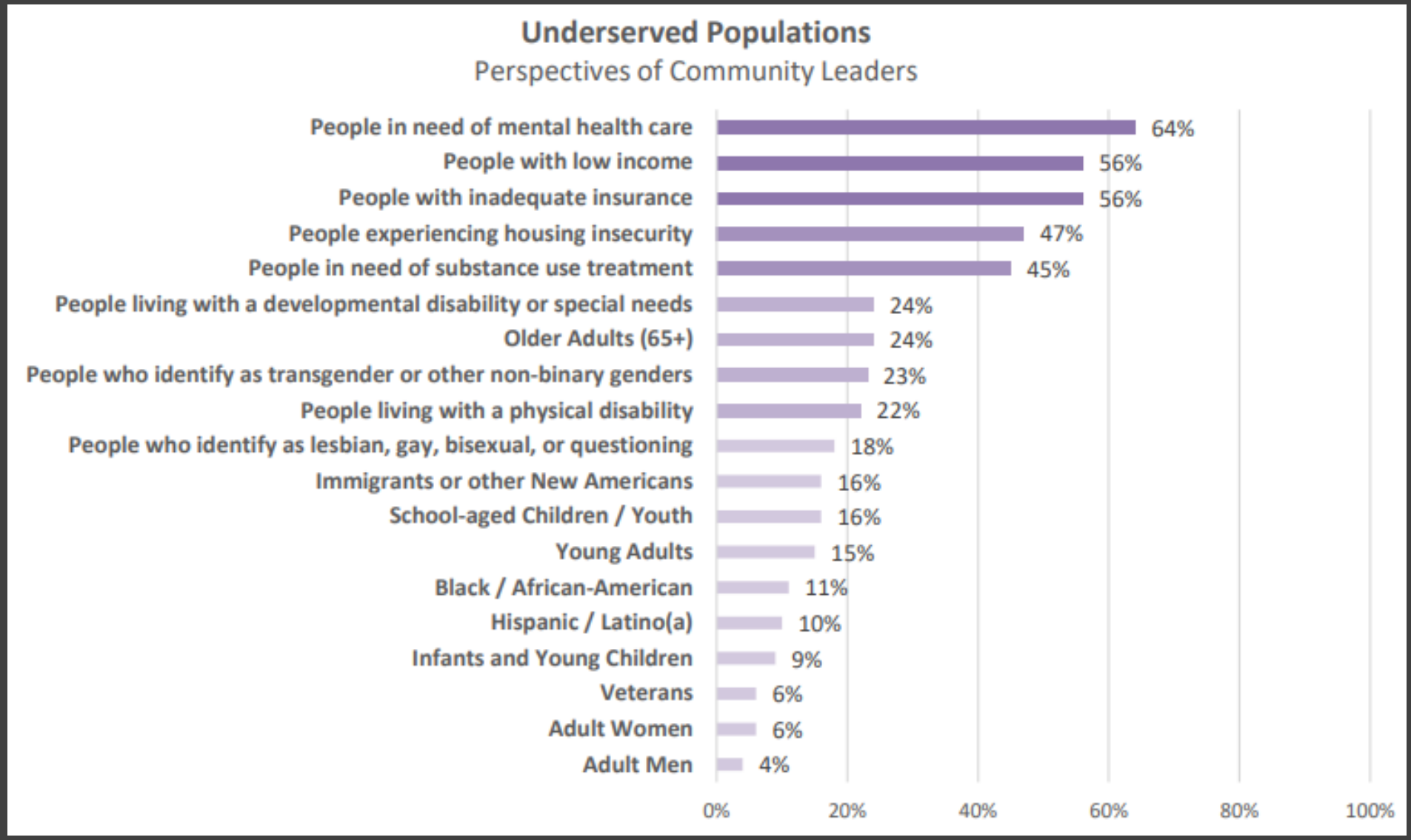



In the past year, have you or someone in your household had trouble getting any of the following types of services that you needed?
Mental health care 23%
Dental care for adults 22%
Primary health care 16%
Child care / day care 13%
Help paying bills 11%
Specialty care (like heart, cancer, skin or surgery) 10%
Help with housing needs 9%
Dental care for children 8%
Help with rides to services 7%
In-home support services 7%
Services for persons with special needs 6%
Emergency dental care 6%
Parenting advice or workshops 5%
Home health care and hospice services 5%
Help with food needs 4%
Legal services 4%
Job training 4%
Drug and alcohol treatment and recovery services 4%
Long-term care (assisted living or nursing home care) 3%
Services for people who face violence at home or in relationships 3%
Translation or interpreter services 2%
0%
5%
10%
15%
20%
25%
30%

