Central
New Hampshire
HEALTH
PARTNERSHIP

Community Health Needs Assessment

2017

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

Central New Hampshire Health Partnership
Community Health Needs Assessment
2017

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Central New Hampshire Health Partnership
Community Health Needs Assessment
2017

Executive Summary

During the period May through September 2017, an assessment of Community Health Needs Assessment of the Central New Hampshire region was completed by the Central New Hampshire Health Partnership. The purpose of the assessment was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. For the purpose of the assessment, the geographic area of interest was 18 municipalities comprising the Central New Hampshire Public Health Region with a total resident population of 30,039, and served by the member agencies of the Central New Hampshire Health Partnership (www.cnhhp.org). Methods employed in the assessment included surveys of community residents made available on-line and paper surveys placed in numerous locations throughout the region; a direct email survey of key stakeholders and community leaders representing multiple community sectors; a set of community discussion groups; compilation of results from assessment activities focused specifically on behavioral health needs and gaps; and a review of available population demographics and health status indicators. All information collection activities and analyses sought to focus assessment activities on vulnerable and disproportionately served populations in the region including populations that could experience limited access to health-related services or resources due to income, age, disability, and social or physical isolation. The table below provides a summary of community health needs and issues identified through these methods.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Surveys**	**Community Discussion Groups**	**Community Health Status Indicators**
Alcohol and drug use prevention, treatment and recovery	Prevention of substance misuse, addiction and access to substance misuse treatment and recovery services were the top issues identified by both community survey respondents and key stakeholders	Identified as a high and continuing priority for community health improvement by all community discussion groups	The overall overdose mortality rate in the region was 24.7 per 100,000 people; a mortality rate higher than most types of cancer except lung cancer
Access to affordable health care services and insurance	Availability of affordable health insurance was the next highest priority after substance misuse identified by community and key stakeholder survey respondents	Community discussions noted improvements in insurance access including Medicaid, but still identified cost and health care service availability barriers	The estimated uninsurance rate has declined substantially in the CNHHP service area (from 14% to about 9%),), but still exceeds the overall uninsurance rate estimate for NH (6.4%)
SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Health Issue**	**Community Health Issue**	**Community Health Issue**
Access to mental health services	Access to mental health care was the fourth highest priority identified by community and key stakeholder survey respondents with 63% considering it a 'very high priority'	Identified as a high and continuing priority for community health improvement by all community discussion groups including concerns for insufficient access to inpatient psychiatric care	Medicaid members with a behavioral health condition residing in the region were over 4 times more likely to have had four or more visits to an emergency department in 2015 and twice as likely to have had an unplanned inpatient readmission compared to Medicaid members without a recent claims history indicating a behavioral health condition.
Domestic violence and childhood trauma	Child abuse or neglect and domestic violence were identified as a high priority or very high priority by over a three quarters of community survey respondents	Community discussion group participants reported concerns about the effects of parental substance use on children in the community; also noted a lack of affordable child care options	The proportion of individuals living near or below the poverty level, including 38% of children, is higher in the region compared to the state overall
Access to healthy foods and opportunities for active living	Opportunities for physical activity, recreation, good nutrition and access to health foods cited as a high or very high priority by about two thirds of community and key stakeholder survey respondents	Community discussion groups identified a need for better communication about available health-related activities and resources	55% of adults in the service area are overweight or obese; about 23% of adults report being physically inactive in the past 30 days

Senior services including assisted living or long term care services	Improved resources for assisted living or long term care was the sixth highest priority identified by key stakeholders	Local access to affordable senior housing and assisted living identified by participants in the public health council and senior advisory council	The service area population has proportionally more seniors (17.7% are 65+) compared to NH overall (15.3%)
Access to transportation	Lack of transportation was identified as the fourth most significant barrier keeping people from accessing services by key stakeholders	Access to transportation Identified by all community discussion groups as an underlying and chronic issue impacting access to services and social isolation, particularly for youth and families with limited income	4.1%of households in the CNHHP region report having no vehicle available

