2025 Community Health Needs Assessment

Final Report

August 2025

THE University of Vermont HEALTH NETWORK

Central Vermont Medical Center

About CVMC and the 2025 CHNA

Central Vermont Medical Center (CVMC) is the primary healthcare provider for 66,000 people who live and work in the 26 communities of central Vermont. We provide a comprehensive range of services through our hospital, 27 community-based medical practices, and 153-bed skilled nursing facility.

For over half a century, CVMC has been a cornerstone of care in central Vermont, committed to nurturing a healthy community through innovative healthcare solutions, advanced treatment options, and educational initiatives that empower individuals to lead healthier lives, while also driving economic growth and stability in the region.

CVMC strives to be a leader in our community by supporting and forging relationships with other organizations who are working toward our shared goals of enhancing the overall quality of life that we cherish as Vermonters. As the hub of the wheel for regional healthcare delivery, CVMC works closely with other groups based in and around the region to provide a full array of health services to central Vermonters.

CVMC is a partner and fiscal sponsor for THRIVE, the accountable community for health in central Vermont. This multi-agency coalition, made up of health providers, social service agencies, government, civic, and religious entities, and numerous other community partners, is dedicated to improving health for residents. CVMC is committed to supporting the advancement of collaborative partners' work. This commitment is a recognition that no single organization has the ability to change population outcomes, however, when many organizations and individuals come together, the resulting collective impact is greater than any individual action taken alone.

As a trusted local healthcare leader and partner, CVMC is dedicated to understanding and addressing the most pressing health and wellness concerns for our community. In collaboration with THRIVE, we conduct a Community Health Needs Assessment (CHNA) every three years to help us better serve our community by measuring the health status of residents, gathering wide community input on health concerns, and identifying opportunities to collaborate with partners.

The CHNA informs the development of CVMC's Community Health Improvement Plan (CHIP) to move from data to action to address priority health needs identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to align community health investments with the highest needs in our community.

We invite our community partners to learn more about the CHNA and opportunities for collaboration to address identified health needs. Please visit our website or submit comments directly to Michelle Gilmour at michelle.gilmour@cvmc.org.

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The 2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies to support a healthy and thriving central Vermont and to foster a collaborative approach for community health improvement.

CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in central Vermont and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, CVMC aims to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

Research Partner

CVMC contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

2025 CHNA Leadership and Oversight

CVMC convened a steering committee of hospital leadership and THRIVE members to collaborate on the CHNA. A subcommittee of THRIVE, the Collaborative Action Network (CAN), met monthly with CVMC representatives to review and guide the CHNA process. This collaboration ensured a comprehensive study and helped to foster collective impact to address the most pressing issues that impact health for central Vermonters.

The following individuals served on the CHNA committee as liaisons to their organizations and the communities they serve.

2025 CHNA Partners and Steering Committee Members

Central Vermont Medical Center, **Anna Tempesta Noonan**, President and Chief Operating Officer

Central Vermont Medical Center, **Ryan Clouser**, DO, Chief Medical Officer

Central Vermont Medical Center, **Michelle Gilmour**, Quality Data Manager

Green Mountain United Way, **Tawnya Kristen**, Executive Director

The University of Vermont Health Network, **Constance Gavin**, Program Manager

Vermont Department of Health, **Joan Marie Misek**, District Director, Barre District Office of Local Health

Vermont Department of Health, **Brielle Sedergren**, Chronic Disease Prevention Specialist

Washington County Mental Health Services, **Jessica Kell**, Chief Operating Officer

Washington County Mental Health Services, **Elizabeth Sightler**, Chief Executive Officer

2025 CHNA Study Area

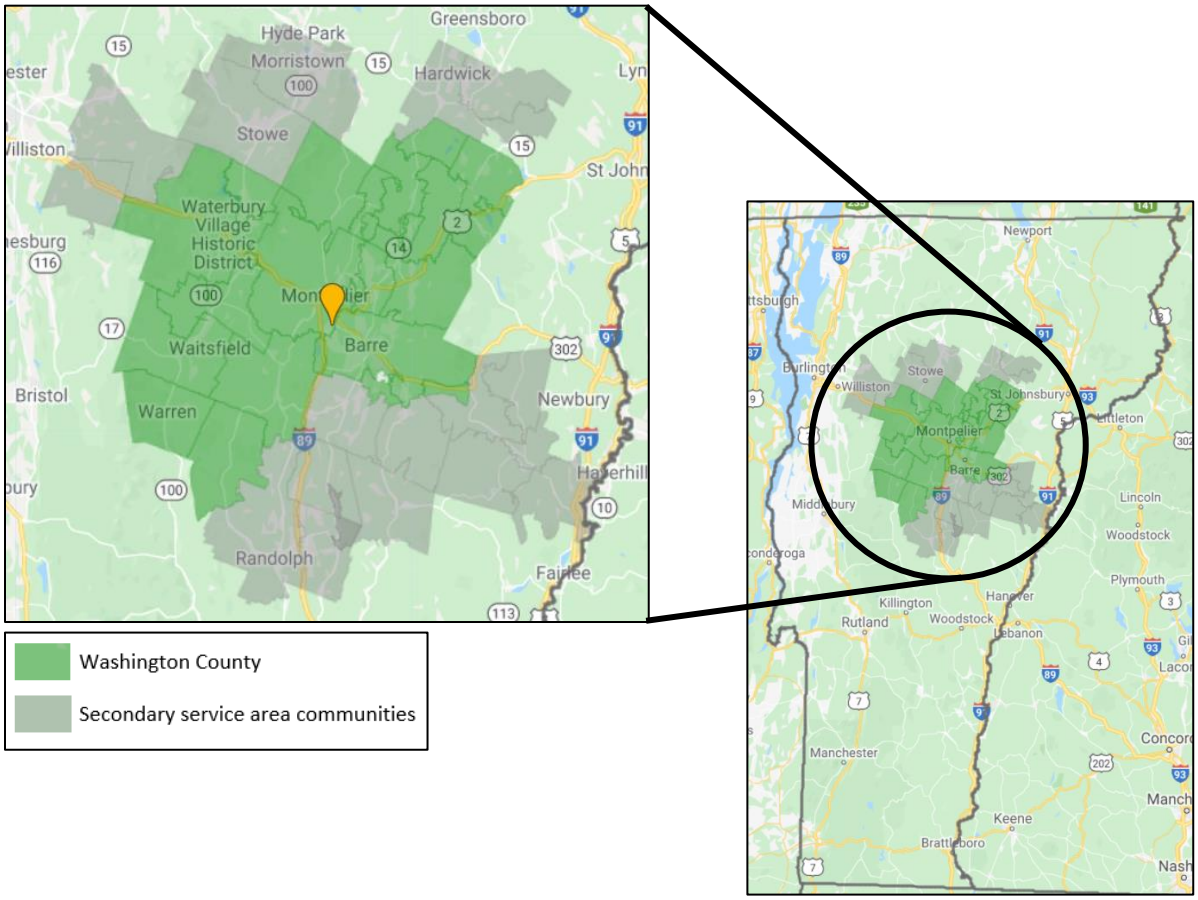
CVMC is part of The University of Vermont Health Network, a six-hospital system serving patients and their families in northern New York and Vermont. CVMC is located in Berlin in Washington County, Vermont.

CVMC used the zip codes of residence for most patients seen at its hospital facility to define its primary service area. CVMC primarily serves residents of Washington County, with secondary service area in neighboring communities in Caledonia, Chittenden, Lamoille, and Orange counties.

For purposes of the CHNA, secondary data focus on Washington County. Demographics and other available indicators for zip codes comprising Washington County were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

Washington County is home to the Vermont state capital of Montpelier. The most populous municipality in the county is the City of Barre. Washington County encompasses vibrant communities and premier outdoor scenery and recreation opportunities, including the Green Mountain range.

Central Vermont Medical Center Service Area



Research Methods

The CHNA was conducted from November 2024 to June 2025 and included primary and secondary research methods to determine health trends and disparities.

Primary Research and Community Engagement
Community engagement was an integral part of the CHNA. Collaborating with community-based organizations across central Vermont, input was invited and received from a wide array of community members with a particular focus on diverse populations, under-resourced areas, and communities that have been historically marginalized. Study participants provided perspectives on unmet health and social needs; community resources available to meet those needs; barriers to accessing services; service delivery gaps; and recommendations to improve health and wellbeing.

Secondary Data Analysis
Secondary data are reported by county and by zip code, as available, to demonstrate localized health needs and disparities. The most recently available data at the time of publication is used throughout the study; due to the time required to collect and analyze these data, it is typical for these data to reflect prior years rather than current year. A comprehensive list of secondary data sources is included in Appendix A.

Analysis of Health and Socioeconomic Data
We collected and analyzed public health statistics, demographic and social measures, housing and economic data, and other data to develop a comprehensive community profile for central Vermont and its residents.

Key Stakeholder Survey
We conducted an online survey with 186 individuals that serve diverse communities and populations across central Vermont to collect input about local health needs, client experiences in receiving and accessing services, and opportunities for collective impact.

Community Survey
We conducted an online survey with 1,312 residents of central Vermont to collect direct community perspectives on health and wellbeing concerns, barriers to accessing care and services, and recommendations for improving community wellness.

Community Conversations
We held community meetings and listening sessions with local health and human service professionals to share CHNA findings and collectively define challenges and strategies for health improvement

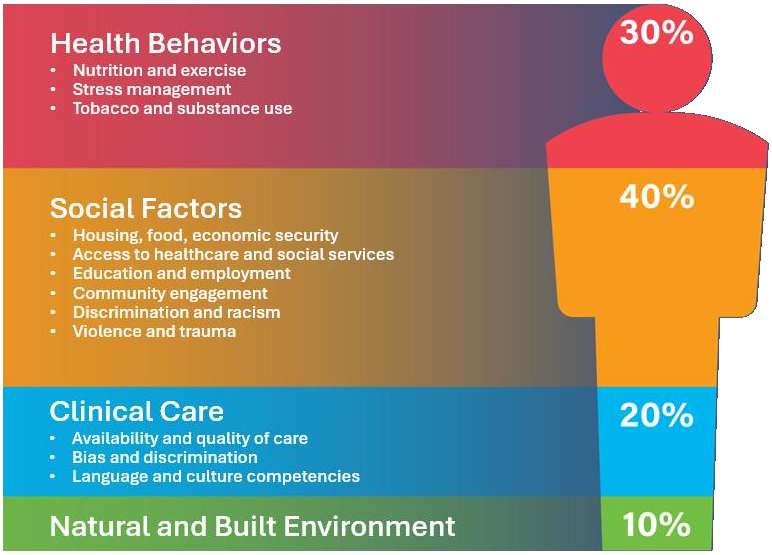
Social Drivers of Health

Where we live impacts choices available to us

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in central Vermont. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors; and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

Graphic Credit: U.S. Department of Health and Human Services

Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



50% of a person's health is determined by social factors and their environment.

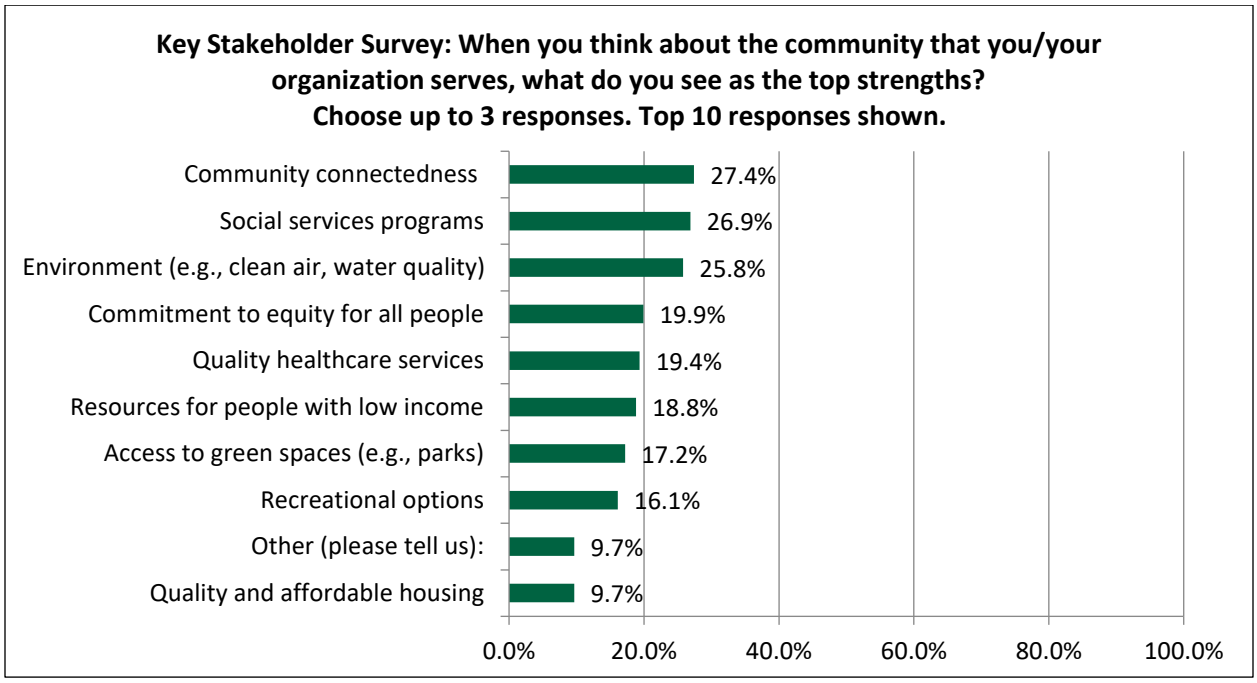
Only 20% of health outcomes are attributed to clinical care.

Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people**.** These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

Our Strengths and Opportunities

Vermont is one of the healthiest states in the nation. Residents as a whole live longer and enjoy better health while they're alive. The region is supported by a strong economy, natural beauty and recreation resources, and collaborative network of health and human service partners.

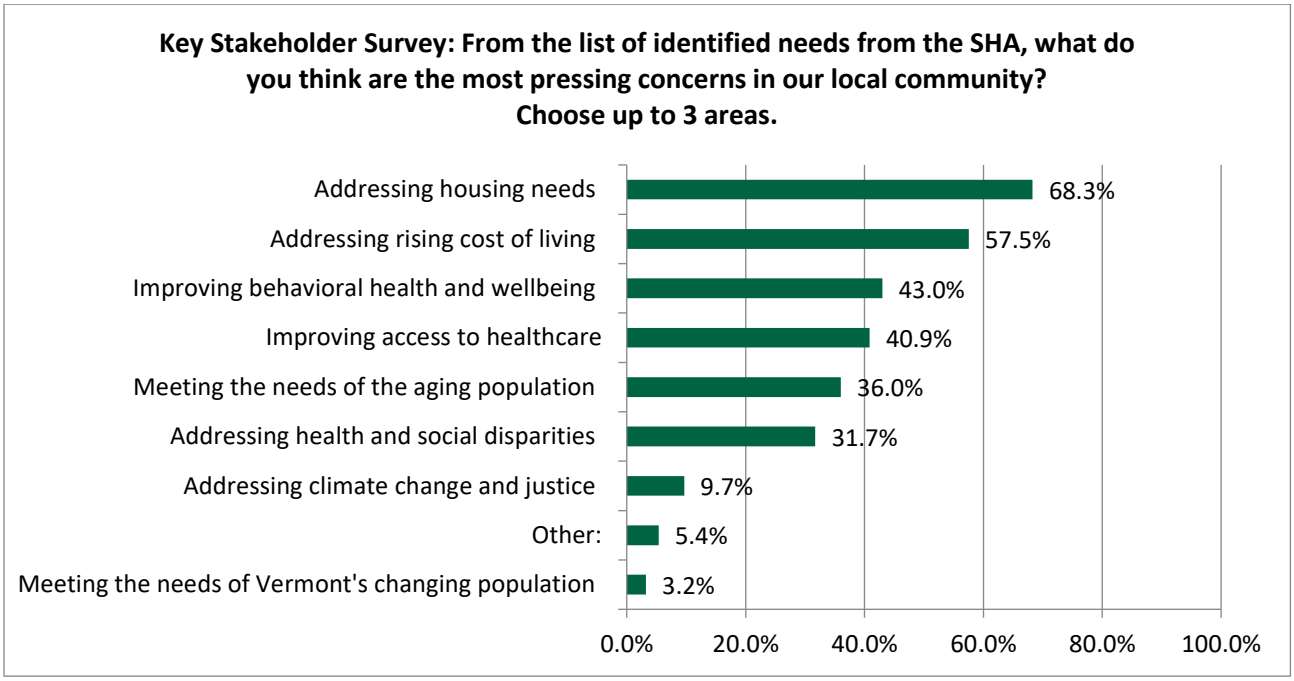
When asked what they see as the top strengths for the community, participants of the Key Stakeholder Survey saw social cohesion factors like *community connectedness* and *commitment to equity for all people,* availability of *social services programs*, and the *environment* among the top attributes. Key stakeholders also identified *quality healthcare* and *resources for people with low income* as top strengths.



Community Strengths

- Commitment to collaborative community impact
- Commitment to health and social equity
- Economic vitality and strong anchor institutions
- High educational attainment and good schools
- High quality healthcare services
- Lower prevalence of disease burden and death
- Natural recreational resources and green spaces
- Sense of community and civic engagement
- Strong social service safety net

Using these existing strengths and community assets, communities can work together to improve health. The Vermont Department of Health conducted a State Health Assessment (SHA) in 2023/2024 and identified eight key health and social issues for Vermonters. When asked to name the most pressing concerns for central Vermonters from the list of issues, Key Stakeholder Survey participants overwhelmingly identified *housing needs* and *rising cost of living*. Other identified issues included *behavioral health and wellbeing*, *access to healthcare*, and the needs of the *aging population*. Key stakeholders' perceptions of these concerns were in line with secondary data statistics for the region.



Community perception and public health data suggest that many of the identified health concerns worsened in recent years due to the lingering impact of the COVID-19 pandemic (e.g., isolation, delayed healthcare, developmental delays) and increasing financial instability. Central Vermont is facing rising homelessness and behavioral health issues and declining access to care at a time when the cost of living is rising in comparison to stagnant wages. These combined factors have strained healthcare and social services and challenged providers to meet new demand.

Community Opportunities

- Access to primary and behavioral healthcare services
- Aging community with more health and social concerns
- Care and support for growing unhoused population
- Economic and health disparities for people of color and income constrained households
- Growing behavioral health concerns for adults and youth
- Healthcare and social service recruitment and retention
- Rising cost of living and lack of affordable housing, childcare, and other basic needs

Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining the issues on which to focus efforts over the next three-year cycle, CVMC collected feedback from community stakeholders and sought to align with the Vermont Department of Health State Health Improvement Plan (SHIP).

Community stakeholders consistently named Access to Care, Cost of Living, Housing, and Mental Health and Substance Use Disorder as the top needs for the community. Community stakeholders' perceptions of these concerns were in line with secondary data statistics for the region, as well as the priorities for the state, as outlined in the Vermont Department of Health 2025-2030 SHIP.

To confirm the priority areas, CVMC leadership applied the following rationale and criteria to determine the issues on which to focus efforts over the next three-year cycle:

- Prevalence of health and social conditions and number of community members affected.
- Prevalence of health and social conditions compared to state and national benchmarks.
- Health differences between community members.
- Existing programs, resources, and expertise to address the issue.
- Input from community partners and representatives.
- Alignment with concurrent public health and social service organization initiatives.