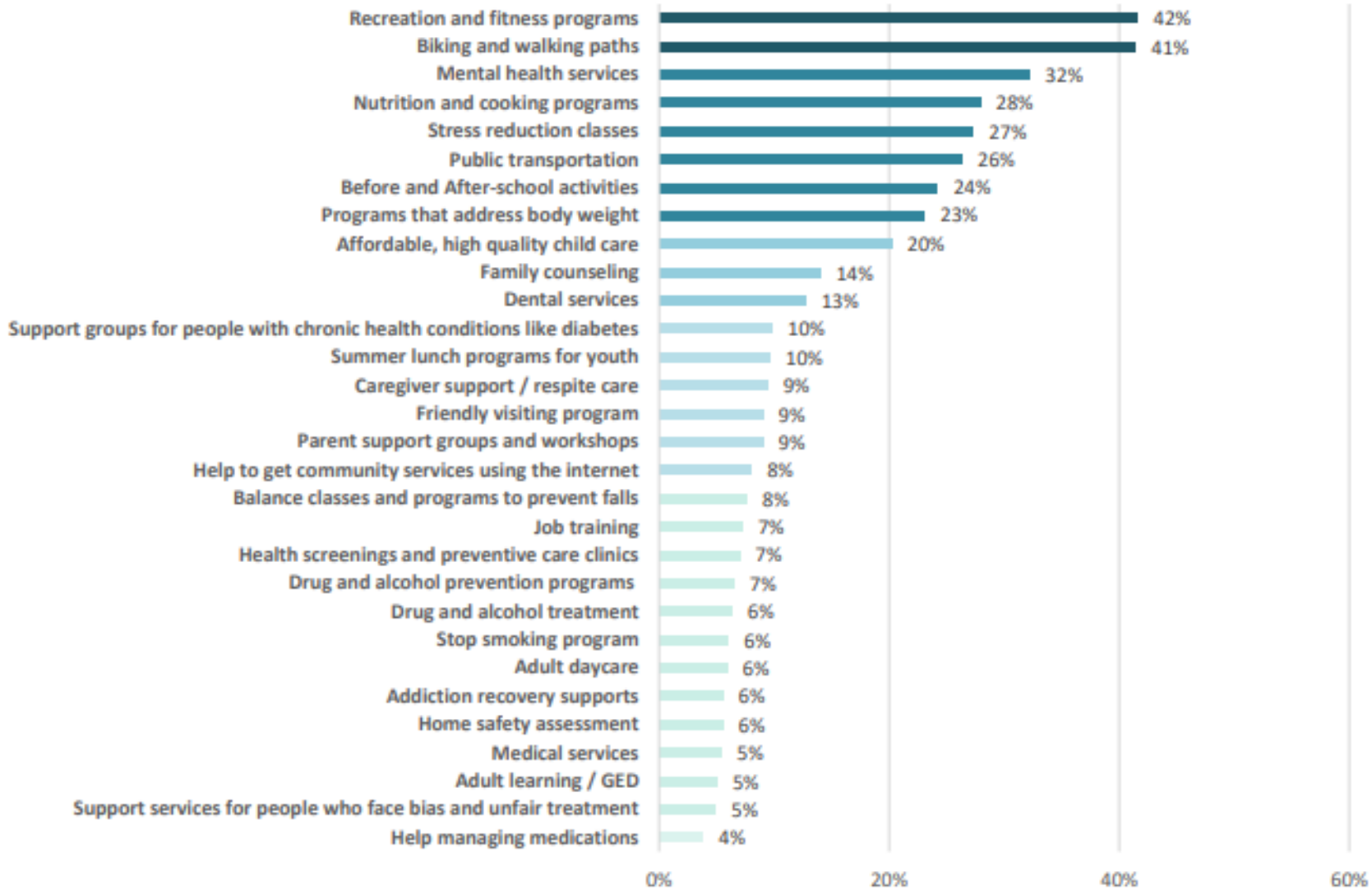
What are the most significant barriers overall that keep people in the community from accessing the health care services they need?

