Dartmouth Health

Dartmouth Hitchcock Medical Center

Community Health Improvement Plan
FY2026-2028

Introduction

The FY26-28 DHMC Community Health Improvement Plan (CHIP) describes intended activities over the next three years to meet the needs of the communities in the DHMC service area. Community needs were assessed in 2024 through multiple approaches to gather input from communities including surveys of community members, surveys of community leaders, and eleven community discussion groups. Concerted efforts were made to hear from persons who have difficulty accessing health care services and who are affected by poverty, transportation barriers, hunger, and other health-harming needs. The DHMC Community Health Needs Assessment (CHNA) was endorsed by the DH Board in June 2025 and this CHIP describes the actions we will take to address those needs.

Despite the wealth of data that informs this improvement plan, the uncertainty of our times challenges us to be adaptable and flexible to adjust plans to meet new needs. Priority health needs identified by our communities in 2024 may not be the priorities that emerge over the coming years. In the first nine months of 2025 changes in policy, politics, regulations, societal norms and values have already changed our health ecosystem. However, this plan identifies broad areas of focus including: Improving Access to Care, Positively Impacting Health-Harming Social Needs, Supporting Cancer Care Treatment, and Meeting the Needs of Older Adults. We will continue to focus on these areas in the years ahead, adjusting plans to be optimally effective and efficient.

Regardless of future adaptation, we remain steadfast in the way we do our work. Our history of community-focused efforts affirms our commitment to work through health system-community partnerships. During the pandemic, we worked together to keep communities safe and to treat those who were infected and we will continue to work with our community partners to address root causes of poor health and barriers to health care services.

Dartmouth Hitchcock is prepared to work as a partner with our patients, our people and our communities to improve health outcomes across our region. The FY26-28 Community Health Improvement Plan describes our future work to improve the health of our populations.

Sally Kraft, MD, MPH
Population Health Officer, Dartmouth Health

Regulatory requirement

This plan meets Dartmouth Hitchcock Medical Center's 501(r) regulatory obligations to document how we plan to address the health needs of the communities in our hospital service area. It details the action we will take to address the needs identified in our 2025 Community Health Needs Assessment.

AIM

Improve access to care

Responding to the following community-identified concerns:

Accessibility of

- Mental health services
- Dental care
- Substance misuse prevention, treatment, and recovery services

Cost of

- Health care services
- Prescription drugs
- Health insurance

Current Regional Status

Poor Mental Health Days

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

Windsor County	5.4
Grafton County	5.4

Dentist Ratio

(people per dentist)

Windsor County	1620 : 1
Grafton County	1200 : 1

Number of Drug Overdose Deaths

Windsor County	56
Grafton County	20

Percent of Adults That Report Having a Personal Doctor or Health Care Provider

Vermont	91%
New Hampshire	91%

Improvement Strategies

Population-oriented prevention

- Facilitate access to NH Medicaid Mobile dental health programs
- Implement programs that reduce access to lethal means
- Provide integrated mental health services at DH Child Advocacy Center
- Offer public flu vaccination clinics

Supporting community capacity

- Provide financial contributions to safety net oral health, healthcare, mental health, & community in-home care/mobile programs
- Collaborate with & invest in local syringe services programs
- Provide scholarships for students participating in HACTC Dental Assistant training program
- Facilitate Dialectical Behavioral Therapy (DBT) groups in local middle & high schools
- Maintain adolescent psychiatry unit at DHMC & Hampstead Hospital

Removing barriers to care for underserved populations

- Provide free & reduced-cost care & assistance accessing Medication Assistance Programs to patents with financial need
- Provide community-based primary care to patients at sites like the Addiction Treatment Program & other nonprofits
- Offer telehealth & econsults to reduce transportation barriers
- Provide behavioral health & medication for opioid use disorder care as part of DHMC primary care

Sources: 2025 CHRM used BRFSS data from 2022, 2025 CHRM used Area Health Resource File data from 2022, 2025 CHRM used NVSS data from 2020-2022, BRFSS data from 2023

AIM

Improve access to care

Additional Strategies

Additional strategies contributing to this AIM

- Offer community trainings for suicide prevention work
- Train DHMC staff & others in their households to identify & respond to signs of suicide
- Facilitate Substance Misuse Continuum of Supports in Upper Valley & Sullivan County
- Provide mental health therapists at Molly's Place & Child Advocacy Center
- Provide Peer Recovery Support Services in DH Emergency Department, Addiction Treatment Program, Moms In Recovery, & Psychiatry
- Provide funding & staff support for multi-service clinics for housing insecure/unhoused community members
- Improve readability of Patient Education materials through the Patient Education Advisory Committee
- Support recovery-friendly, trauma-informed pediatric practices
- Host & support the development of the Upper Valley & Greater Sullivan County NH Regional Public Health Networks
- Offer Project ECHO programs to improve ability of rural caregivers to provide care close to home
- Provide Medical Direction for regional EMS services
- Provide scholarships & training to help develop healthcare professionals working at VT/NH healthcare facilities.
- Provide grants through the Boyle Pediatric Funds to support family services programs at community organizations
- Provide safety supplies like bike helmets to lower-income families through the DH Injury Prevention program
- Improve access to DHMC hospital beds through DHART shuttles & other methods
- Train new EMS workforce to expand regional capacity for medical & non-medical transport
- Contribute leased land to David's House to support housing needs of families with hospitalized children
- Increase access to mental health services through the Cobalt program for DHMC employees

AIM

Positively impact social drivers of health

Social drivers of health include:

Food | Housing | Transportation | Employment | Financial Stability

Current Regional Status

Food Insecurity

(Percent of population who lack adequate access to food)