Based on the CHNA findings, CVMC will focus on the following priority areas:

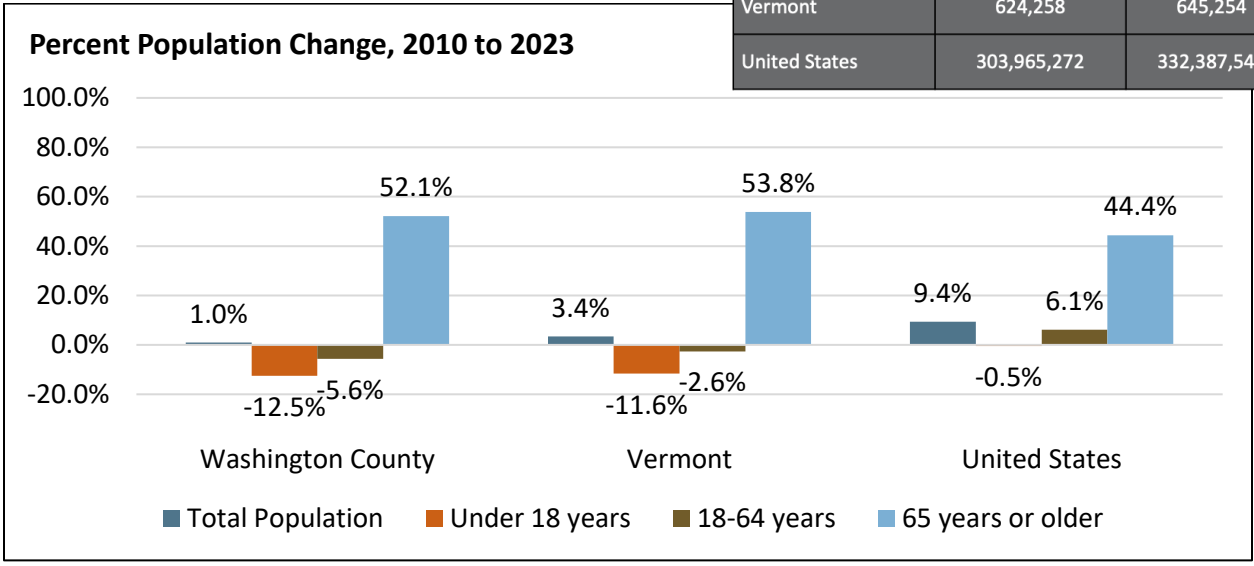
CVMC recognizes the growing need for aging services, as well as the unique health and social needs of older adults. While not a named priority, CVMC is committed to serving aging central Vermonters. CVMC will address strategies to support older adults when developing nuanced and whole-person initiatives to improve access to care, cost of living, housing, and behavioral health. CVMC will also continue to collaborate with and support community agencies focused on older adults.

Our Community and Residents

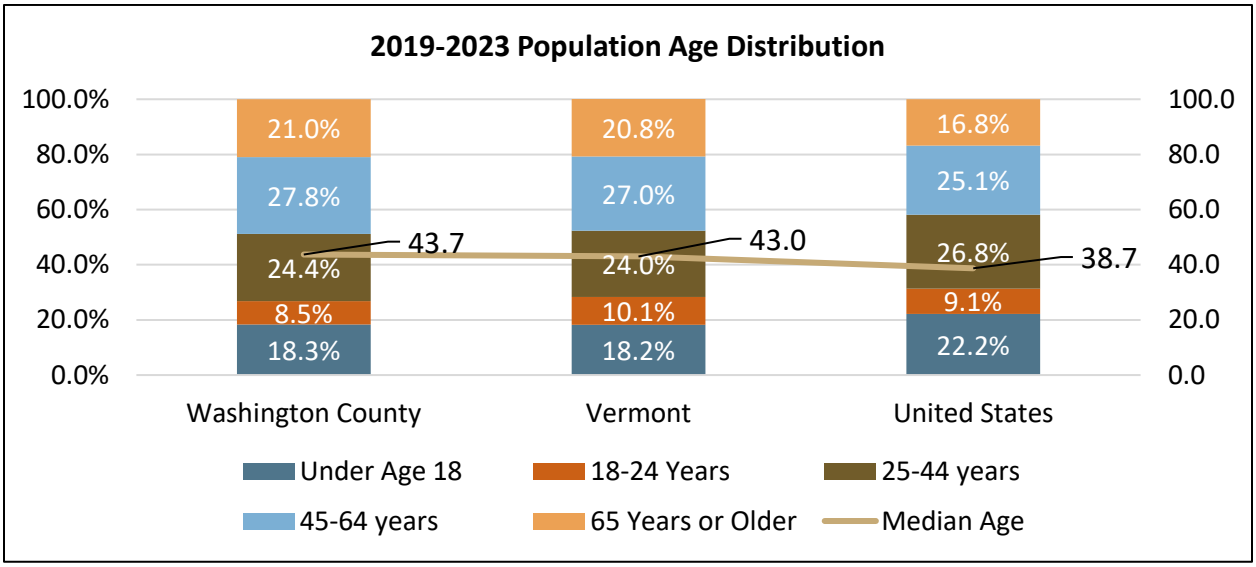
Washington County had a total population of 59,958 people in 2023 and overall population growth of approximately 1% from 2010 to 2023. The total population of Washington County, and all of Vermont, is growing at a slower rate than the nation. However, the state saw a more than 50% increase in adults aged 65 or older from 2010 to 2023. Vermont is one of the oldest states in the nation with nearly 1 in 5 residents aged 65 or older and a median age that is 4 years older than the national median. Many older Vermonters are choosing to stay in their homes and communities, while low birth rates and a net out-migration of younger people contribute to the overall aging trend.

Total Population by Year

	Total Population 2010	Total Population 2023
Washington County	59,379	59,958
Vermont	624,258	645,254
United States	303,965,272	332,387,540



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Disability is a physical or mental condition that limits a person's movements, senses, or activities. Across the US, 13% of the population and about 33% of older adults live with a disability. The total population of Washington County and Vermont is slightly more likely to experience disability than the national average. This finding reflects in part the state's older population and higher prevalence of disability among older adults.

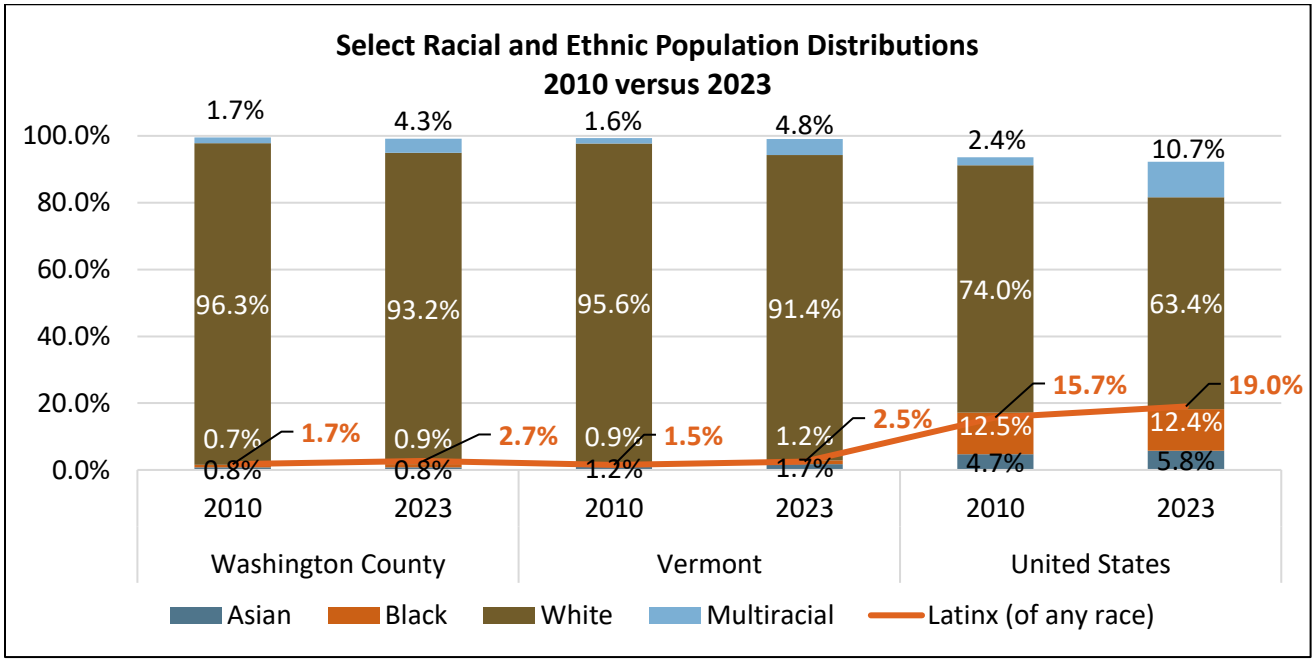
2019-2023 Population with a Disability

	Washington County	Vermont	United States
Total population	14.2%	14.5%	13.0%
Youth under 18 years	5.2%	5.5%	4.7%
Older adults 65+ years	30.1%	29.2%	32.9%

Source: US Census Bureau, American Community Survey

Consistent with national trends, population diversity is increasing across central Vermont. People of color, particularly those that identify as Latinx and/or multiracial, make up a larger portion of the population than in prior years. These findings inform a heightened community need for bilingual and culturally appropriate resources and workforce efforts to ensure that providers and staff reflect the diversity of residents.

Community representatives shared that the current political climate in the U.S. may be influencing how residents perceive and express their racial identities. The increasing political polarization around issues of race and identity have led some to feel pressured or reluctant to identify with a "non-white" racial category. Racial and ethnic population data will continue to be monitored for emerging trends.

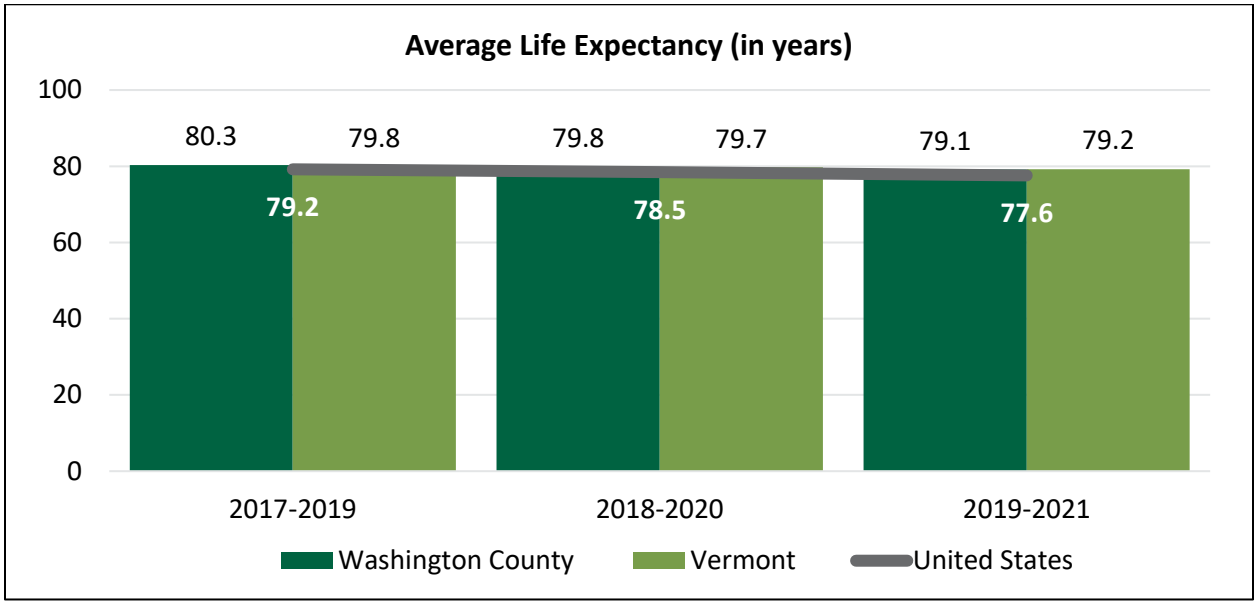


Source: US Census Bureau, American Community Survey

Measuring Health in Our Community

Vermont is one of the healthiest states in the nation and Washington County reports overall better health outcomes and higher average life expectancy than the national average. Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors.

Life expectancy measures how long people generally live within the defined geography and is the culmination of living conditions, health status, economic security, and the overall experience of residents within a community.



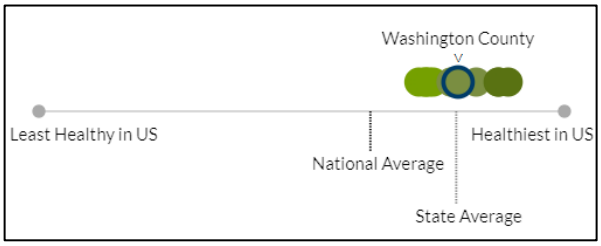
Source: Centers for Disease Control and Prevention

The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing health equity. Washington County's overall higher life expectancy reflects strong SDoH factors, including a diverse economy, highly educated workforce, rich health and social services, civic engagement, and robust recreational and green spaces.

The University of Wisconsin Population Health Institute produces the County Health Rankings & Roadmaps, a national index to measure population health and wellbeing and community conditions for counties across the U.S. Findings for Washington County reinforce the community's overall positive health outcomes and their roots in SDoH factors.

Population health and wellbeing is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Wellbeing covers both quality of life and the ability of people and communities to contribute to the world.

Population Health and Wellbeing
Washington County vs. State and National Averages

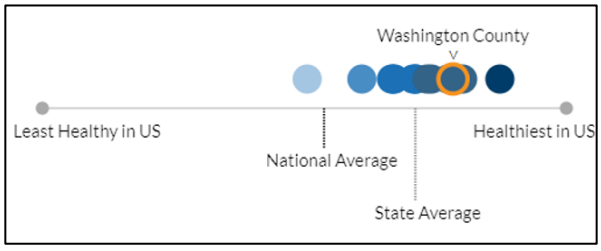


Washington County is faring about the same as the average county in Vermont for Population Health and Wellbeing, and better than the average county in the nation. Washington County *exceeds* state and national averages for community conditions.

Legend: Each dot represents a county in Vermont, with those experiencing the best outcomes towards the right in darker shades.

Community conditions include the social and economic factors, physical environment, and health infrastructure in which people are born, live, learn, work, play, worship, and age. Community conditions are also referred to as the social drivers of health (SDoH).

Community Conditions
Washington County vs. State and National Averages



Washington County overall boasts better health and community conditions, but not all residents share these outcomes. Within Washington County, historical data indicates potential for a nearly 13-year difference in average life expectancy between communities with the highest and lowest averages, reflecting the impact of SDoH and historical disparities.

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

In Washington County there is a 35-point difference between zip codes with the highest and lowest UNS value, demonstrating community-level health and social disparities.

Unmet Need Score by Washington County Zip Code and Select Social Drivers of Health (2019-2023)^

Zip Code	Total Population in Poverty	Children in Poverty	Families with Low Income*	No Health Insurance	Cost Burdened Home-Owners**	Unmet Need Score
05654, Graniteville	2.9%	NA	18.4%	7.8%	68.8%	35.78
05641, Barre	11.0%	16.1%	18.5%	2.2%	25.3%	31.10
05669, Roxbury	27.9%	48.8%	31.3%	1.9%	22.5%	25.61
05674, Warren	17.2%	2.2%	22.6%	5.4%	50.9%	23.28
05647, Cabot	5.3%	3.1%	28.9%	3.5%	60.5%	22.75
05658, Marshfield	9.7%	15.5%	26.2%	5.9%	34.5%	22.35
05663, Northfield	15.0%	21.2%	22.8%	3.0%	27.1%	22.00
05667, Plainfield	11.5%	20.0%	24.0%	1.3%	36.6%	19.72
05682, Worcester	3.1%	NA	9.6%	7.2%	29.3%	18.57
05649, East Barre	15.2%	NA	8.9%	0.7%	21.9%	17.59
05650, East Calais	5.1%	NA	7.4%	0.6%	32.5%	13.96
05648, Calais	10.5%	11.9%	21.6%	5.4%	32.6%	10.96
05676, Waterbury	10.2%	14.7%	9.8%	4.2%	14.2%	10.68
05660, Moretown	3.5%	0.0%	6.7%%	2.5%	36.3%	10.04
05602, Montpelier	6.8%	3.6%	9.9%	2.1%	25.6%	8.73
05651, East Montpelier	2.1%	0.6%	9.6%	7.8%	26.3%	8.64
05673, Waitsfield	6.5%	NA	6.0%	3.0%	26.5%	6.89
05677, Waterbury Center	1.0%	NA	NA	3.5%	2.1%	1.40
Washington County	9.4%	10.7%	14.9%	2.9%	25.9%	NA
Vermont	10.3%	10.8%	14.5%	3.9%	28.2%	NA

Source: Health Resources & Services Administration (HRSA) & US Census Bureau, American Community Survey
^Select social drivers of health indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.
*Families with incomes at or below 185% of the Federal Poverty Level (FPL). In 2024, a family of four people at 185% of the FPL had an income of $57,720.
**Households that spend 30% or more of their combined income on mortgage expenses alone.

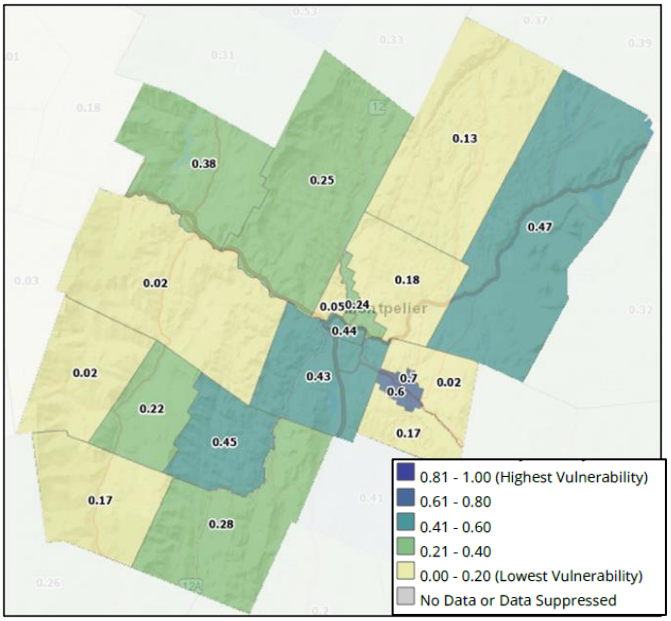
The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level.

Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts cover the entire United States and typically contain between 1,500 and 8,000 people.

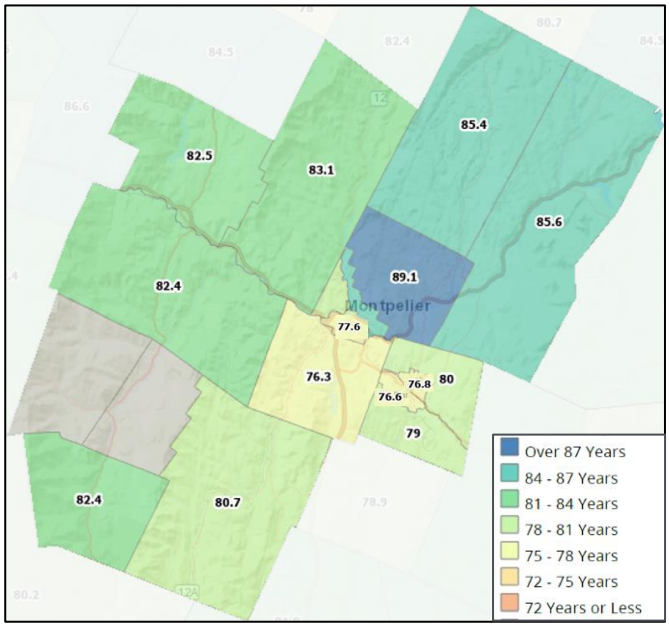
The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Examining the SVI in conjunction with average life expectancy demonstrates how SDoH impact health outcomes. Within Washington County, historical data indicates potential for a nearly 13-year difference in average life expectancy between communities with the lowest and highest averages. Affected areas, most notably Barre, also have the highest SVI values of 0.6-0.7 out of a maximum score of 1.0, reported as recently as 2022.

2022 Social Vulnerability Index by Census Tract



2010-2015 Life Expectancy by Census Tract



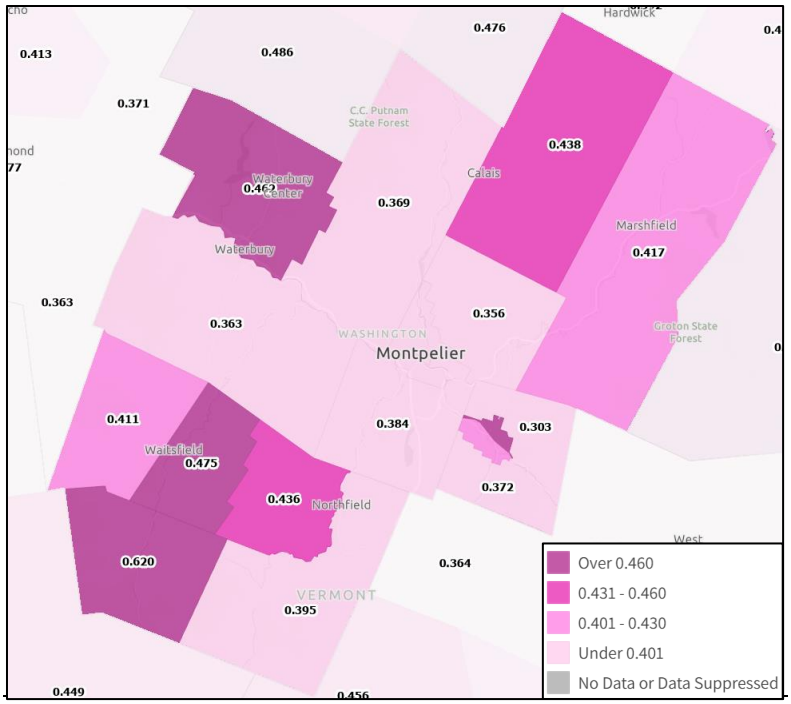
Source: Centers for Disease Control and Prevention

At the root of social vulnerabilities and disparities are inequities in access to community resources and opportunities that foster economic stability and wellbeing. The Gini index is a measure of income inequality within a community, ranging from 0 to 1. A measure of 1 indicates perfect inequality, i.e., one household having all the income and rest having none. A measure of 0 indicates perfect equality, i.e., all households having an equal share of income.