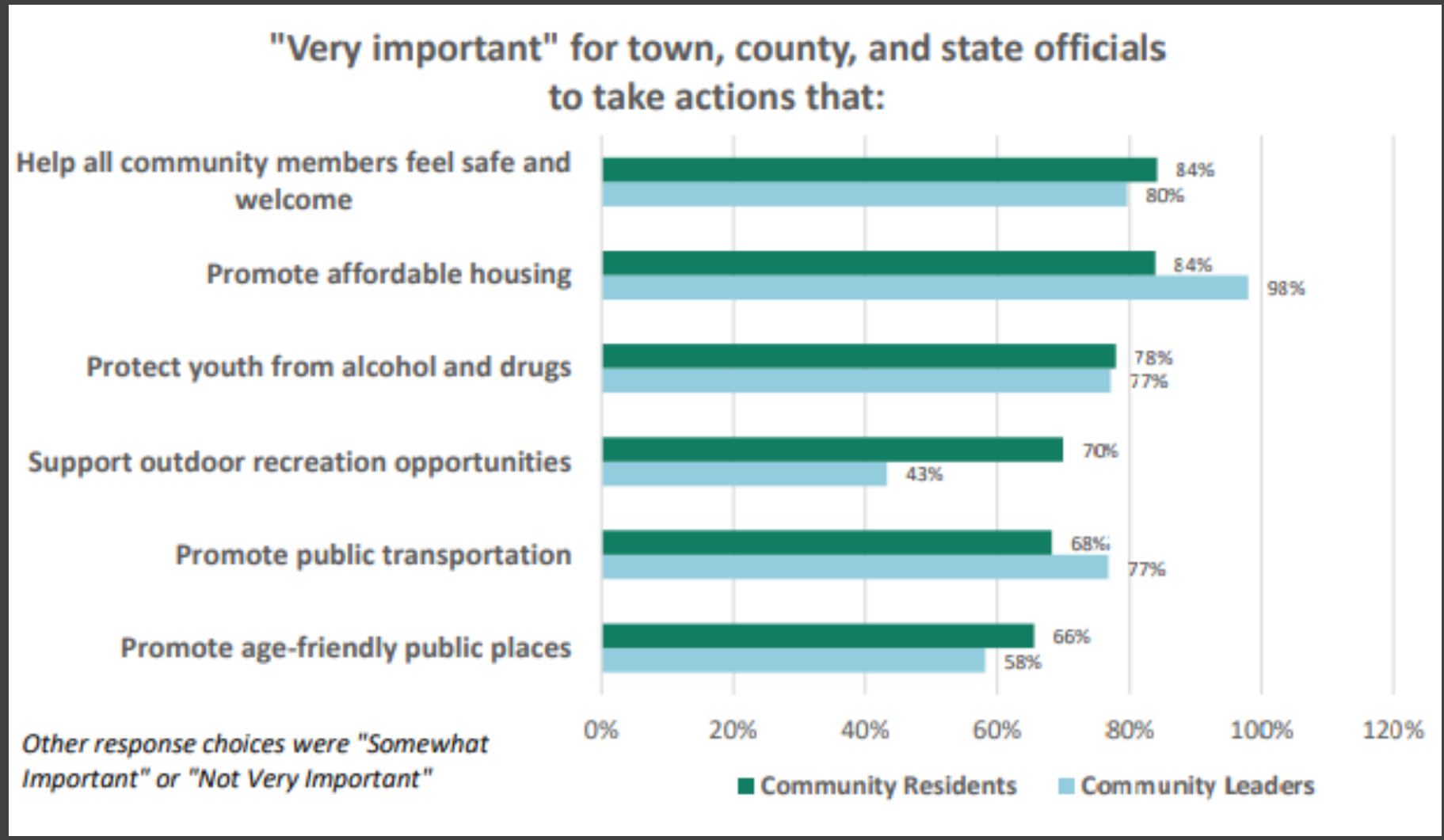
Perspectives of Community Leaders




Underserved Populations
Perspectives of Community Leaders
People in need of mental health care
64%
People with low income
56%
People with inadequate insurance
56%
People experiencing housing insecurity
47%
People in need of substance use treatment
45%
People living with a developmental disability or special needs
24%
Older Adults (65+)
24%
People who identify as transgender or other non-binary genders
23%
People living with a physical disability
22%
People who identify as lesbian, gay, bisexual, or questioning
18%
Immigrants or other New Americans
16%
School-aged Children / Youth
16%
Young Adults
15%
Black / African-American
11%
Hispanic / Latino(a)
10%
Infants and Young Children
9%
Veterans
6%
Adult Women
6%
Adult Men
4%
0%
20%
40%
60%
80%
100%

Which of the following programs or services would you or your family use if it were more available in your community?




"Very important" for town, county, and state officials to take actions that:
Help all community members feel safe and welcome
84%
80%
Promote affordable housing
84%
98%
Protect youth from alcohol and drugs
78%
77%
Support outdoor recreation opportunities
70%
43%
Promote public transportation
68%
77%
Promote age-friendly public places
66%
58%
0%
20%
40%
60%
80%
100%
120%
Other response choices were "Somewhat Important" or "Not Very Important"
Community Residents
Community Leaders

Community discussion groups: major themes & priorities

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Community Health Workers	• All of those issues are relevant still regardless of COVID • Access to mental health services is definitely up there if not #1. Nowhere for anybody to go. • Extremely long waitlists which puts a burden on primary care. • Housing shortages and costs; cost of living; family stress • Services for child protection, domestic violence are understaffed, resources exhausted. Especially shelter capacity and housing. • The cost of healthcare services is something very high on the list of priority issues.	• The need for subsidized housing is much greater than the need for affordable housing • Homelessness • Affordable child care	• There are more resources, like community health workers as an example. • Collaborative care and integrated health and things like that have been improved. • But at the same time the amount of behavioral health that we can offer in the clinic isn't always enough for what the people need.