Central New Hampshire Health Partnership

2017 Community Health Needs Assessment

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

The total population of the primary service area of the Central New Hampshire Health Partnership in 2015 was 30,039 according to the United States Census Bureau, which is a decrease of -1.9% or about 600 people since the year 2010. The FY2017 Community Health Needs Assessment Survey conducted by the Central NH Health Partnership yielded 409 individual responses of which 88% were residents of towns within the primary service area or approximately 1.5% of the total adult population. As shown by Table 1, survey respondents from the service area are represented in relatively close proportion overall to the service area population by town. It is also important to note that FY2017 survey respondents were more likely to be female (74.8% of respondents) and older (29.5% age 65 years or more) compared to the overall adult population in the service area.

Table 1: Service Area Population by Town;
Comparison to Proportion of FY2017 Community Survey Respondents

	2015 Population	Zip Code*	% Service Area Population	% of Respondents
CNNHP Service Area	**30,039**			
Plymouth, Bridgewater	7382	03264	24.6%	22.4%
Bristol, Alexandria, Bridgewater	5520	03222	18.4%	14.8%
Campton, Ellsworth	3366	03223/19	11.2%	10.6%
Holderness	2174	03245	7.2%	7.4%
Rumney	1611	03266	5.4%	6.9%
Thornton	2104	03285	7.0%	6.3%
Ashland	2196	03217	7.3%	4.7%
Hebron, Groton	1259	03241	4.2%	4.7%
Lincoln, Livermore	1345	03251	4.5%	4.0%
Woodstock	1054	03262	3.5%	1.8%
Wentworth	941	03282	3.1%	1.8%
Warren	873	03279/38	2.9%	1.9%
Waterville Valley	214	3215	0.7%	0.8%
Other / Unknown	New Hampton (2.4%), Meredith (1.1%), Danbury (1.1%), Laconia			11.9%