A Gini index greater than 0.4 indicates a big income gap between residents, and an index between 0.5 and 1.0 indicates severe income inequality. Within Washington County, severe income inequality is seen

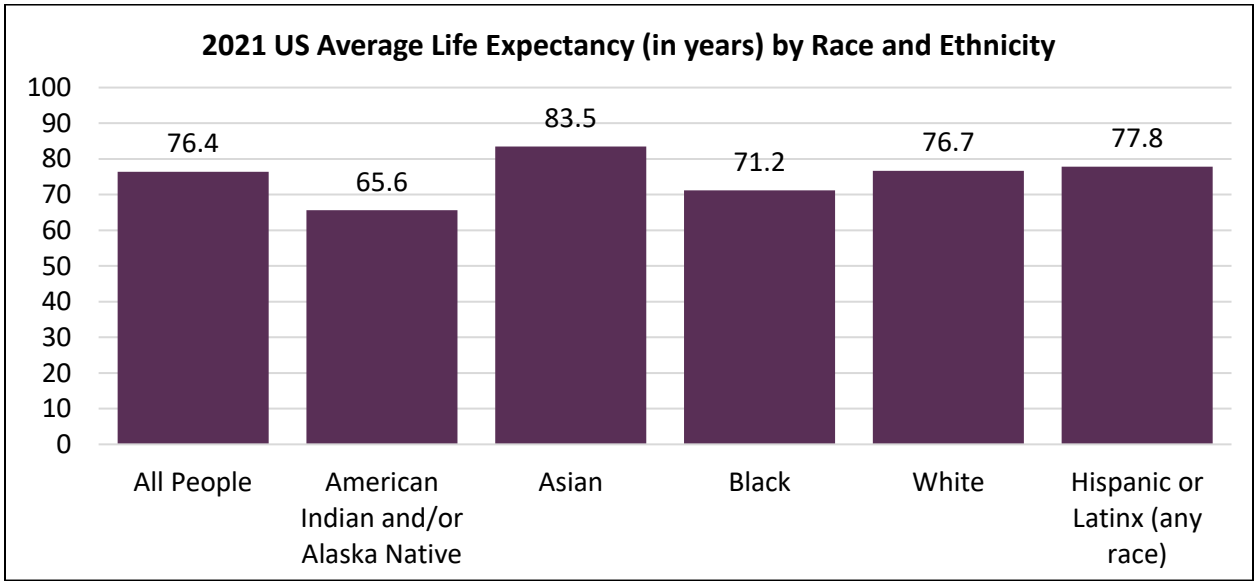
in Barre (0.561), where the SVI was also the highest (0.7). Severe income inequality is also seen in Warren (0.620) and should be explored for potentially underserved populations.

2019-2023 Gini Index by Census Tract



Source: US Census Bureau, American Community Survey

Average life expectancy also varies by population group, reflecting underlying health and social disparities. National data for 2021 show a more than 10-year difference in life expectancy between racial and ethnic groups with the highest and lowest reported averages, a disparity that starkly aligns with social barriers and our country's long history of racist and exploitative laws and policies.



Source: Centers for Disease Control and Prevention

Community Health Needs

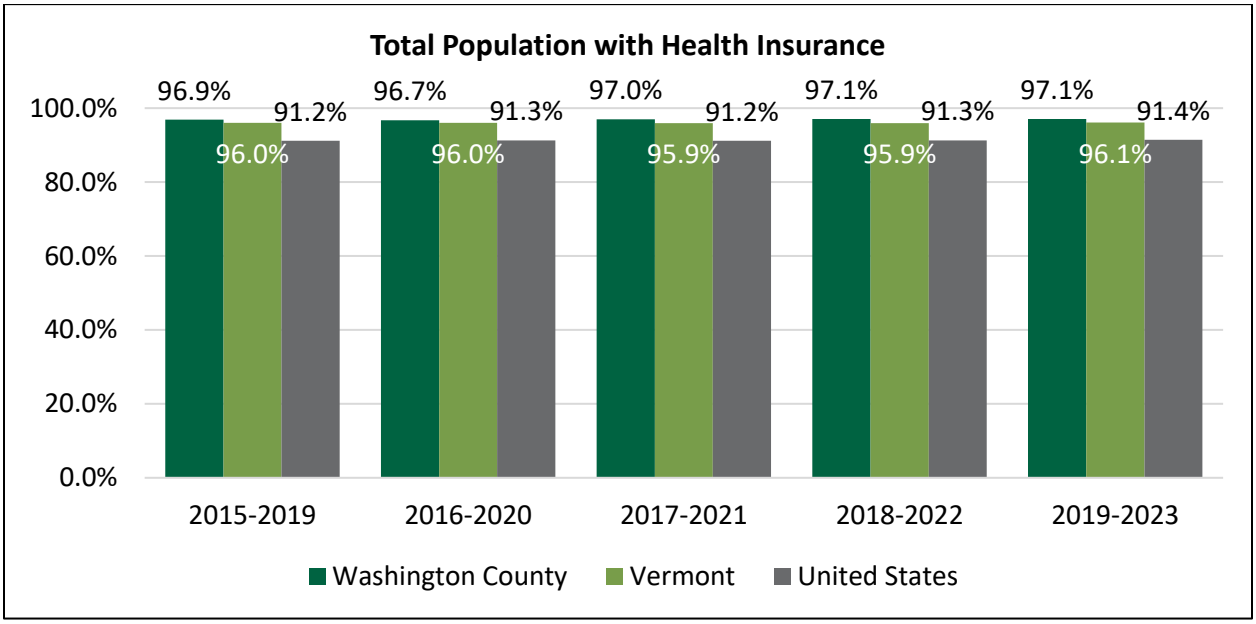
The CHNA was a comprehensive study of health and socioeconomic indicators for Washington County residents. The following section highlights key health and wellbeing needs as determined by secondary data statistics and community stakeholder feedback.

A full summary of secondary data findings for the region is also provided on CVMC's website and available to our community partners to serve as a resource for grant making, advocacy, and to support their many programs and services.

Access to Care and Services

Washington County is home to high quality and comprehensive healthcare and social services. Residents benefit from programs that provide free and reduced cost healthcare for uninsured and underinsured people, and a wide array of human service agencies committed to helping residents. Agencies, providers, and advocates are active partners in community planning and coordinated service delivery.

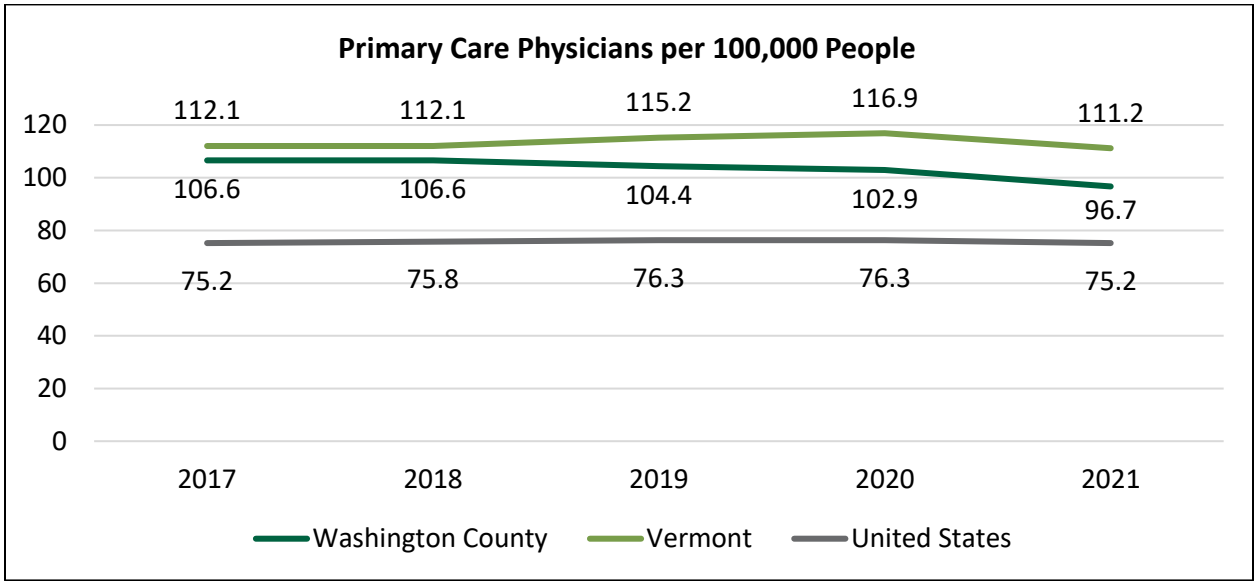
Health insurance coverage among Washington County residents has been consistently high with 97.1% of residents covered in 2023 compared to 91.4% of residents nationally. A high proportion of insured residents obtain their insurance through an employer (58.0%), providing cost-sharing benefits and typically more comprehensive coverage. An increasing proportion of residents are insured by Medicare (23.3%), a finding that is consistent with the county's aging demographic.



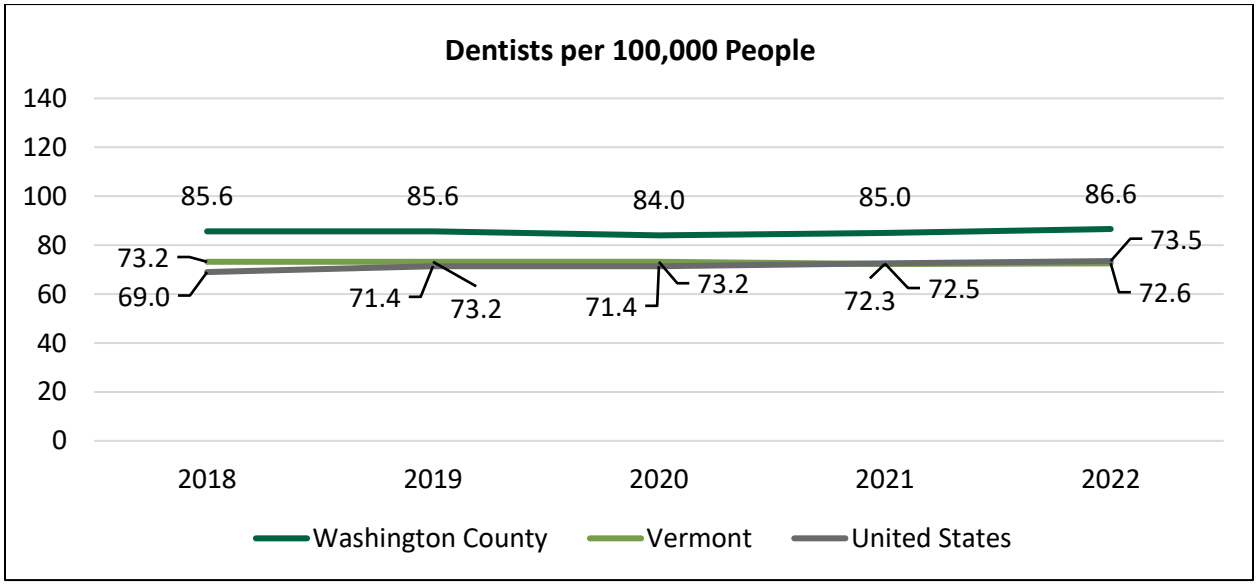
Source: US Census Bureau, American Community Survey

Despite health insurance trends, availability and access to primary and dental care services is increasingly challenging for Washington County residents. Availability of primary care providers in Washington County remains above national levels but declined since 2018. Approximately 70% of Washington County adults received a primary care visit or checkup in 2022 compared to 72.9% of adults statewide and 74.2% of adults nationally.

Dental care services have grown in Washington County and have historically been higher than state and national averages. More Washington County adults received routine dental care in 2022 (69.1%) compared to the state (67.5%) and nation (63.4%), but still about 3 in 10 adults did not receive care.



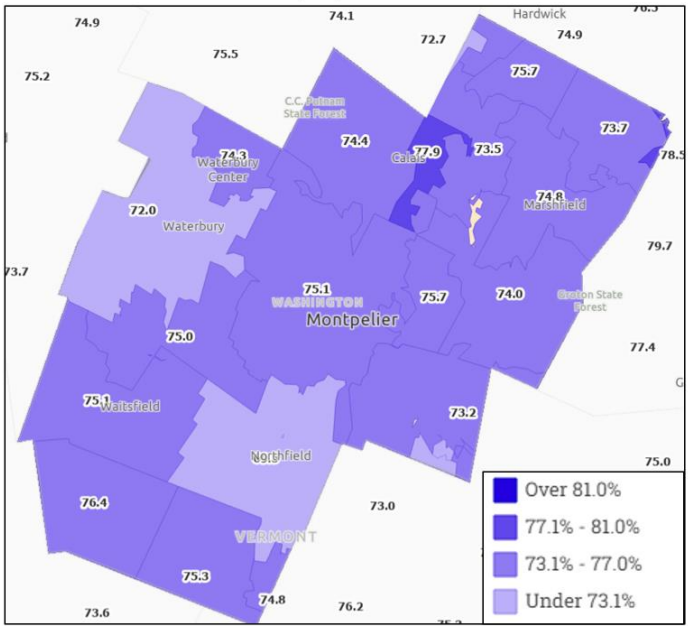
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services



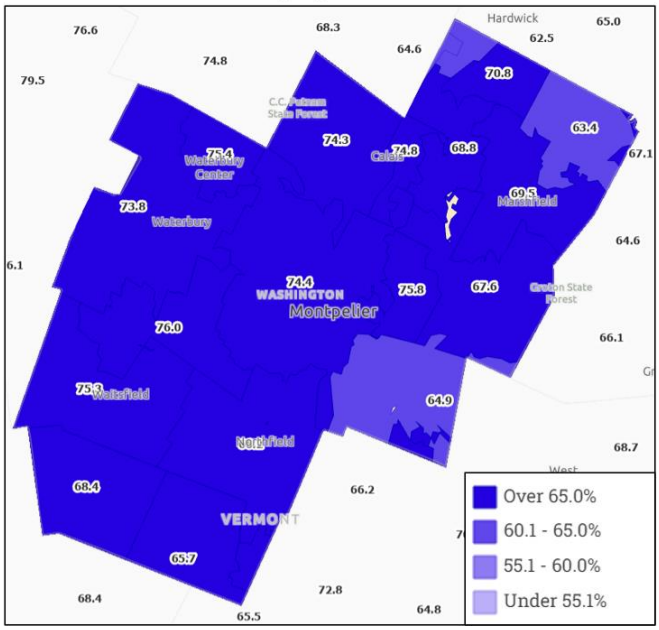
Source: Health Resources & Services Administration & Centers for Medicare and Medicaid Services

The proportion of adults accessing routine primary care is generally consistent across Washington County communities. Disparities in dental care access are evident in and around Barre and Marshfield.

2022 Adults with a Primary Care Visit Within the Past Year by Zip Code



2022 Adults with a Dental Care Visit Within the Past Year by Zip Code



Source: Centers for Disease Control and Prevention

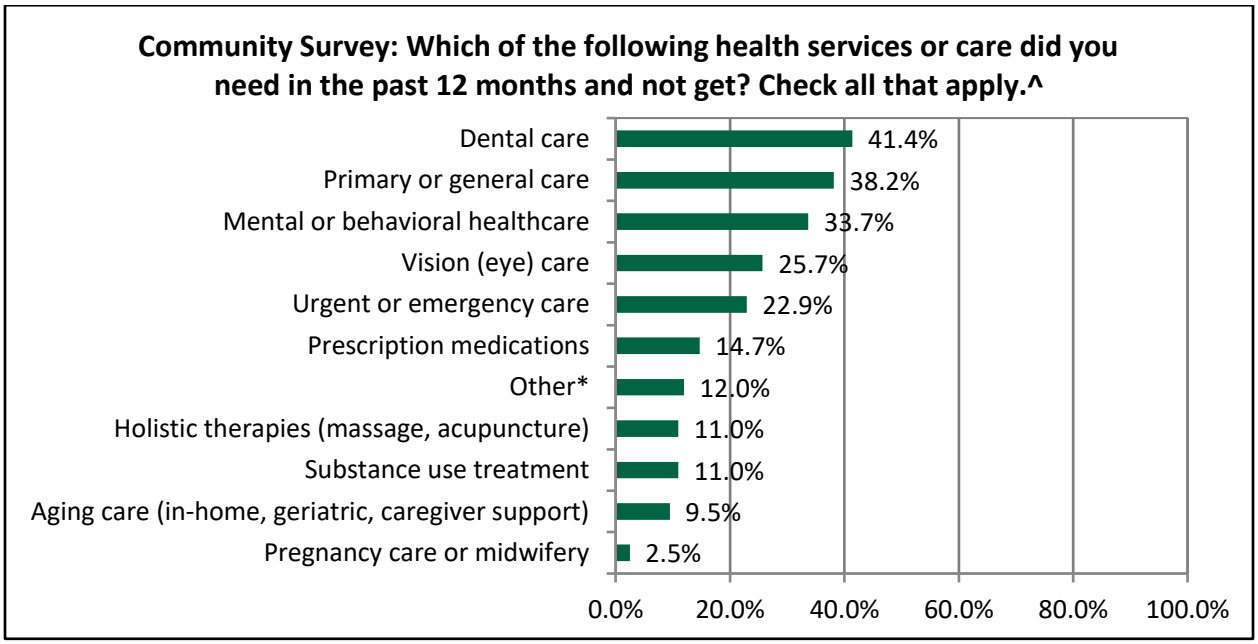
Participants of the Key Stakeholder Survey and Community Survey identified rising cost of care (e.g., copays, premiums, prescriptions) and shortage of providers as key barriers to accessing adequate and timely healthcare services.

> *"Please support universal health care for all—I am constantly in financial debt for my medical needs." (Community Survey)*

> *"No providers are taking patients! They say there's a wait list but refuse to add you. We're still using telemedicine from old [doctor] in former state we moved here from. We're flying back there in June for vision & annual physical. Can't find dentist- 2 yrs since last visit." (Community Survey)*

> *"Trends I am seeing/hearing are community members not able to see primary or specialty providers in a "reasonable" amount of time. Example: scheduling a colonoscopy will take over a year to be seen. For community members who are trying to be preventative in their health, this trend makes it difficult." (Key Stakeholder Survey)*

About 33.3% of Community Survey participants shared there was a time in the past 12 months when they needed healthcare services and did not get it, most commonly dental and primary care. Among participants that needed and did not receive healthcare, about 55% cited long wait times for appointments, 28.8% cited cost concerns, and 25% said the provider did not accept their insurance.