Food Insecurity	• "Definitely." • Affordable health care is still challenging; • The area has a pretty big drug problem, which leads to a lot of mental health issues. • Still need more support for people who are having substance abuse issues.	• More effective strategies for substance use treatment and recovery • Youth-focused community resource center is needed; many kids are bored, feel stuck, not receiving guidance at home • Starting the same cycle of unhealthy behaviors they see at home	• There are more resources available in the community than there used to be • Since COVID started, there's been a little bit more help out there. Especially with food • The resources for substance use are better. There's still a stigma around it. Past use = Less likely to get hired for a job; Impairs ability to get help
Substance Use Recovery Coaches	• Captures all of the most urgent needs in our community. • There are certain areas that are gaps, but if these are target groups then all of those gaps can be addressed within those bigger categories. • They all connect and are all important.	• More specific focus on alcoholism is needed • Big needs for people with substance use disorder are opportunity for vocational training, job placement and transitional and recovery housing	• There have been improvements in addressing stigma • Improvements in incorporating the work of recovery coaches in hospital settings • More emphasis on overdose prevention and Narcan availability

Secondary data review

Area	Primary Care FTE per 100k Population	Psychiatrist FTE per 100k Population
White River Junction Health District	70.0	
Upper Valley Public Health Region	111.7	17.2
Vermont	69.6	
New Hampshire	42.6	5.0

Data Source: VDH, 2018; NHDHHS, Office of Rural Health and Primary Care, 2021

Area	Experienced food insecurity, past year
Windsor County	**10%**
Grafton County	**10%**
Vermont	11%
New Hampshire	9%

Data Source: USDA data, 2019 accessed through Feeding America, Mapping the Meal Gap.

FY23 Community Health Improvement Plan: Aims

https://www.dartmouth-hitchcock.org/sites/default/files/2022-10/community-health-improvement-plan-2023.pdf

How do the identified health needs align with your perceptions of the community?

What the community knows and their local expertise + what you bring to the table

What impact will you have?

Whose input do you need to be successful?

How will you approach community partnership?