Windsor County	11%
Grafton County	11%

% of Children in Poverty

Windsor County	10%
Grafton County	10%

Severe Housing Cost Burden

(Percent of households that spend 50% or more of their household income on housing)

Windsor County	11%
Grafton County	14%

Sources: *2025 CHRM used Map the Meal Gap data from 2022, 2025 CHRM used SAIPE data from 2023, 2025 CHRM used American Community Survey data from 2019-2023*

Improvement Strategies

Population-oriented prevention

- Provide Social Care Navigators (CHWs) & Nurse Navigators in Primary Care, two Cancer Centers, Pediatrics & some specialty care
- Invest in low-barrier & emergency shelter programs to ensure safe, accessible housing options for individuals experiencing homelessness or housing instability
- Continue impact investments in housing to support development of affordable housing

Supporting community capacity

- Contribute financial resources to emergency & supplemental food programs that address food insecurity
- Provide financial support to sustain public transportation systems
- Invest in case management services offered by community-based organizations to enhance the coordination of healthcare & social support for people with complex social needs
- Continue development of Center for Advancing Rural Health Equity
- Commit to improving opportunities for un- & under-employed persons to access career growth & income growth through DH Career Institute

Removing barriers to care for underserved populations

- Address health-harming legal needs by strengthening partnerships that embed legal support in healthcare for families with young children & those in substance use treatment
- Create coalitions to support community collaboration that addresses barriers to accessing prenatal & postnatal care & support
- Provide food bags to address immediate food needs for patients & families
- Operate Resource Rooms at Heater Road & Molly's Place to connect families with health education, social service referrals, & basic needs resources

AIM

Positively impact social drivers of health

Additional Strategies

Additional strategies contributing to this AIM

- Support UniteUS implementation in clinic & community settings for closed loop referrals in our region
- Develop Food is Medicine programs in specialty care
- Participate in the NH Transportation Task Force to advocate for & inform sustainable transportation solutions that meet patient needs
- Provide education & resources for the region to improve quality of respectful & equitable perinatal care
- Develop the DH Social Care Program
- Facilitate North Country & other maternity networks that enhance regional maternity care & improve referral pathways to speciality care
- Provide patient coaching & support on how to access & navigate free transportation services
- Continue Boyle Pediatric Resident rotation to community-based locations & state advocacy initiatives
- Use hospital grounds to grow & distribute fresh produce with Willing Hands

AIM

Support cancer care & treatment

Areas of focus include:

- Patient & family support services
- Preventing youth tobacco use & vaping

Current Regional Status

% Women Who Received a Mammogram

(in the past two years, ages 50-74)

Vermont	78.6%
New Hampshire	81.1%

% of Adult Smokers

(no youth indicators available in CHRM)

Windsor County	12%
Grafton County	13%

High School Student Electronic Vapor Use

(% of high school students who currently use electronic vapor products)

Windsor County	15%
Grafton County	11%

Sources: *National Cancer Institute used data from 2021, 2025 CHRM used BRFSS data from 2022, 2023 Youth Risk Behavior Survey data*

Improvement Strategies

Population-oriented prevention

- Conduct school & community trainings on vaping & tobacco prevention including Fall 2025 ECHO on youth vaping
- Continue utilizing social media & web-based health targeted outreach & education about colorectal screening, prioritizing rural areas

Supporting community capacity

- Explore opportunities for a new infusion center location to ease patient travel burden
- Collaborate with local partners to develop & implement multi-pronged health promotions campaign about lung cancer & screening

Removing barriers to care for underserved populations

- Connect patients to resources & support services through support of Connect Share Care
- Offer virtual access to Complementary Care Program wellness classes & groups that support the whole person - body, mind, & spirit - from time of diagnosis & beyond
- Host an onsite food pantry for food insecure patients receiving cancer care

AIM

Support for Older Adults

Areas of focus include:

- Healthcare for the aging
- Support geriatric workforce
- Promote wellness & education for older adults

Current Regional Status

% of Adults Ages 65+ Who Reported Falling

(in the past 12 months)

Overall US	27.8%
VT	31.9%
NH	27.4%

Risk of Social Isolation for Ages 65+

(normalized values are 1 to 100, with a higher value indicating greater risk)

VT	34
NH	20

Index of social isolation risk factors: *poverty; living alone; divorced, separated or widowed; never married; disability; & independent living difficulty among adults ages 65 and older*

Sources: BRFSS 2023, America's Health Rankings used American Community Survey data from 2019-2023

Improvement Strategies

Population-oriented prevention

- Offer programs focused on reducing social isolation in-person & online through DH Aging Resource Center
- Continue research & education for healthcare professionals through the Geriatric Center of Excellence
- Continue to deliver evidence-based programs to address falls risk reduction in-person & virtually

Supporting community capacity

- Invest in senior transportation services
- Provide medical direction to nursing homes & assisted living facilities
- Deliver updated, evidence-based training for health professionals on geriatric best practices & practice change initiatives

Removing barriers to care for underserved populations

- Provide funding to senior centers providing meals & social supports to older adults
- Offer tech support for older adults through Aging Resource Center to improve learning capacity & decrease social isolation
- Provide in-home care for homebound patients
- Offer online & in-person education & support to reach older adults facing transportation, geographic, or technological barriers

AIM

Support for Older Adults

Additional Strategies

Additional strategies contributing to this AIM

- Support professional development of state & local senior support service staff (GCSSC, NH REAP, SASH of VT)
- Provide support groups, education, & engagement opportunities for unpaid caregivers of people living with dementia
- Provide pocket talkers for hearing impaired patients
- Offer classes on health & wellness, life skills & planning, dementia & caregiver support & opportunities for social connection using in-person & virtual methods
- Provide experiential training in nursing homes to build student skills & attract future long-term care professionals