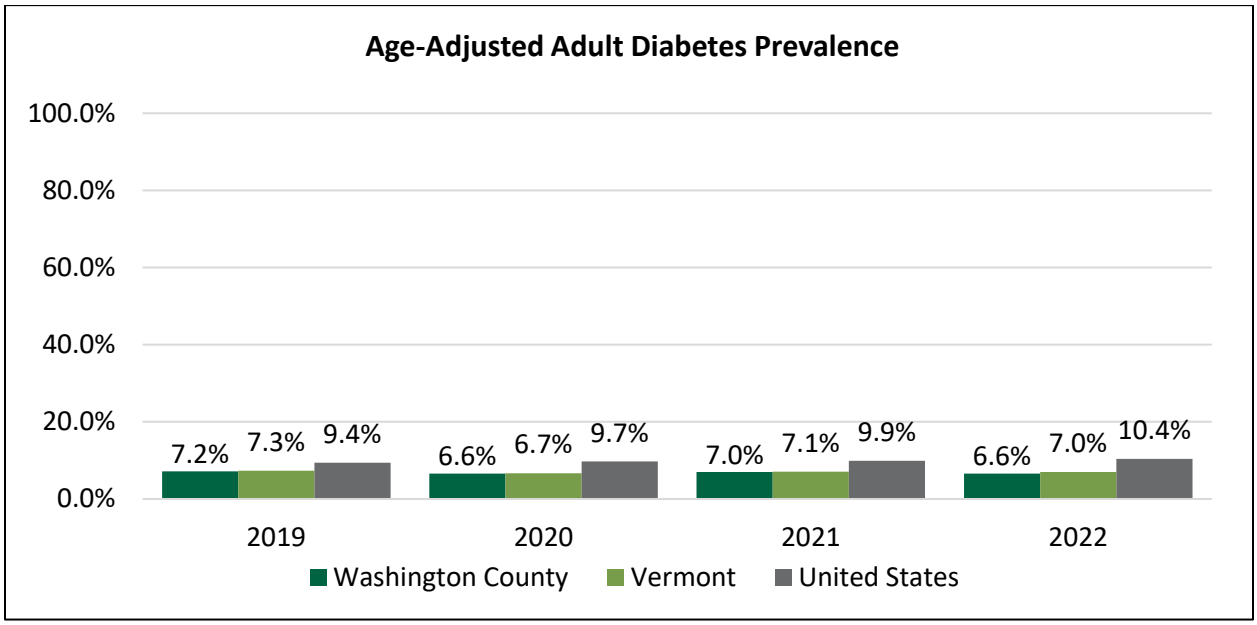
^Among the 33.3% of participants that did not get needed healthcare services within the past 12 months.

Community stakeholders also saw transportation as a key limiting factor for accessing community resources, noting few public transportation options and recent clinic closures. The on-demand *MyRide* bus was reported to lack timeliness and coordination, contributing to missed rides and appointments. Rural clinic closures now require long drives for some residents, and that can be particularly difficult for an older population.

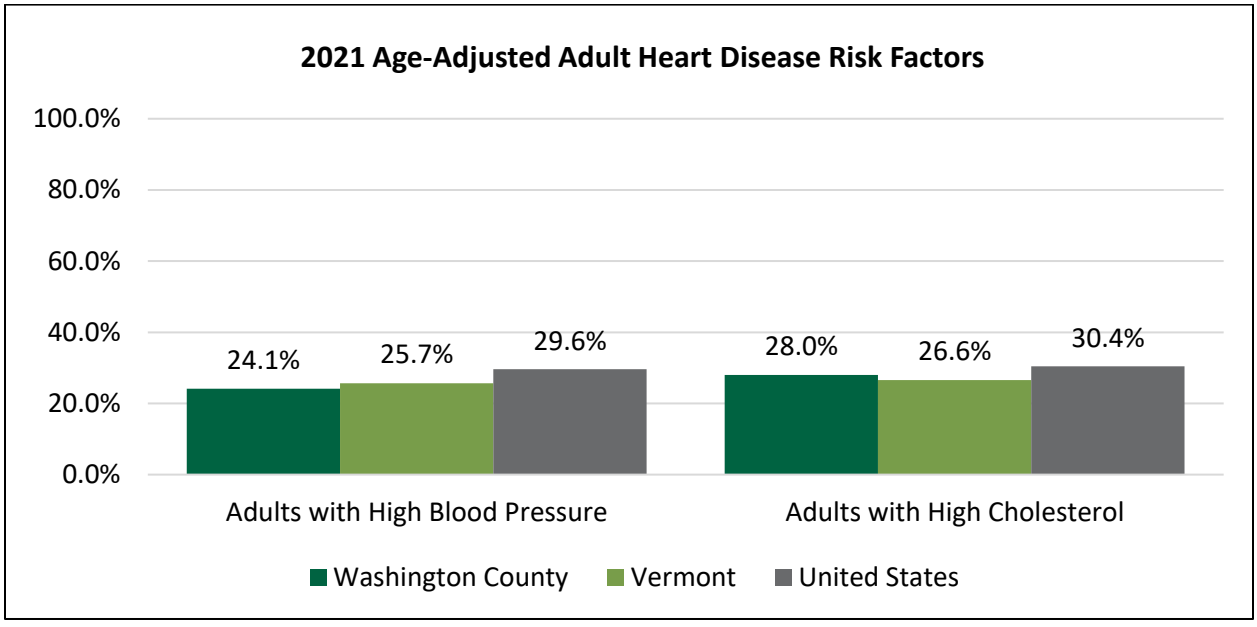
> *"Pharmacy closed after fire. Now CMVC Mad River is closing. I can't drive 120 mins roundtrip to go to the doctor. That's embarrassing to live in the US and in Vermont where our standard of living should be better than that." (Community Survey)."*

> *"[We need] Increased transportation options around central VT, to UVMMC, and further medical facilities in Dartmouth and Boston." (Key Stakeholder Survey)*

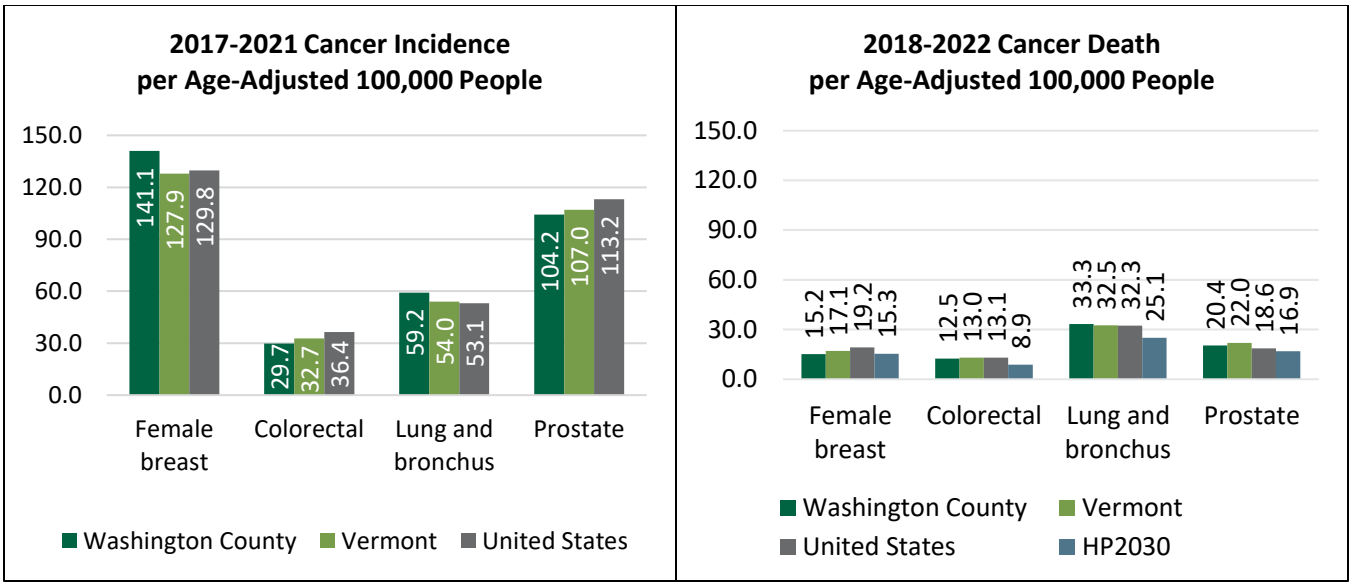
Community barriers that limit access to routine care contribute to chronic disease prevalence and unmanaged conditions. While fewer Washington County residents experience chronic disease compared to their peers statewide and nationally, it continues to be the leading cause of morbidity and mortality. Nearly 1 in 10 Washington County adults live with diabetes and approximately 1 in 4 adults have high blood pressure and/or high cholesterol. A higher proportion of Washington County adults smoke (15.1%) compared to state (13.4%) and national (13.2%) averages, contributing to respiratory disease and higher incidence and death due to lung cancer.



Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention & Vermont Department of Health



Source: Centers for Disease Control and Prevention & Vermont Department of Health
*Cancer incidence data lag and are reported for most recent years available.

Key Stakeholder Survey participants recognized that groups who have been historically marginalized were more likely to experience health disparities. These underserved communities—including those that identify as people of color, LGBTQIA+, and/or people with disabilities—are more likely to face economic insecurity, have cultural and language barriers, and have experienced social injustices; all of which reduce their trust in social systems.

> *"We are seeing people who have been shunned by medical providers and the community. They don't have a safety net and can't get the care they need. Having Medicaid isn't the solution- we need more providers accepting them into practice." (Key Stakeholder Survey)*

Stakeholders acknowledged that the political climate has increased fear and distrust for many, and further restricted access to care. They underscored the importance of staff and provider training in cultural competency and humility and increased outreach to diverse communities.

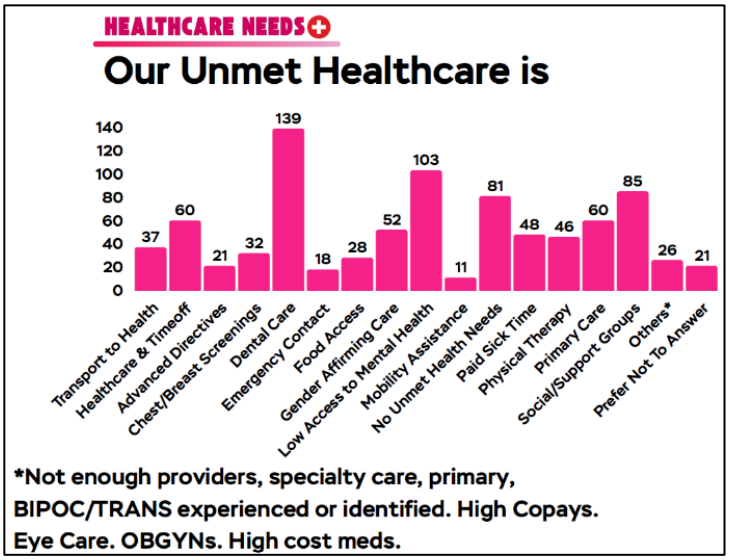
> *"We recommend bringing healthcare and health access to the folks most in need. We'd love to see a mobile care unit in central Vermont that can deliver care to folks in our shelter network and on the street. We'd like to see that combined with mental healthcare-- staffed with individuals who are willing to build relationships with a population who is frequently skeptical to engage in systems, as many have been failed by those systems." (Key Stakeholder Survey)*

> *"Bring the voices of the people who are impacted the most to the table and create programs where people with lived experience play an active role- that is compensated." (Key Stakeholder Survey)*

> *"Promote safe gender affirming, weight inclusive, etc. spaces in health care/community gatherings, etc.; empower these communities to be leaders and be a part of decision-making in communities; support broad publicly available facts, data, and storytelling so Vermonters better understand inequitable challenges facing these groups. Over next several years we will need to come together as a unified community to ensure these folks feel valued and are well cared for." (Key Stakeholder Survey)*

The Pride Center of Vermont's 2024 2STLGBQIA+ Health and Wellness Survey highlighted healthcare concerns and challenges for the state's diverse 2STLGBQIA+ (two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual) community. The survey garnered response from 425 Vermonters, including 53 Washington County residents.

Feedback from 2STLGBQIA+ community members suggested that while some members had positive healthcare experiences, including trusted providers and gender affirming care, others had experienced care that was discriminatory, impersonal, and lacking cultural humility. 2STLGBQIA+ community members had unmet healthcare needs, primarily for dental care, mental healthcare, and social/support groups. Approximately 40% of members needed sexual health and STI (sexually transmitted infection) testing. Many members lived with neurodivergence, mental disabilities, and/or loneliness.



Source: Pride Center of Vermont 2024 2STLGBQIA+ Health and Wellness Survey

Community Recommendations to Improve Access to Care and Services

- Advocate for universal healthcare, expanded Medicaid benefits, and better cross-agency collaboration to leverage and apply resources for sustainable, long-term solutions
- Address recent closures of healthcare sites contributing to longer wait time and transportation barriers
- Increase free/reduced cost healthcare options
- Provide career advancement for mid-level providers (e.g., RN to NP)
- Provide mobile healthcare services bringing care to residents
- Engage people with lived experience to be leaders and part of decision making
- Address transportation barriers, including reliable fixed-route bus service, hospital shuttles, and better sidewalks and lighting around existing healthcare facilities

Financial Wellbeing

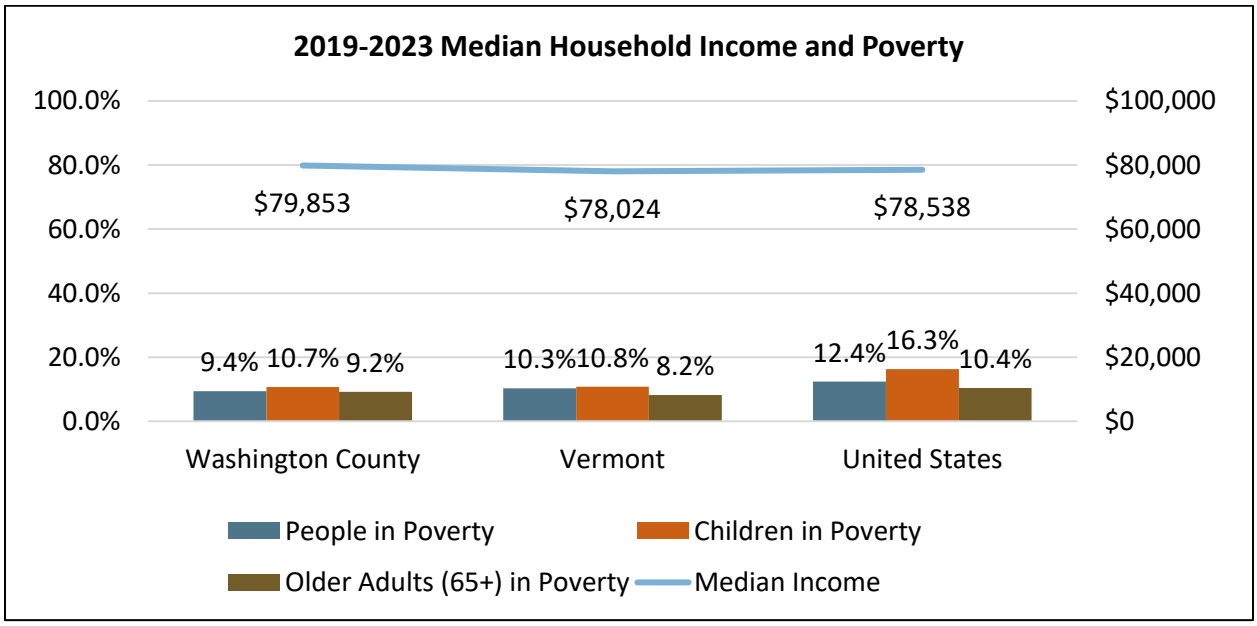
Washington County benefits from strong economic factors, including higher incomes and lower poverty. Experiences of poverty among historically vulnerable groups, including children and older adults, are below national averages. However, recent increases in the cost of living have significantly challenged the wellbeing of residents.

The rising cost of living has increased demand for social services, contributed to delays in accessing vital services, and negatively affected community vitality. In Washington County, the proportion of older adults experiencing poverty increased from 6% in 2019 to 9.2% in 2023. The proportion of food insecure residents increased from 8.5% in 2021 to 11.5% in 2022, with an outsized impact on children. Median home value rose nearly 30% from 2019 to 2023; median rent rose nearly 20%. The cost of childcare for a household with two children in Washington County, measured as a percentage of median household income, increased from 25.3% in 2021/2022 to 38.6% in 2022/2023.

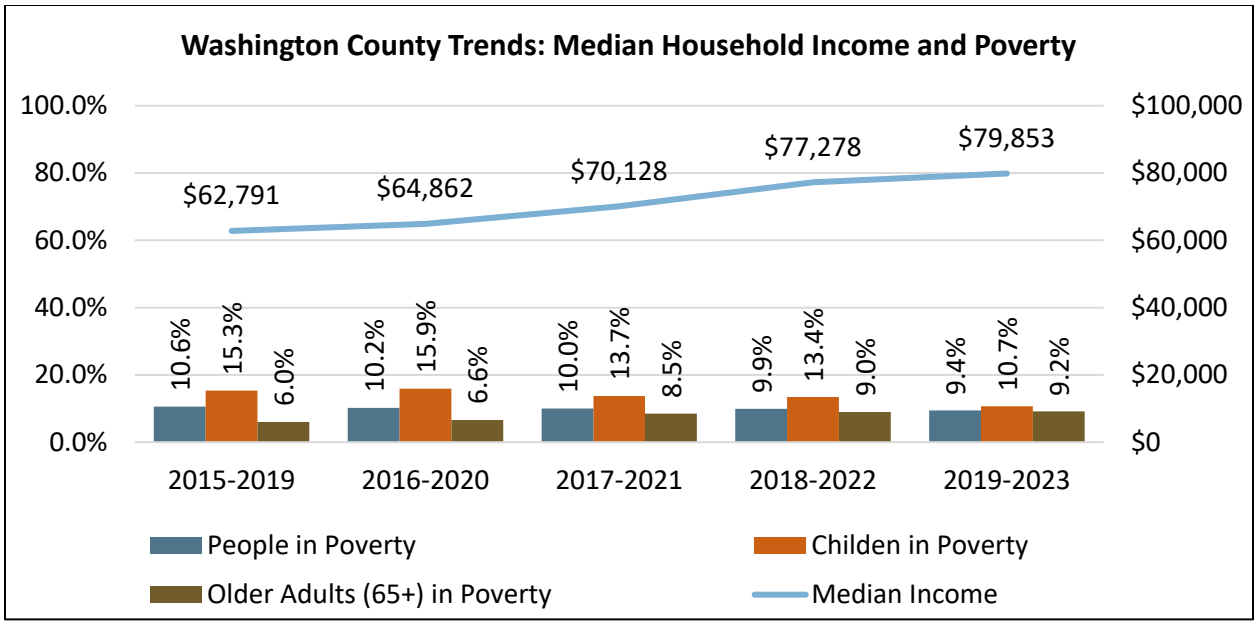
> *"People cannot afford to buy groceries, fix their cars, purchase reliable cars, or pay their utility bills. The cost of everything is going up and has been since Covid. Wages have not kept pace and it is becoming absolutely unlivable for working families." (Key Stakeholder Survey)*

> *"With rising taxes and cost of housing, it is becoming impossible to live in this state. There are plenty of jobs available, but they are not paying appropriately." (Key Stakeholder Survey)*

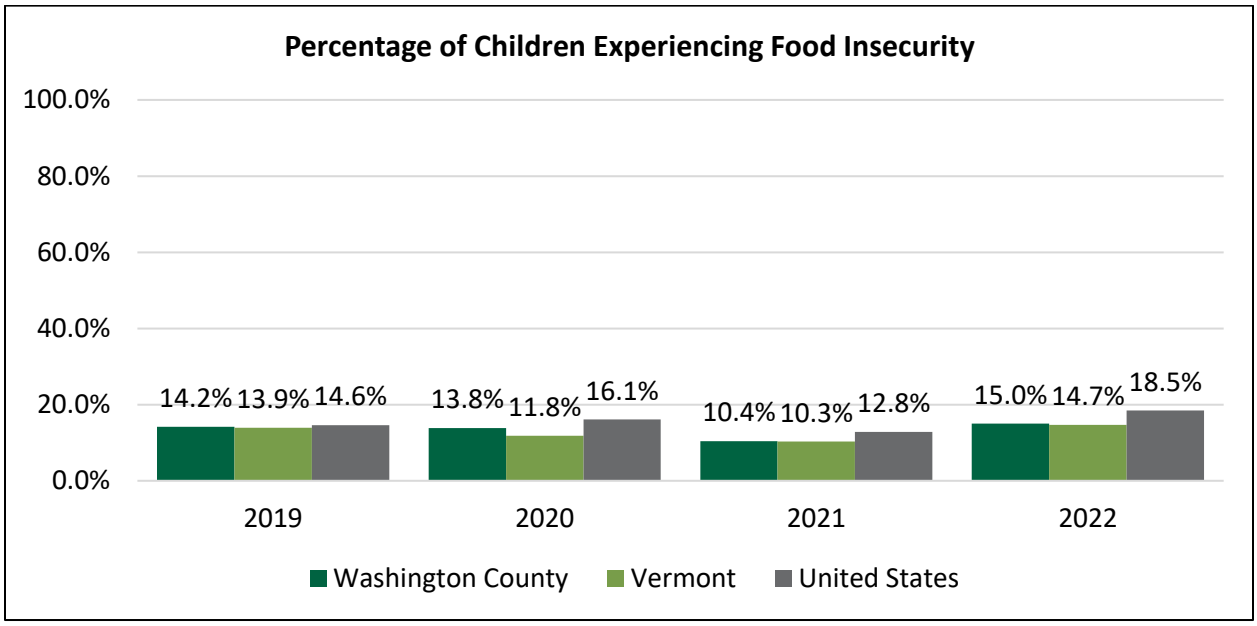
> *"People are living check to check and in a state of scarcity. We've seen a huge rise in eviction due to non-payment." (Key Stakeholder Survey)*



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



Source: Feeding America

Childcare Costs

	Childcare costs for a household with two children as a percent of median household income
Washington County	38.6%
Vermont	40.3%
United States	27.0%

Source: The Living Wage Calculator, Small Area Income and Poverty Estimates, 2023 & 2022

Key Stakeholder Survey participants acknowledged significant downstream issues for both families and the community due to rising costs of living, noting less family structure and support, barriers to accessing healthcare, and more community crime. Some residents are leaving the community in pursuit of affordable options and employers are struggling to recruit new employees to the area.

> *"Many families are struggling, working multiple jobs and less available as parents, to support their families." (Key Stakeholder Survey)*
>
> *"People are unable to meet their needs due to rising costs of food and other basic necessities. We're seeing an increase in theft, panhandling and other crimes related to unmet needs." (Key Stakeholder Survey)*
>
> *"Education, taxes, and lack of adequately paying jobs are making it almost impossible for Vermonters to live here and there is little to no incentive for people to want to move here to raise a family." (Key Stakeholder Survey)*
>
> *"Families are being pinched by the cost of living and many are leaving our community (and many others), when they would rather stay. The quality of life is decreasing due to the cost of living." (Key Stakeholder Survey)*

Lower- and moderate-income individuals have been most affected by rising costs of living and are at risk due to issues like the benefits cliff. A "benefits cliff" occurs when an individual or family relying on public assistance benefits experiences a sudden loss of those benefits due to a small increase in earnings, potentially to account for rising costs of living, leaving them financially worse off than before the increase.

> *"[…] with specific mention of the Benefits Cliff effects. This includes a person or family who are stabilized through social service benefits in food, housing, heat, insurance and childcare but lose all benefits when a small increase of income occurs or the household situation changes. The negative loss of income requires the working person to either refuse a raise/advancement to remain stable or navigate an unsustainable cost of living situation." (Key Stakeholder Survey)*

Community Recommendations to Improve Financial Wellbeing

- Advocate for equitable taxing of high-income earners, second homeowners, rental homes, and out-of-state homeowners
- Advocate for universal basic income and healthcare and higher education funding
- Provide benefits cliff education and solutions for employers
- Promote economic mobility and development (e.g., trade and skilled labor programs, subsidized childcare, shared living spaces)

Housing

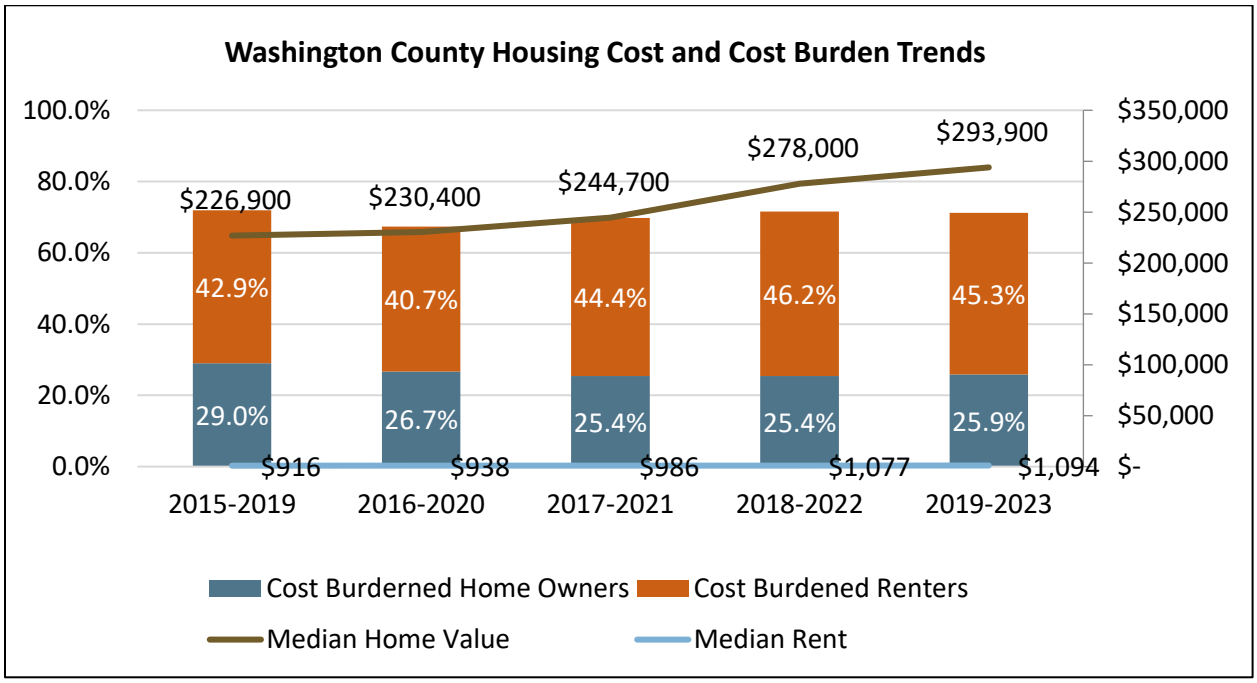
Nearly 70% of Key Stakeholder Survey participants identified housing needs as a pressing concern for central Vermont. Participant feedback highlighted high and rising housing prices, a shortage of available and planned affordable housing and shelter options, zoning and building policies that limit housing development, and an increase in unhoused people.

> *"The housing crisis is a major barrier to full participation in society for a large number of poor folks. Housing instability and cost affect many, many families with young children, and it indirectly affects parents' and children's stress levels, mental health, and ability to participate in school." (Key Stakeholder Survey)*

> *"Many working class are being priced out of their communities. The cost of building and rules to build are barriers that that make it not affordable to create more housing." (Key Stakeholder Survey)*

Washington County housing costs have increased. Median home value rose nearly 30% from 2019 to 2023; median rent rose nearly 20%. The National Low Income Housing Coalition estimated that in 2023 the hourly wage a full-time worker needed to earn to afford a two-bedroom rental home at fair market rent was $27.94. The state minimum wage is $13.67.

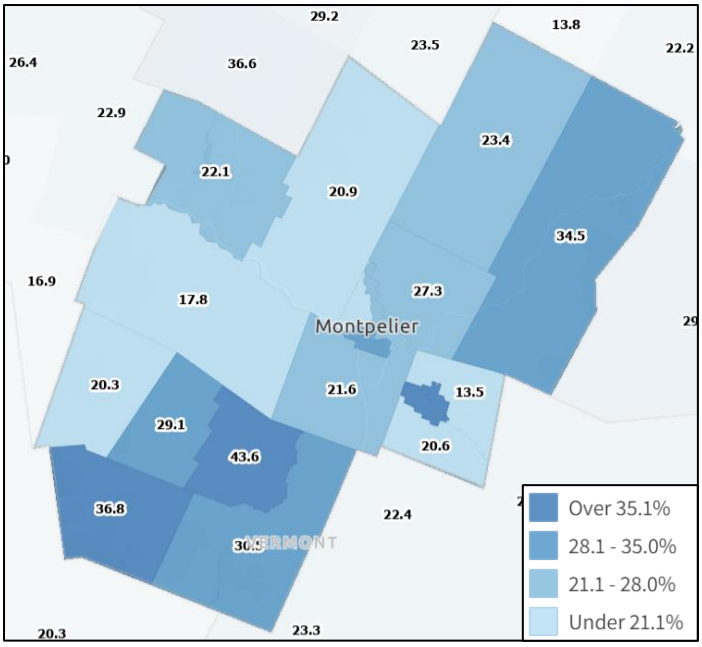
Approximately 73% of Washington County households own their home, and 1 in 4 homeowners are cost-burdened by their home, spending 30% or more of their income on mortgage expenses. Renters, who make up roughly one-quarter of households, are almost twice as likely to be cost-burdened compared to homeowners, with nearly half facing financial strain due to rent costs.



Source: US Census Bureau, American Community Survey

When viewed by census tract, more than one-third of households in Barre, downtown Montpelier, Marshfield, and the southern portion of the county are cost burdened by mortgage or rent expenses.

2019-2023 Cost Burdened Households, Owner or Renter, by Census Tract (Costs Exceed 30% of Household Income)



Source: US Census Bureau, American Community Survey

Consistent with feedback about rising costs of living, Key Stakeholder Survey participants shared that housing costs have negatively affected community vitality and economic development. Working class families are being pushed out of the community and employers struggle to attract a new workforce.

> *"I think this is obvious but trying to hire new employees into VT is tough unless you have a budget of a 1/2 million dollars." (Key Stakeholder Survey)*

> *"Housing/cost of living is very expensive, so my guess is that healthcare providers may not be making enough money to stay here, so they move. People need to be paid a livable wage, AND they need to have a place to live." (Key Stakeholder Survey)*

> *"Access to housing is critical. It is stifling recruitment for all roles. Additionally, senior housing is necessary to provide the elder population with support, while their transitions can open housing for the workforce." (Key Stakeholder Survey)*

Key Stakeholder Survey participants identified unmet demand for affordable housing and shelter services, noting months-to-years-long wait lists and the closing of the motel program for the state's most vulnerable populations (e.g., families with children, people with acute medical needs).

> *"Ten years ago, we used to be able to house people living in our shelter in one month. When I started this job three years ago (before the floods and in the middle of booming housing prices) it would take me 3-6 months to house folks depending on family size and other barriers. Now I am lucky if I can house a single person in 9 months and families take 1-2 years to house, even if they do everything*

they need to do within the timelines they are asked to do it and tick all the priority boxes for being housed 'quickly'. There are no three-bedroom apartments ANYWHERE. Every family with three children that I have housed has gone into a 2-bedroom." (Key Stakeholder Survey)

More Vermonters are experiencing homelessness due to rising housing costs and general costs of living. The Point-in-Time (PIT) count is a nationwide count of sheltered and unsheltered people experiencing homelessness. The count is usually conducted in the last 10 days of January each year.

According to the 2024 PIT count, there were 3,458 unhoused Vermonters statewide, representing a more than 300% increase over pre-COVID levels. Unhoused people included 737 children and 646 people aged 55 or older. Because of our country's long history of racist and exploitative laws and policies, Black Vermonters were 5.6 times more likely to be unhoused compared to white Vermonters.

Among the 3,458 unhoused Vermonters in 2024, 464 resided in Washington County, representing a nearly 42% increase from 2021 (n=327). Unhoused Washington County residents included children, people aged 55 or older, veterans, and people fleeing domestic or sexual violence. Approximately 35% of unhoused people had been unhoused for three months to one year and 33% had been unhoused for one year or more.

2024 Point-in-Time Count of Unhoused People in Washington County

	Washington County
Number of unhoused residents	464
Number of unhoused children	87
Number of unhoused residents over 55 years old	100
Number of veterans	21
Number of people fleeing domestic or sexual violence (adults only)	20
Number of times more likely that Black residents are unhoused compared with white residents	4.57

Source: Housing & Homelessness Alliance of Vermont

Community Recommendations to Improve Housing

- Advocate for equitable taxing of second homeowners and fewer vacation home rentals
- Advocate for new policies that allow for rapid housing development
- Include housing as part of broader community development and economic plans
- Develop community housing plans that prioritize diverse and higher density options
- Develop more short-term shelter options that include wraparound supports and clear pathways to long-term housing

Behavioral Health

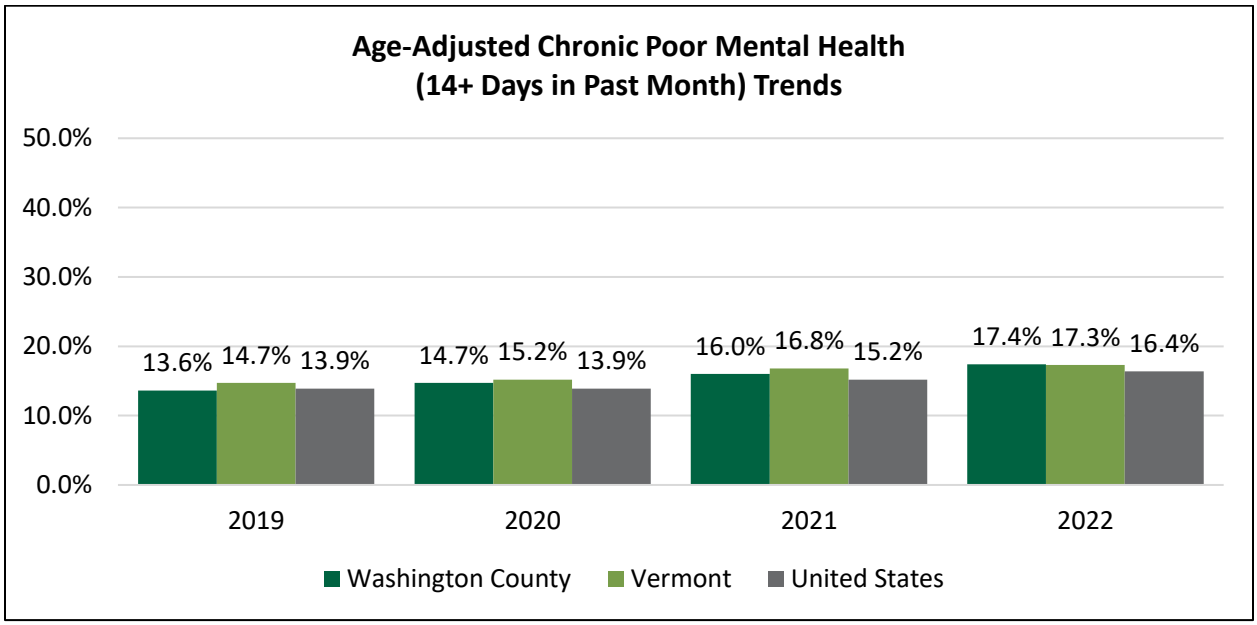
Experiences of mental distress have increased statewide and nationally. In 2022, approximately 17.4% of Washington County adults reported having chronic poor mental health (14 or more days in the past month) compared to 13.6% in 2019. Approximately 28% of adults reported being diagnosed with a depression disorder compared to 26% of adults statewide and 21% of adults nationally.

Key Stakeholder Survey participants reinforced widespread mental distress among residents, spanning all population groups. They noted that recent increases are due in part to loss of community connection and sense of belonging coming out of the pandemic; they called for more upstream efforts to rebuild community bonds and resiliency among residents.

> *"Behavior health, mental health and wellbeing are at an all-time low for nearly all populations; older folks are lonely, parents/families/caregivers feel unsupported, folks in recovery feel neglected or ostracized by their larger communities, medical providers, teachers and other staff feel overwhelmed on the daily." (Key Stakeholder Survey)*

> *"So many people need not only medical/dental services but also just the help and reassurance that they have a purpose in life and are part of a community." (Key Stakeholder Survey)*

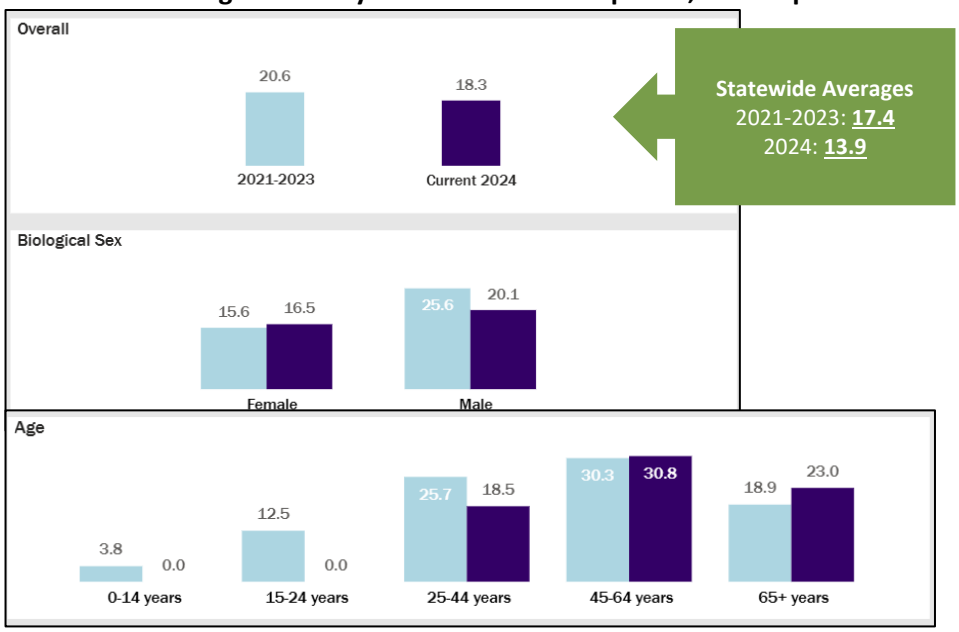
> *"The isolation of COVID has exacerbated mental health challenges exponentially and we have not recovered." (Key Stakeholder Survey)*



Source: Centers for Disease Control and Prevention

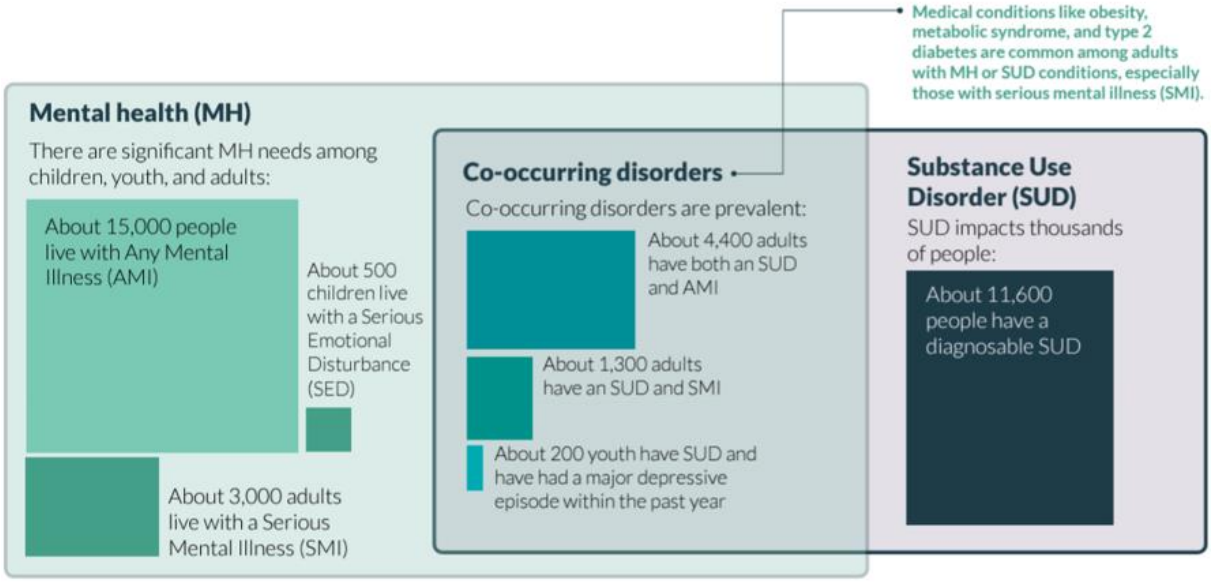
Washington County had the fourth highest suicide death rate in Vermont in 2024 and has historically had more deaths by suicide than the state overall. While the overall death rate decreased in 2024 from prior years, it increased for older adults aged 65 or over. This finding is consistent with other emerging health and social barriers for older adults.

Washington County Suicide Death Rate per 10,000 People



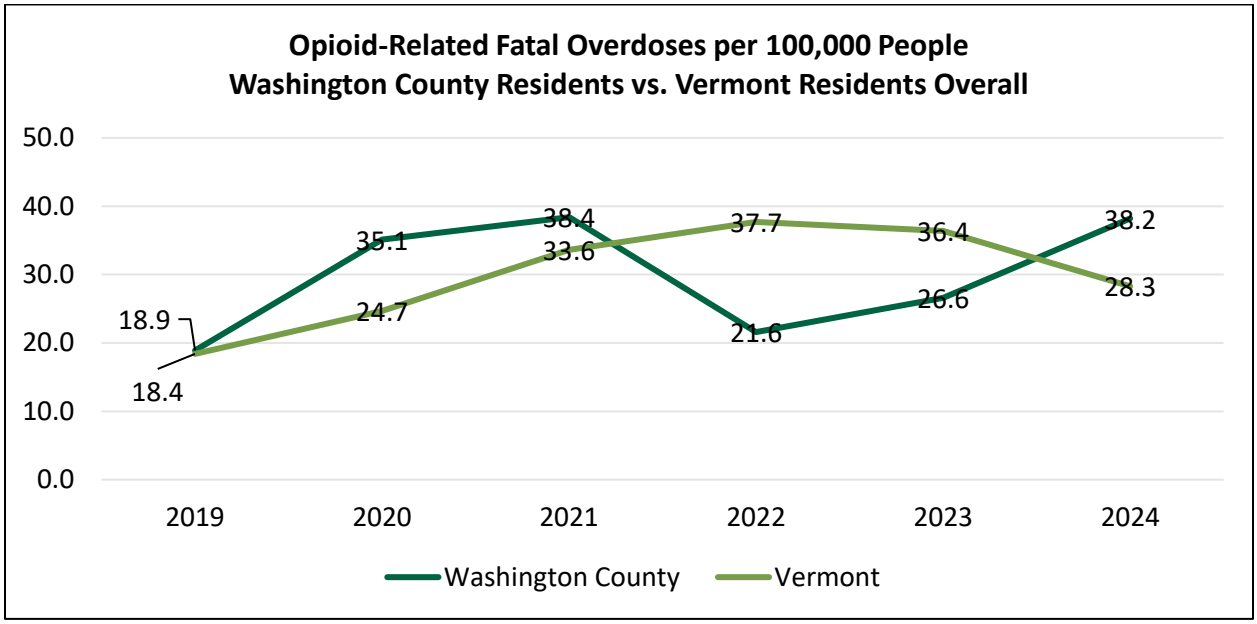
Source: Vermont Department of Health

A Community Health Assessment conducted by Washington County Mental Health Services in 2024 also identified growing mental health and substance use disorder needs for Washington County residents. About 15,000 residents were estimated to have any mental illness, about 11,600 were estimated to have substance use disorder, and 4,400 had both a mental illness and substance use disorder.



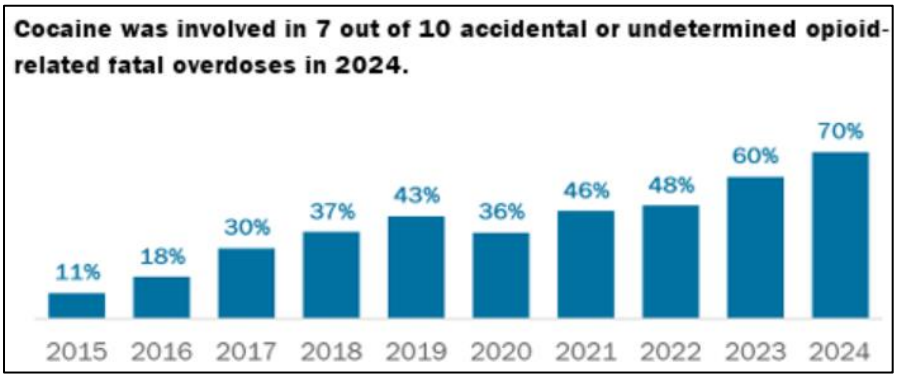
Source: Washington County Mental Health Services 2024 Community Needs Assessment

Opioid-related fatal overdoses in Vermont have been on the rise for the past decade and peaked in 2022, likely due in part to the COVID-19 pandemic which caused delays in care, social isolation, and unemployment. Data for 2024 suggests that statewide fatal overdoses may have fallen with a 22% decrease in the number of deaths from 2023 (236) to 2024 (183). Washington County differed from statewide trends with an increase in opioid-related deaths in 2023 and 2024. Washington County saw 23 opioid-related deaths in 2024 compared to 16 in 2023.



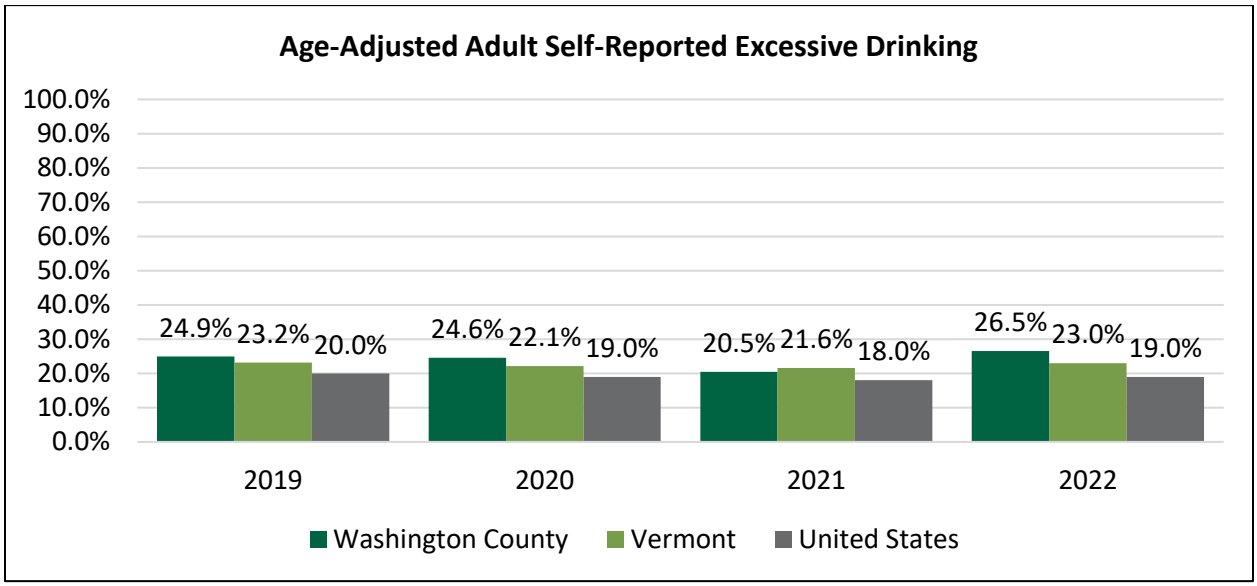
Source: Vermont Department of Health

Most opioid-related deaths involve multiple substances. In 2024, 95% (174) of statewide opioid-related fatal overdoses involved two or more substances, with 39% (70) involving four or more substances. While fentanyl continues to be the most common substance involved in opioid-related deaths (involved in 93% of deaths in 2024), cocaine was the second most common drug (involved in 70% of deaths in 2024). The number of cocaine-involved deaths has steadily increased since 2015.



Source: Vermont Department of Health

The Vermont Department of Health reported on its website that, "National data shows that Vermonters in all age groups - youth (12-17), young adults (18-25), and adults (26+) - drink alcohol at higher rates compared to the country overall." In 2022, more than 1 in 4 (26.5%) Washington County adults reported excessive alcohol use (heavy and/or binge drinking), the highest proportion among all Vermont counties. While based on a small count, Washington County also saw the second highest proportion of driving deaths due to alcohol impairment. From 2018 to 2022, Washington County had 19 driving deaths and 9 (47.4%) of them involved alcohol impairment.



Source: Centers for Disease Control and Prevention

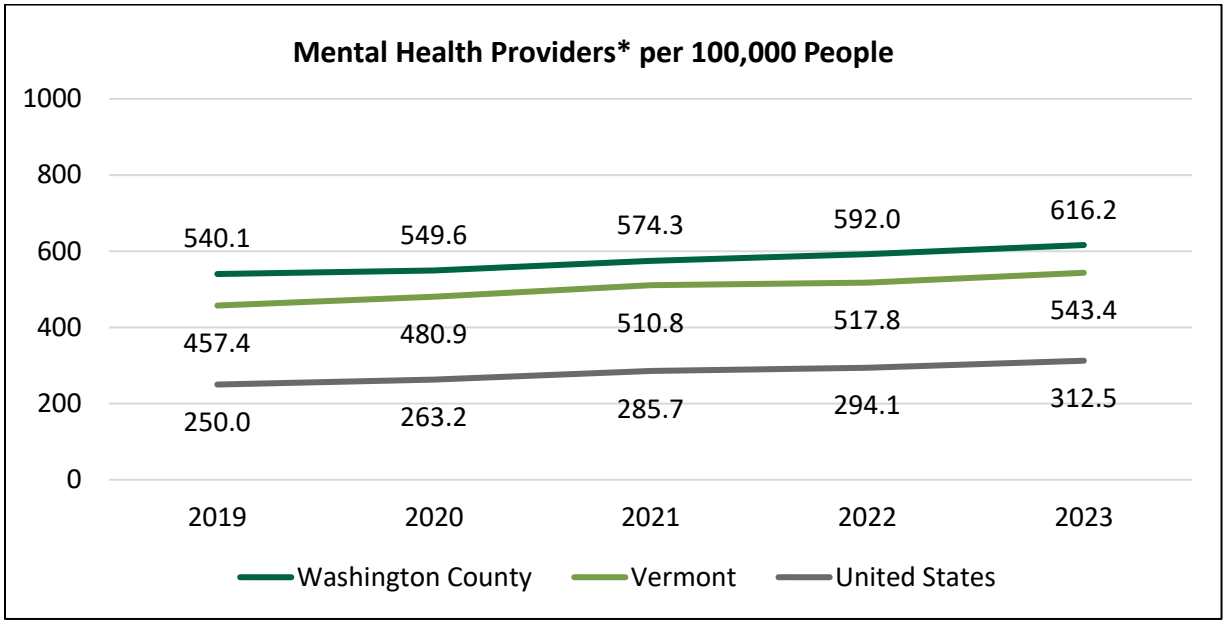
Recent flooding events in Washington County and resulting trauma have contributed to mental distress and substance use for residents. Among Community Survey participants, 29.4% stated they had been negatively impacted by recent flooding events. Among those impacted, 62.7% said they experienced mental distress or trauma. Nearly a third reported significant financial loss due to home damage, medical expenses, etc. Their first-hand accounts underscore the far-reaching health and social impacts for areas placed at risk by environmental changes.

> *"My child is acutely aware of weather events, experiencing anxiety and fear when it rains, that more flooding will happen and his friends might be in trouble or people will need help." (Community Survey)*

> *"[The flooding] contributed to burnout in my career as a social worker in primary care in Berlin/Barre area." (Community Survey)*

> *"Daughter, granddaughter and two pets needed to live with me for 8 months after 2023 flood. They lost pretty much everything. I have been helping them with expenses for two years as they recover financially." (Community Survey)*

Washington County and Vermont have a consistently higher rate of behavioral health providers compared to the national average, and the rate is increasing. Despite these trends, gaps in access to care and services persist.



Source: Centers for Medicare and Medicaid Services

*Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.

Community stakeholders reported patients seeking behavioral healthcare in the emergency department and being admitted to the hospital for conditions that could be better managed in the community. Perceptions were that a lack of outpatient resources (e.g., counselors, detox programs) were top reasons for people seeking behavioral healthcare at hospitals. Inpatient services were also seen as lacking in the community and negatively affected by the recent closure of the CVMC psychiatric unit. Stakeholders called for better integration of behavioral health within the healthcare system, creating the same level of services and understanding that currently exists for physical health conditions.

> *"Our local emergency department often becomes the last resort when individuals experience a mental health or substance use crisis. There is a critical need for an appropriate urgent care and in-patient option specifically equipped to handle these unique situations without criminalizing the individuals involved." (Key Stakeholder Survey)*

> *"More SOBER and transitional housing including opportunities for support for sustainable substance abuse rehab and recovery. More community support for reintegration into communities after incarceration. More diverse and trauma-informed options to meet specific individual needs to support sustainable life changes for people in the criminal legal system. Increased and more equitably available supports for youth and young adults and their families to intercept generational issues." (Key Stakeholder Survey)*

"There aren't any psychiatrists available within a reasonable time frame … after 6+ months of waiting, neither were comfortable treating me … only option is $500/hr more than 1 hour away." (Community Survey)

"Mental health services have been challenging to access for years. Lengthy wait lists and limited providers. With the closure of psychiatric beds at our local hospital has increased concern for how to help those that are in crisis in the community." (Key Stakeholder Survey)

"I would like to see a focus on mental health care as health care… Staff say they wish mental health patients would go somewhere else. That doesn't make me feel safe." (Community Survey)

Community stakeholders also cited a lack of providers that accept Medicaid and Medicare as a key barrier for accessing behavioral healthcare.

"We need mental health providers desperately, especially those who will accept insurance, including Medicare. Primary care providers do not have time to provide mental health care for their patients, yet there is no one for them to refer to." (Community Survey)

"Greater access to psychiatric nurse practitioners for Medicaid recipients. I lost my clinician due to the state's underpayment and attempted claw backs for her services; she no longer takes Medicaid. I'm newly diagnosed with ADHD and need a medical (NP, MD, etc.) mental-health clinical specialist." (Community Survey)

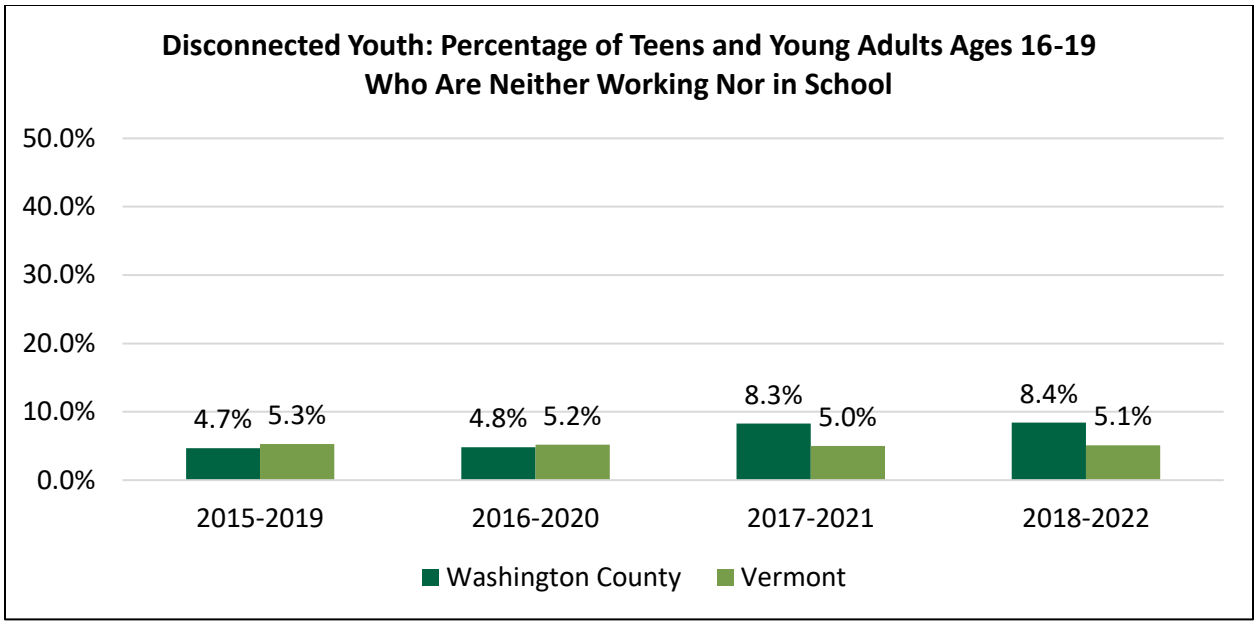
Community stakeholders noted an increase in mental health and substance use concerns among youth, often rooted in adverse childhood experiences (ACEs) like living in poverty and exposure to addiction among caregivers. Isolation and developmental delays from the COVID-19 pandemic also have had lingering impact on youth.

"More than half of the issues we see in school and our community among children, young people, and our adults are mental health related. These concerns are greatly impacting the ability of our people to live their full lives, puts a strain on our already overtaxed school system, and prevents families from thriving." (Key Stakeholder Survey)

"We see a lot of increased behaviors, not only in school, but in the community at large. So many of our residents have addictions which only add to existing behaviors for themselves and their children. They only know what they see. Parents have such an influence on their children." (Key Stakeholder Survey)

One indicator of behavioral health concerns for youth is truancy or chronic absenteeism from school. Statewide, the percentage of chronically absent Vermont students more than doubled from 2019 (18%) to 2022 (42%) and only declined to 30% in 2023. Truancy rates vary widely across student groups, often reflecting underlying health and social disparities and community inequities.

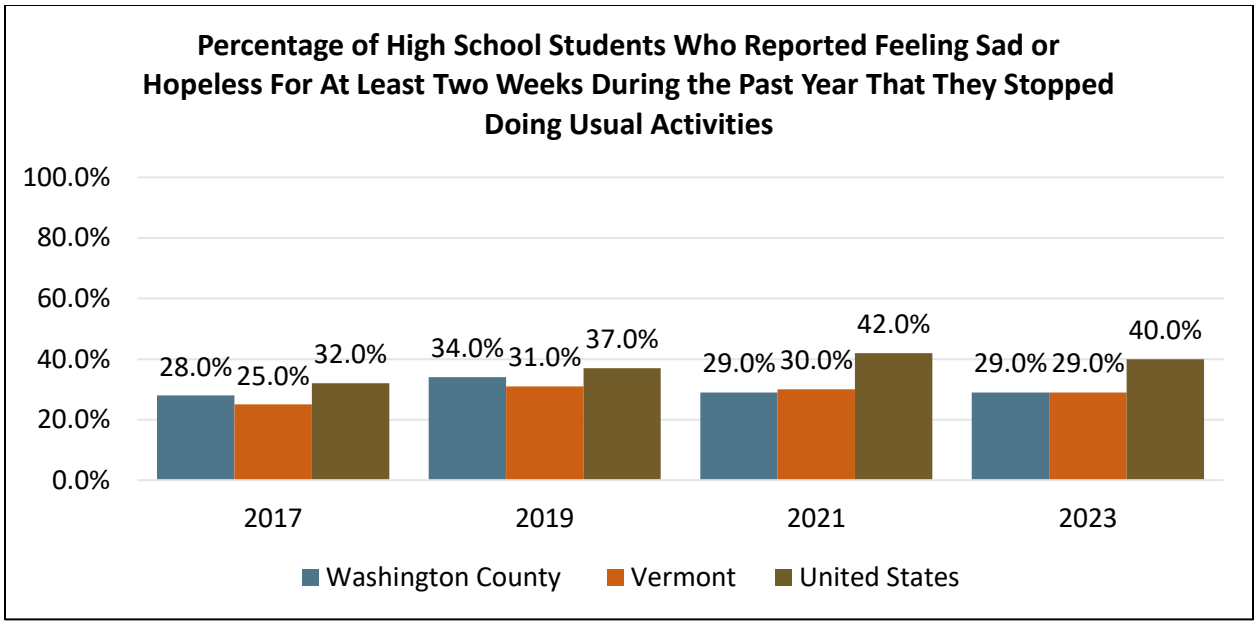
Related to truancy concerns is the growing proportion of disconnected youth, defined as youth ages 16-19 who are neither working nor in school. The proportion of disconnected youth almost doubled in Washington County from 2019 to 2022, surpassing the statewide average.



Source: US Census Bureau, American Community Survey

The Youth Risk Behavior Survey (YRBS) is a national school-based survey that monitors the health-risk behaviors that contribute to the leading causes of death and disability among youth and young adults. Since 2011, Vermont has conducted two separate surveys: a high school survey of students in grades 9 through 12, and a middle school survey of students in grades 6 through 8. Statewide reporting is available for both high school and middle school students; county-level reporting is available for high school students. In 2023, 1,309 Washington County high school students participated in the YRBS.

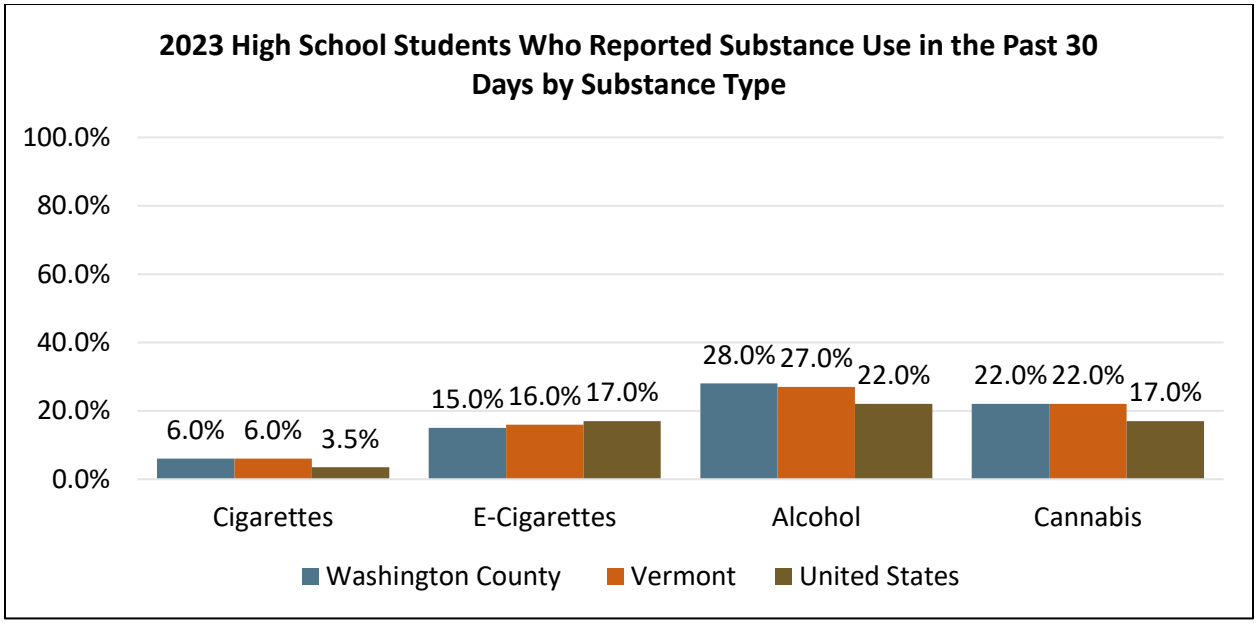
The most recent survey administered in 2023 found that Washington County and Vermont high school students are less likely than their national peers to report mental distress, but nearly 1 in 3 students still reported feeling very sad or hopeless. Approximately 7% of Washington County high school students reported an attempted suicide, a similar proportion as the statewide average. Statewide, students who identify as female, LGBTQIA+, BIPOC, and/or have IEPs (Individualized Education Program) are disproportionately affected, reporting higher rates of both mental distress and attempted suicide.



Source: Vermont Department of Health & Centers for Disease Control and Prevention

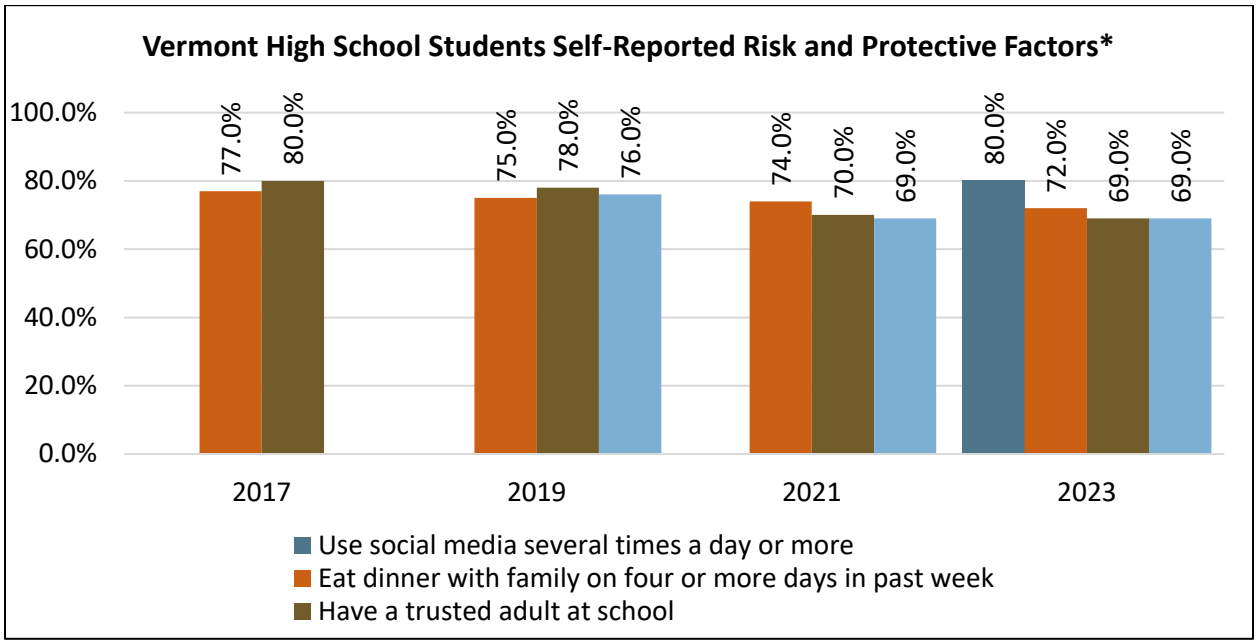
In Vermont, substance use among students more than triples or quintuples from middle to high school. Vermont high schoolers, including Washington County students, are more likely to use tobacco, alcohol, and cannabis than their peers nationally.

Use of e-cigarettes and cannabis among Washington County and Vermont students peaked pre-COVID and has declined since. While e-cigarette use remains below national trends, cannabis use among Vermont high schoolers exceeds national averages.



Source: Vermont Department of Health & Centers for Disease Control and Prevention

Youth protective factors like planning to attend college, having a trusted adult at school, and spending time with family have steadily decreased amongst high school students since 2017, while risk factors like excessive social media use are prevalent. In 2023, 4 out of 5 students statewide reported using social media several times a day; 3 in 10 students used social media more than once an hour.



Source: Vermont Department of Health; *Social media data are not reported before 2023.

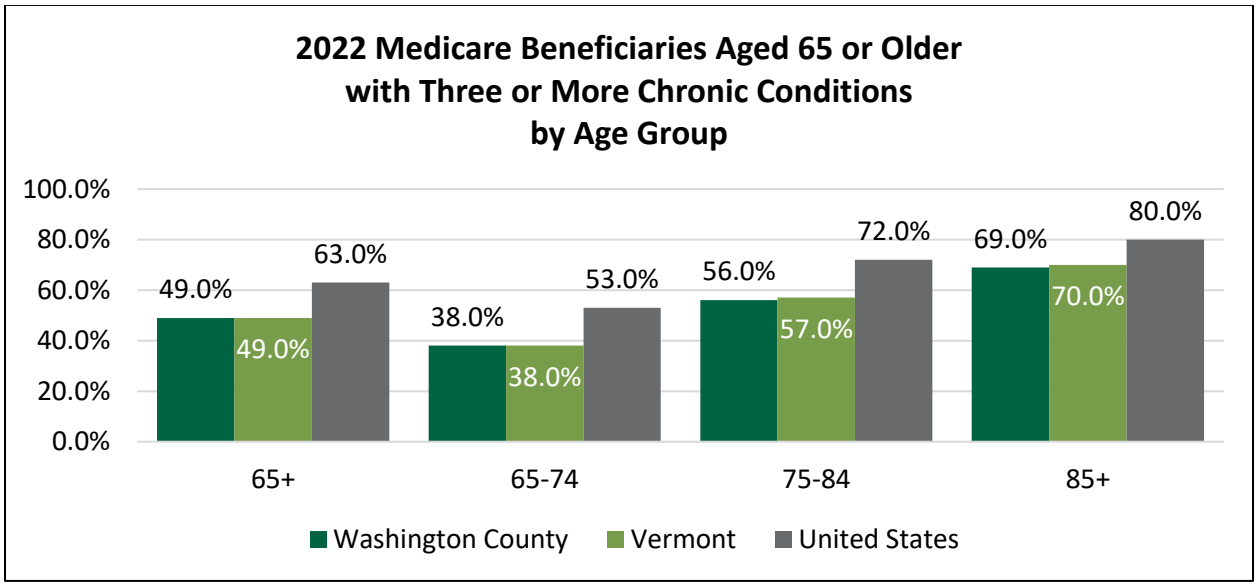
Community Recommendations to Improve Behavioral Health

- Advocate for better integration of behavioral health within the healthcare system, creating service lines and access points that mirror those available for physical health conditions
- Advocate for statewide investment in behavioral healthcare services
- Address recent closure of CVMC inpatient psychiatric unit and community plan for serving people in crisis
- Embed behavioral healthcare staff within law enforcement, schools, and social service systems
- Incentivize mid-level careers in behavioral health (e.g., recovery coaches, behavioral health nurses)
- Invest in economic support and meaningful employment opportunities for residents
- Invest in upstream, preventive initiatives to rebuild community connection and sense of belonging and community member resiliency
- Provide more youth engagement activities

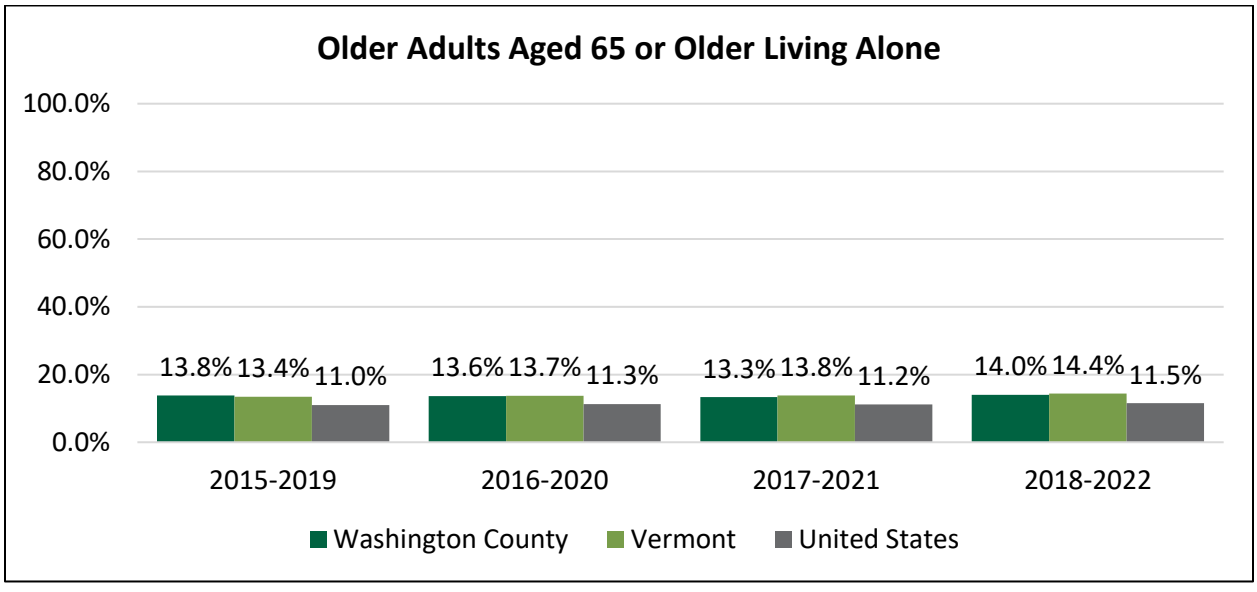
Older Adult Health and Wellbeing

Vermont is slated to be the oldest state in the U.S. within the next decade. From 2010 to 2023, the number of residents aged 65 or older grew 53.8% statewide and 52.1% in Washington County.

Older adults are more at risk for chronic disease, as well as factors that impede disease management, including economic insecurity, social isolation, and access barriers (e.g., transportation, digital literacy). In 2023, 49% of Washington County Medicare beneficiaries aged 65 or older managed three or more chronic conditions, most commonly high blood pressure, high cholesterol, arthritis, diabetes, and depression. An increasing percentage of older adults live alone, estimated at 14% in 2023.



Source: Centers for Medicare & Medicaid Services



Source: US Census Bureau, American Community Survey

As part of the CHNA, a Listening Session was held with 11 aging services professionals providing care to older adults in central Vermont. Professionals noted that the care system for older adults in Vermont faces numerous challenges, including growing complexity of health needs, fragmented payment and delivery care models, limited community- and facility-based services, and workforce shortages.

Older adults increasingly present with multiple health conditions, including behavioral health challenges, cognitive difficulty (e.g., dementia), and chronic physical conditions (e.g., heart disease, diabetes). These comorbidities make it difficult to place individuals in appropriate care settings, especially when facilities cannot handle both medical and psychiatric needs. Many older adults also struggle with housing and financial instability, transportation barriers, and lack of social support, compounding the difficulty of care planning.

> *"From a nursing home standpoint, we're seeing a lot more psych patients needing placement. There is a misunderstanding that we're able to accommodate psych needs in the nursing home. Patients are attacking staff and we don't have the ability to restrain under federal regulations. We have to send them to the hospital, which is frustrating for them. They medicate them and send them back, and sometimes it's the same patient multiple times in the same weekend."*

A critical mismatch exists between how aging services are structured and funded, often perpetuating siloed approaches that do not address the holistic needs of individuals. Medicaid services are divided by funding streams (physical, behavioral, or disability services), forcing patients to "choose" a condition to treat. The system isn't designed to handle multi-morbidity or meet the continuum of care needs. Geriatric psychiatric services are increasingly unable to accept individuals with dementia, exacerbating the challenges of providing appropriate care for older adults with cognitive impairments. Many unhoused older adults with psychiatric needs get stuck in hospitals due to a lack of suitable placement or post-discharge care.

> *"People have to pick residential mental health treatment or an aging care facility. We want to meet the whole person, but the pay source system is counter to that."*
>
> *"That's really where we struggle, managing their entire health. They're only becoming more complex. The hospital team does a great job but it's only so much."*

The healthcare sector is facing significant staffing challenges. Programs such as in-home care and peer support remain underfunded and understaffed. Personal Care Assistants, Licensed Nursing Assistants, and home health staff are in critical short supply. Inadequate salaries, especially in community or home-based care programs, hinder recruitment and retention. Long-term care facilities (e.g., assisted living and nursing homes) and geriatric psychiatry facilities are limited, not meeting current demand for services.

Aging services solutions require policy shifts, investment in the workforce and infrastructure, and integrated, person-centered care models.

Community Recommendations to Improve Older Adult Health and Wellbeing

- Advocate for systemic reform and cross-agency collaboration to break down funding silos
- Advocate for better integration of behavioral health, aging, and medical care services; idea for “a la carte” Medicaid services
- Develop more coordinated approaches and transitions of care for individuals with complex needs
- Expand peer support services to help older adults navigate the healthcare system
- Explore community wellness centers that offering facilities such as swimming pools, fitness centers, prescription exercise programs, and opportunities for social connection
- Explore onsite pharmacy services at CVMC for point of care fulfillment
- Invest in community and in-home wraparound supports (e.g., housing, transportation, case management, in-home care, social inclusion, etc.)
- Invest in long-term care facilities to serve the increasing number of older adults and build capacity to meet the holistic needs of the aging population
- Invest in workforce recruitment and retention with comprehensive training programs and competitive salary opportunities

Our Response to The Community's Needs

Background

The 2022 Community Health Needs Assessment identified priority areas of need for central Vermonters. Based on CVMC's existing expertise and resources, the medical center was best positioned to lead efforts in the following areas:

- Diversity, Equity and Inclusion
- Chronic Disease Prevention
- Mental Health
- Social Drivers of Health (SDoH)
- Substance Use Disorders

For over half a century, CVMC has been a cornerstone of care in central Vermont, committed to nurturing a healthy community through innovative healthcare solutions, advanced treatment options, and educational initiatives that empower individuals to lead healthier lives, while also driving economic growth and stability in the region. CVMC measured contributions and community impact from these investments, as outlined in the following sections.

Investments

In 2023 and 2024, CVMC made a total of **$81,500** investments to community organizations:

Central VT Prevention Coalition (CVPC): $50,000

Community Benefit Investment dollars were used on the following projects in 2023 and 2024:

- NaloxBox project: Ensuring access to emergency use naloxone in community organizations and businesses.
- Project BEACON: A community based post-overdose response project in partnership with EMS that links overdose survivors at high risk of subsequent fatal overdose to community resources in harm reduction, treatment and recovery.

Community Organization and Initiative Investments: $31,500

As a member of THRIVE, CVMC provided **$25,000** of VTCHEP funds in support of nine organizations and projects that directly support diverse and underserved populations within our community:

- All Brains Belong: $3,500
- Community Resilience Organizations: $3,500
- Education Justice Coalition of Vermont: $2,000
- Montpelier Roxbury Public Schools Partners in Education: $5,000
- Mosaic Vermont: $1,000
- Peer Plus: $1,000
- Pride Rides: $3,500
- Vermont Kindness Project: $3,500
- Working Bridges: $2,500

Other community investments totaling **$6,500** supported the following initiatives:

- Event sponsor of Barre Heritage Festival, Barre's free four-day cultural celebration, supporting a community with higher poverty levels and social health challenges.
- Sponsor of It Takes a Village – A free family event by Good Beginnings of Central Vermont.
- Annual contribution to VT Ethics Network, ensuring access to a vital statewide healthcare resource.
- Sponsor of Vermont Mountaineers – Providing family-friendly entertainment and youth baseball camps, strengthening community ties.
- Sponsor of annual diaper drive fundraiser with Family Center of Washington County.
- Co-hosted a screening of Just Getting By with Capstone Community Action, highlighting the challenges and resilience of low-income Vermonters and the need for more support.

Community Outreach and Partnership

As a dedicated partner and fiscal sponsor for THRIVE, the accountable community for health in central Vermont, CVMC is committed to supporting the advancement of collaborative partners' work. Central Vermont Medical Center partnered with the following agencies in 2023 and 2024 to advance community health across the region:

- THRIVE
- Central Vermont Prevention Coalition (CVPC)
- Family Center of Washington County
- Vermont Foodbank
- People's Health and Wellness
- Capstone Community Action
- Vermont CARES
- Turning Point Center of Central Vermont
- BAART/Central Vermont Addiction Medicine
- Washington County Mental Health Services
- Montpelier and Barre Community Justice Centers
- Downstreet Housing & Community Development
- Elevate Youth
- Montpelier & Barre Police Departments
- District 6 EMS
- VAMHAR
- Agency of Human Services
- Vermont Department of Health
- Montpelier Food Pantry
- Mosaic
- Washington County Diversion Program
- Central Vermont Chamber of Commerce
- Good Beginnings of Central Vermont
- Green Mountain United Way
- Central Vermont Home Health and Hospice

Summary of Accomplishments

Community benefit and engagement highlights from 2023 and 2024 reflect CVMC's continued commitment to supporting our community through every challenge.

2023:

- **Healthcare Career Pathway Programs**: In partnership with Vermont colleges and universities, CVMC was able to offer 7 training programs in 2023 with 47 participants. Program focus areas included Licensed Practical Nursing, Registered Nursing and Surgical Technologists.
- **Flood Response**: Central Vermont experienced severe flooding resulting in road, school and business closures, and evacuation of many community members from their homes while others found themselves stranded in place. To meet the urgent needs of the community, the hospital responded with the following efforts:
    - CVMC maintained operations with staff members working beyond their scheduled shifts and navigating challenging routes to bypass high water and make it into work safely.
    - The CVMC pharmacy team quickly established a process to provide 72-hour refills for patients who ran out or lost their medications in the flooding.
    - CVMC staff established Flood Relief Pop Up First Aid/PPE stations in community centers to assist those who needed medical attention with many providers and staff volunteering their time to support this effort.
    - Members of THRIVE met regularly to identify community needs and mobilize their resources to support those impacted by the flooding.
- **VT Community Health Equity Partnership grant:** THRIVE was a recipient of a Vermont Health Equity Partnership (VTCHEP) grant funded by the CDC to create a public health framework for reducing health inequities exacerbated by the COVID-19 pandemic. A consultant was hired through the VTCHEP grant to conduct outreach and engage with diverse groups of individuals to gather information and better understand how these individuals experience the healthcare system. The testimonials were integrated into discussions when policy questions arose related to needs such as homelessness/housing.
- **Central Vermont Prevention Coalition:** CVMC served as the convener for CVPC. In this role, CVMC supported monthly meetings and CVPC activities, building safe harbor initiatives to prevent substance use, the elimination of stigma and misunderstanding of substance use, and equitable and affordable access to services.

2024:

- On July 10-11, 2024, central Vermont experienced severe flooding for the second year in a row, affecting homes, businesses, and water sources, and increasing mental health needs. **Leaders from THRIVE and a multi-sector partnership quickly coordinated a flood response**, earning the 2024 Vermont Public Health Champion Team Award.
- **CVMC promoted Job Shadow programs** with local high schools and a newly renovated clinical classroom to enhance learning. Staff dedicated thousands of hours mentoring students and non-traditional learners.

- **CVPC continued to fight stigma around substance use and secured a 5-year and $1.875 million SAMSHA (Substance Abuse and Mental Health Services Administration) grant**: FUTURE VT-Families Uniting to Understand and Resolve Substance Use Effects in Vermont.
- **CVMC employees hosted Bosom Buddies**, a monthly breastfeeding support group in Montpelier.
- **Project BEACON** strengthened relationships between EMS, recovery, and harm reduction, fostering collaboration at the state level. About 25 EMS providers trained in Project BEACON, 100 in "Caring for People Who Use Drugs," and 75 attended Stephen Murray's keynote.
    - Among overdose survivors who refused transport to the CVMC Emergency Department, 88% accepted a Leave Behind Kit, 62% received BEACON kits, and 15 phones were distributed.
- **The NaloxBox Project** installed 18 boxes at three locations and co-hosted overdose prevention training for 30 food pantry managers. Established three sites to always have naloxone available.

Priority Area: Diversity, Equity, and Inclusion

Goal: Create a care environment that honors the diversity of our community, continually expands cultural knowledge, and adapts services to meet the culturally unique needs of patients, Woodridge residents, staff and our community.

Key Accomplishments:

- Created safe, inclusive spaces for leaders, staff, providers, and community members to connect and learn through cross-cultural trainings – like the Human-to-Human course for new employees – and practical tools to navigate challenging situations.
- Recruited Patient and Family Advisors (PFA) to sit on committees and bring the patient experience to improvement efforts. In 2024, CVMC expanded PFA engagements by 51%, exceeding FY2024 goal of 25%, with more than 41 engaged.
- Implemented and tracked patient experience surveys to ensure BIPOC community members receive equitable care at CVMC. Implemented new internal dashboard for patient concerns, tracking events related to elements of diversity, equity or inclusion.
- Implemented a process to assess and collect sexual orientation and gender identity (SOGI) data and race ethnicity and language (REal) data upon admission.
- Received a grant through the Vermont Program for Quality in Health Care to address disparities in rates of screening for colon cancer among Medicaid patients. Early results showed increased use of fecal immunochemical tests (FIT), improving access to lower-barrier screening options.
- Reviewed hospital-wide services to incorporate culturally and linguistically appropriate services. CVMC utilized both in-person interpreters as well as iPads to incorporate televideo interpreters for non-English speaking individuals

- Through their VTCHEP Grant, CVMC and THRIVE supported active listening and learning sessions with diverse stakeholders to encourage and seek input to improve health equity.
- Modified recruitment and hiring processes to attract and support diverse staff and invested in workforce career ladders for entry-level positions (e.g., Medical Assistant, Licensed Nurse Assistant, Licensed Practical Nurse, Respiratory Therapy).
- Grew workforce pipelines, including international staff recruitment, to shepherd diverse candidates through hiring and successful long-term employment. CVMC has signed a contract with Avante to source international RNs.

- Nutrition and Food Services department launched an initiative to offer cultural recognition of cafeteria meal offerings throughout the year.
- Implemented HR collection of staff diversity data to better understand existing workforce dimensions of diversity and measure meaningful change overtime.
- Implemented purchasing goods from local and diverse vendors. Locally sourced food vendors include Maple Wind Farm, Paul Mazza Produce, Cabot Creamery, Black River Produce and Meats, and MacKenzie Meats, among others
- Participate in the Vermont Fresh Network, as well as the Healthy Food in Health Care Pledge through the “Health Care Without Harm” national organization
- Supported the Washington County Crisis Intervention Team.

Priority Area: Chronic Disease Prevention

Goal: Identify barriers and change processes to ensure equitable access to healthcare and community-based services.

Key Accomplishments:

- Continued to support the development and implementation of the UVMHN Population Health Service Organization and associated High Value Care workflows. Screenings for SDoH and behavioral health concerns have been standardized and captured discretely within the medical record. Risk-based algorithms are being leveraged to assign patients into a value-based care pathway and align scheduled visit volumes, care management and additional resources to support the patient in managing their health, based on their level of need.
- Promoted use of e-consults to improve access to specialty care. Rather than placing a referral and waiting for the patient to be seen, a provider can send a targeted question to a specialist and receive a response they can incorporate into their care plan, avoiding further delays.
- Primary care practices have added RN care managers who are using clinical care pathways to engage with patients and additional care team members, such as a diabetes educator or wellness coach, to navigate with the patient towards better health.

- Launched 12 evidence-based Healthy Living workshops aimed at improving health and wellbeing. Workshops focused on conditions of High Blood Pressure, Chronic Pain Management, Diabetes Prevention, Diabetes Self-Management and Tobacco Cessation.
- Worked with local partners at CVHHH, WCMHS, Woodridge and local SNFs to improve care coordination and transitions of care to get patients to the appropriate care setting and reduce hospital readmissions.
- VMC Women's Health and Washington County Mental Health have worked to ensure access to doula support services for pregnant individuals during and after delivery to support healthy families. All patients are screened for SDoH and teams work to connect patients to resources when needs are identified.
- CVMC supported convening teams and the participation of 198 employees in the Vermont Corporate Cup Challenge, covering registration fees and providing CVMC T-shirts.
- Provided virtual trainings to improve cultural competence of providers and adopt inclusive healthcare environments (e.g., Med SafeZone, a facilitator-led LGBTQIA+ health course that has been reviewed by our Pride Center of Vermont partners).
- Provided education and guidance on how to care for wounds due to Xylazine. Trainings included Xylazine 101 for CVPC members and wound care for 40 clinicians. A low-barrier care site was established and materials were compiled into a repository for stakeholders to access.
- CVMC received primary stroke certification from the Joint Commission.

Priority Area: Mental Health

Goal: Strengthen and support community initiatives that promote mental wellness, recovery and resilience.

Key Accomplishments:

- CVMC joined the state Community Health Team (CHT) Expansion pilot via the Vermont Blueprint for Health. The aim is to increase screening for mental health concerns and SDoH among our population to improve access to mental healthcare and initiate interventions.
- CVMC adopted the model of Primary Care Mental Health Integration in all its primary care clinics, recognizing conditions like anxiety and depression are common and impact overall health. Primary care providers have access to psychiatric consultation and a collaborative care mental health clinician who works with the care team and patient to develop and track progress through an individualized care plan.
- Offered an Employee Assistance Program (EAP) with numerous opportunities for staff to participate in workplace wellness events. 'Headspace' offered as an accessible resource to support healthy lifestyles.

Priority Area: Social Drivers of Health

Goal: Strengthen and support community initiatives that create social conditions that promote health.

Key Accomplishments:

- Standardized screening for SDoH in primary care sites as well as the inpatient hospital. When a need is identified our team of care managers work with the patient as well as community organizations to overcome barriers for that patient to have the ability to live a healthy life.
- CVMC was awarded a $10,000 grant to partner with Community Rides Vermont to provide community members with transportation to medical appointments using Gopher, a transportation service with a fleet of zero- emission electric vehicles serving central Vermont. In the first 6 months of the partnership around 50 individuals were served, covering a span of nearly 950 miles.
- Expanded from three SASH housing sites to all six SASH sites in Barre for a total of 12 sites this year. Despite the repeated flooding in Barre this year, the program continued without interruption.
- Served as the convener for THRIVE, the regional Accountable Community for Health, meeting monthly, or more frequently, to connect on community needs, strategies underway and identify opportunities for additional support or advocacy.
- Partnered with THRIVE to implement the Barre area Working Communities Challenge to lower the rate of single female heads of household in poverty.
- Partnered with the Vermont Youth Conservation Corps to continue the Health Care Share program to connect patients with fresh local food:
    - Provided shares from June-October, never missing a week, even during the floods. Expanded from nine to 12 distribution sites, and increased shared from 165 in 2023 to 199 in 2024, reaching a total of 419 household members..
- Partnered with the Vermont Foodbank to sponsor monthly Veggie Van Go food distribution on the 4th Friday of the month. A total of 5,646 households were served in 2024.
- Partnered with Green Mountain United Way and United Way of Northwest Vermont to be a Working Bridges employer site. United Way's Working Bridges is an innovative program designed to improve job retention, stability, and advancement by supporting employees and students with community resources. Using the workplace to connect with employees directly, Working Bridges helps working Vermonters achieve financial, resource, and emotional stability, while supporting human resource departments, reducing employee turnover, and increasing productivity and workplace safety.

BY THE NUMBERS

5,646

Households served by CVMC-sponsored monthly Vermont Food-bank Veggie Van Go distribution

419

Household members in 2024 through the **Health Care Share program,**

"We ate healthier this summer than we ever have. I'm a single mom with three kids on Reach Up, so food is always hard."

— Healthcare Share Participant

89%

Participants agreed or strongly agreed with the statement:

"I am more confident in my ability to eat healthy foods"

Priority Area: Substance Use Disorders

Goal: Build a seamless network where anyone can access substance use support anytime, preventing initiation and promoting recovery.

Key Accomplishments:

- CVMC promoted a "community-wide systems" framework for the prevention and treatment of substance use disorders by acting as a convener for CVPC and supporting their monthly meetings and activities, safe harbor initiatives to prevent substance use, elimination of stigma, and addressing equitable access to services.
    - Convened inclusive partners to address regional challenges, eliminate stigma, provide education, and advocate for Central Vermont's needs through a collaborative network. Monthly meetings included 30 organizations, with two new members.
    - In 2024 CVPC completed its first strategic plan, guiding efforts through FY26.
    - Staff presented at national conferences and secured $2M in grants.
    - CVPC aligned with Region 1 for prevention work and helped address substance use concerns after the July 2024 floods.
    - CVPC led initiatives like ROAD, Project BEACON, NaloxBox, Recovery Coaches in the ED, RAM, and Xylazine care.
- Improved access to substance use disorder services and supports along a full continuum of care:
    - Peer recovery/support services in both community and emergency department settings.
    - Access to medication-assisted treatment (MAT) in the emergency department and coordination of follow-up treatment within the appropriate setting.
    - Education and training related to distribution and use of opioid overdose reversal medications, opioid prescribing, chronic pain management, and MAT protocols for prescribing practitioners.
    - The CVMC MAT team, with our community partners, continued strong collaboration to address the impact of problematic substance use.
    - Made efforts to expand clean needle distribution sites and increase easy access to harm reduction kits across our community.
    - CVMC placed an emphasis on training primary care and express care staff and now has nine sites offering harm reduction kits.
    - In collaboration with CVPC, implemented NaloxBox to increase access to emergency use naloxone in community organizations and businesses.
- Supported and collaborated with the Refocus on Alcohol Dependence (ROAD) program, an innovative hub/spoke approach to outpatient detox services. Through October 2023, members of the ROAD team interacted with 253 patients in the CVMC ED presenting with symptoms of alcohol use disorder, of which 17% successfully engaged in treatment through the program.

Next Steps and Board Approval

Thank you to our community partners and residents that provided guidance, expertise, lived experience, and ongoing collaboration to inform the 2025 CHNA and foster collective impact in improving the health and wellbeing of central Vermont residents.

The Community Health Needs Assessment was approved by the Central Vermont Medical Center Board of Directors in August 2025. Following the Board's approval, the CHNA report was made widely available to the public via CVMC's website**.**

A full summary of secondary data findings for the region is also provided on the website and available to our community partners to serve as a resource for grant making, advocacy, and to support their many programs and services.

We value your input on the CHNA. To contact us, please visit our website or email Michelle Gilmour at michelle.gilmour@cvmc.org.

Appendix A: Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

The following is a list of represented community organizations and the participants' respective title, as provided.

Organization	Title/Role
Abenaki Health and Heritage	Programs and Grants Coordinator
Adult Primary care-Barre	Site leader
AIDS Project of Southern Vermont	Outreach Nurse/Overdose Prevention
BAART	Treatment Center Director
Barre City Elementary and Middle School	Registered Nurse
Barre Community Justice Center	Executive Director
Building Bright Futures	Regional Manager
Capstone Community Action	Housing Counselor
Capstone Community Action	Housing Program Manager
Capstone Community Action	Coordinated Entry Specialist
Capstone Community Action	Capstone Community Action
Capstone Community Action	Capstone Community Action
Central Vermont Adult Education	Executive Director
Central Vermont Home Health and Hospice	Medical Social Worker
Central Vermont Home Health and Hospice	CCC
Central Vermont Home Health and Hospice	Staff
Central Vermont Home Health and Hospice	CVHHH
Central Vermont Home Health and Hospice	Physical Therapist
Central Vermont Medical Center	Physical Therapist
Central Vermont Medical Center	Physical Therapist
Central Vermont Medical Center	Rehab Tech
Central Vermont Medical Center	Physical therapist
Central Vermont Medical Center	Physician
Central Vermont Medical Center	Manager
Central Vermont Medical Center	Emergency physician
Central Vermont Medical Center	Physical Therapy
Central Vermont Medical Center	Director of Rehabilitation Services
Central Vermont Medical Center	Tech
Central Vermont Medical Center	Physical Therapist
Central Vermont Medical Center	Occupational Therapist
Central Vermont Medical Center	Physical Therapist
Central Vermont Medical Center	Director of Performance Improvement
Central Vermont Medical Center	Director
Central Vermont Medical Center	Hospitalist
Central Vermont Medical Center	Director
Central Vermont Medical Center	Administrator
Central Vermont Medical Center	Per diem Physician IP/OP
Central Vermont Medical Center	Director
Central Vermont Medical Center	Nurse Director

Central Vermont Medical Center	Department Director
Central Vermont Medical Center	Director
Central Vermont Medical Center	Director of Nursing Education and Workforce Development
Central Vermont Medical Center	MD
Central Vermont Medical Center	CNC
Central Vermont Medical Center	Patient Navigator
Central Vermont Medical Center	Behavioral Health Services Manager
Central Vermont Medical Center	Care Coordinator
Central Vermont Medical Center	Care Manager
Central Vermont Medical Center	Psychotherapist
Central Vermont Medical Center	Rehab Supervisor
Central Vermont Medical Center	Nurse
Central Vermont Medical Center	Quality
Central Vermont Medical Center	MD
Central Vermont Medical Center	ED Nurse Manager
Central Vermont Medical Center	Nurse Practitioner
Central Vermont Medical Center	No
Central Vermont Medical Center	Doctor
Central Vermont Medical Center	Physician
Central Vermont Medical Center	CFO
Central Vermont Medical Center	Radiation Oncology Manager
Central Vermont Medical Center	Physician
Central Vermont Medical Center	Clinic Manager
Central Vermont Medical Center	Care Management
Central Vermont Medical Center	Case Manager
Central Vermont Medical Center Rehabilitation Therapy	Patient Services Specialist
Central Vermont Medical Center Rehabilitation Therapy	Rehab Support Specialist
Central Vermont Medical Center/University of Vermont	Physician
Central Vermont Medical Center-Rehab	Front Office Manger
Central Vermont Prevention Coalition	Coordinator
Central Vermont Regional Planning Commission	Central Vermont Regional Planning Commission
Central VT Home Health & Hospice	Administration
Christ Episcopal Church and Vermont Interfaith Action	Deacon and shelter organizer
Church of the Good Shepherd	Pastor
Circle	Shelter Coordinator
Circle	Chair, Board of Directors
City of Montpelier	City Manager
Department of Children and Families/Economic Services	District Director
Downstreet Housing and Community Development	Director of Property Management
Downstreet Housing and Community Development	Housing Director
Downstreet Housing and Community Development	Operations Manager
Downstreet Housing and Community Development	Director of Homeless Services
Downstreet Housing and Community Development	Property Manager
Downstreet Housing and Community Development	Resident Services
Downstreet Housing and Community Development	Development Manager
Downstreet Housing and Community Development	Capital Needs Coordinator

Downstreet Housing and Community Development	Facilities manager
Downstreet Housing and Community Development - SASH	SASH Coordinator
Elevate Youth Services	Executive Director
Family Center of Washington County	Family Supportive Housing service coordinator
Family Center of Washington County	Early Intervention
Family Center of Washington County	Housing Case Manager
Family Center of Washington County	Director
Family Center of Washington County	Family Engagement Specialist
Family Center of Washington County	Community Development Manager
Gifford Health Care	Clinical Care Coordinator Care Team Lead
Good Samaritan Haven	Street Outreach, Health and Safety
Good Samaritan Haven	Deputy Director
Good Samaritan Haven	Crisis Interventionist
Good Samaritan Haven	Executive Director
Good Samaritan Haven	Director of Administration
Good Samaritan Haven	Director of case management
Good Samaritan Haven	Eligibility and Data Specialist
Good Samaritan Haven	Street Outreach Worker
Green Mountain United Way	Working Bridges Resource Coordinator
Green Mountain United Way	Resource Coordinator
Green Mountain United Way	Director of Development & Community Engagement
Green Mountain United Way	Director of Community Impact
Green Mountain United Way	Executive Director
Hannah's House	Executive Director
Mad River Glen	Ski coach
Mad River Seniors	Board Member
Mad River Valley Ambulance - MRVAS	EMT
Mad River Valley Health Center	Admin
Mad River Valley Interfaith Council	Volunteer at Community Pantry
Montpelier Community Justice Center	Restorative Programs Coordinator
Montpelier Community Justice Center	Director
Montpelier Community Justice Center	Volunteer
Montpelier Community Justice center	Volunteer
Montpelier Community Lunches - interfaith food group	Monday site manager
Montpelier Food Pantry	Volunteer
Montpelier Housing Authority	Executive Director
Mosaic	Director of Social Change
National Alliance on Mental Illness Vermont	Executive Director
Northeast Washington County Community Health	Chief Operation Officer
People’s Health and Wellness Clinic	APRN
People’s Health and Wellness Clinic	Registered Dental Hygienist & Oral Health Care Manager
People’s Health and Wellness Clinic	Physician Volunteer
People’s Health and Wellness Clinic	Volunteer RN
People’s Health and Wellness Clinic	Community Resource Manager
People’s Health and Wellness Clinic	People's Health and Wellness
People’s Health and Wellness Clinic	Volunteer Nurse

People’s Health and Wellness Clinic	Clinical Director
People’s Health and Wellness Clinic	Volunteer MD
People’s Health and Wellness Clinic	RN volunteer
People’s Health and Wellness Clinic	Family Nurse Practitioner - Volunteer
People’s Health and Wellness Clinic	Volunteer PA
Private Citizen	None
Rainbow Bridge Community Center	Executive Director
Restorative Justice	Panel Member, Volunteer
River Rock Treatment	Director
State of Vermont - Department of Health, Barre	Public Health Specialist II
The University of Vermont Medical Center	Patient Care Coordinator
The Vermont Association for Mental Health and Addiction Recovery	Director of Communications
Town of Washington	Town Clerk
Town of Woodbury	Select Board (elected)
Town of Worcester	Town Clerk
Treatment Associates, a Division of Washington County Mental Health Services	Assistant Director
Turning Point Center of Central Vermont	Recovery Coach
Turning Point Center of Central Vermont	RCED Program Supervisor
Turning Point Center of Central Vermont	Assistant Director
Turning Point Center of Central Vermont	Program and Revenue Development
Turning Point Center of Central Vermont	Certified Recovery Coach
Turning Point Center of Central Vermont	Recovery coach
U32	SAP/Counselor
U-32 Junior-Senior High School	Director of Student Services
U-32 Middle and High School	Administrator
University of Vermont Children's Hospital	Pediatrician
University of Vermont Health Network	RNCM
University of Vermont Health Network	Network Director of Emergency Management, Security, EHS
University of Vermont Health Network - CVMC service area	Resource Coordinator
University of Vermont Health Network at Central Vermont Medical Center	Clinical Practice Manager (outpatient primary care)
University of Vermont Health Network Integrated Care Management (PHSO)	Resource Coordination for Patients in Primary Care offices
University of Vermont Medical Center	WRAP Community Care Liaison
University of Vermont Medical Center	Care Manager
University of Vermont Medical Group	Physician
University of Vermont Mental Health Network	Blueprint Program Manager
University of Vermont Mental Health Network Central Vermont Medical Center	PHSO RN Care Manager
UVMHN/CVMC	Physician, Leader of Express Care; Division Chief of Urgent Care
Valley Reporter	Owner/Editor
Vermont Department of Health	Public Health WIC Supervisor
Vermont Department of Health	Public Health Nurse
Vermont Department of health	Emergency Preparedness Specialist

Vermont Department of Health	WIC Nutritionist
Vermont Department of Health - Barre Local Health Office	Public Health Nurse Supervisor
Vermont Department of Health- Barre Office of Local Health	District Director
Vermont Dept of Health	VT Dept of Health-DSU
Vermont Professionals of Color Network	Executive Director, Community and Policy
Washington Central Unified Union School District	Principal, Calais Elementary School
Washington Central Unified Union School District	School Counselor
Washington Central Unified Union School District	School Counselor
Washington Central Unified Union School District- U32 High School	Administration
Washington County Diversion Program	Executive Director
Washington County Mental Health Services, Inc.	Chief Operating Officer
Washinton County Mental Health Services, Inc.	Wellness-Employee, Client, Community
Working Bridges	Resource Coordinator