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

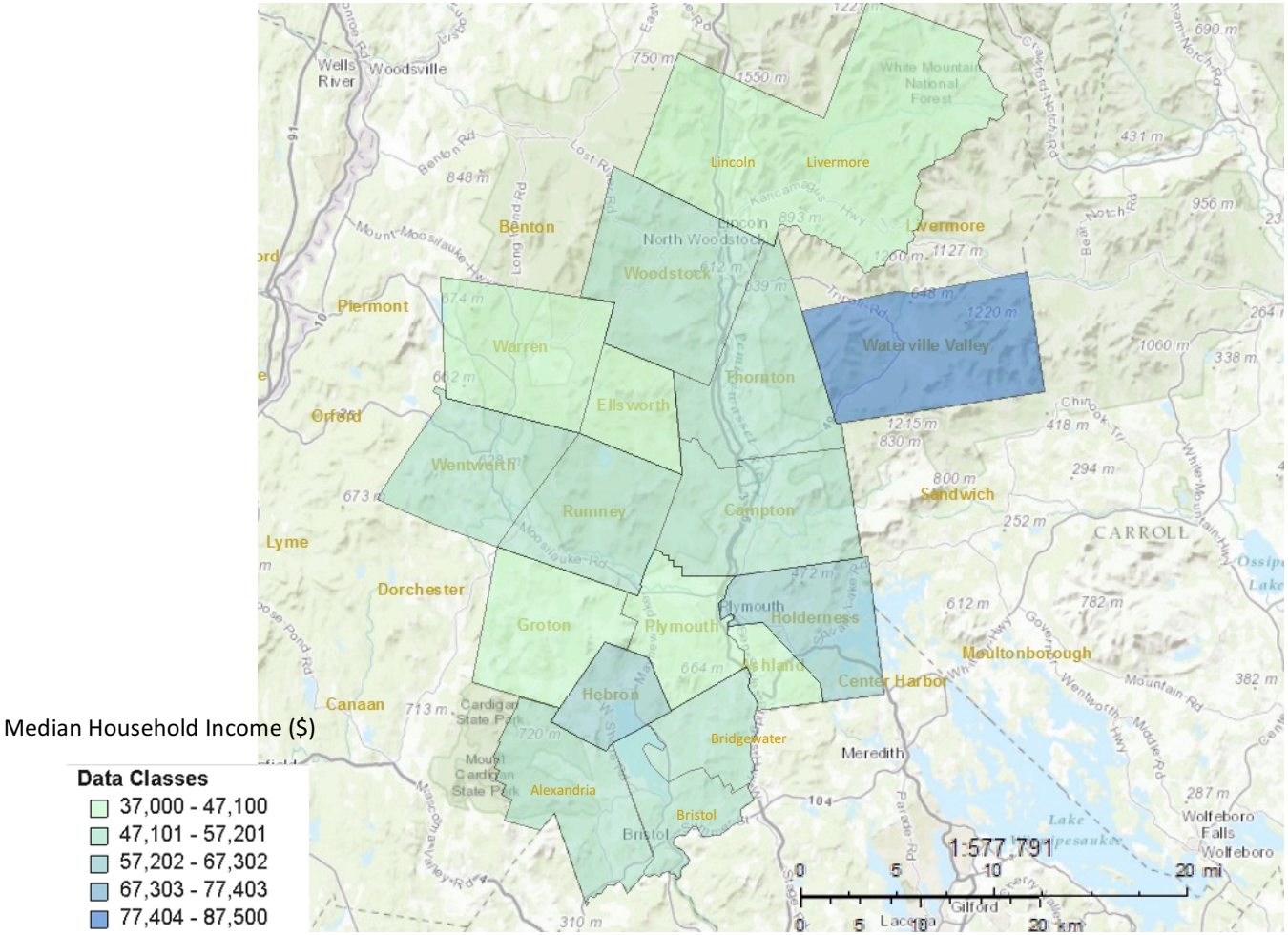
Table 2 below displays additional demographic and economic information for the towns of the CNHHP Service Area. On this table, municipalities are displayed in order of median household income with comparison to the median household income in the region and state overall. As displayed by the table, all towns in the service area except Waterville Valley have lower median household incomes than the State of New Hampshire overall. In addition, all except 3 towns have a higher proportion of individuals with household incomes at 200% of the federal poverty level or less when compared to the state overall. Figure 1 following this table displays a map of the service area with shading depicting the median household income by town in 5 categories from low to high median household income.

Table 2: Selected Demographic and Economic Information

	Median Household Income	% with income under 200% Poverty Level	% family households with children headed by a single parent	% population with a disability
Ellsworth	$37,000	23.2%	0.0%	14.3%
Lincoln	$37,095	49.6%	78.4%	20.7%
Plymouth	$40,745	42.9%	16.3%	9.9%
Warren	$40,769	47.7%	43.5%	19.0%
Groton	$43,846	36.2%	43.2%	17.2%
Ashland	$45,938	31.0%	32.8%	18.6%
Woodstock	$49,063	25.8%	44.8%	12.0%
Bristol	$50,080	29.1%	49.8%	13.8%
CNNHP Service Area	**$50,872**	**31.5%**	**30.1%**	**13.4%**
Rumney	$51,250	29.5%	39.4%	14.7%
Wentworth	$54,306	34.5%	9.6%	16.9%
Alexandria	$55,066	30.4%	12.6%	16.0%
Bridgewater	$55,500	16.8%	27.3%	17.4%
Thornton	$56,058	15.7%	12.8%	14.1%
Campton	$56,429	25.1%	29.0%	10.7%
Hebron	$57,222	38.7%	53.7%	13.1%
Holderness	$59,079	25.5%	24.0%	8.7%
New Hampshire	**$66,779**	**22.3%**	**29.1%**	**12.1%**
Waterville Valley	$87,500	7.0%	35.7%	6.5%

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

2009-2013 American Community Survey; Map source: American Factfinder



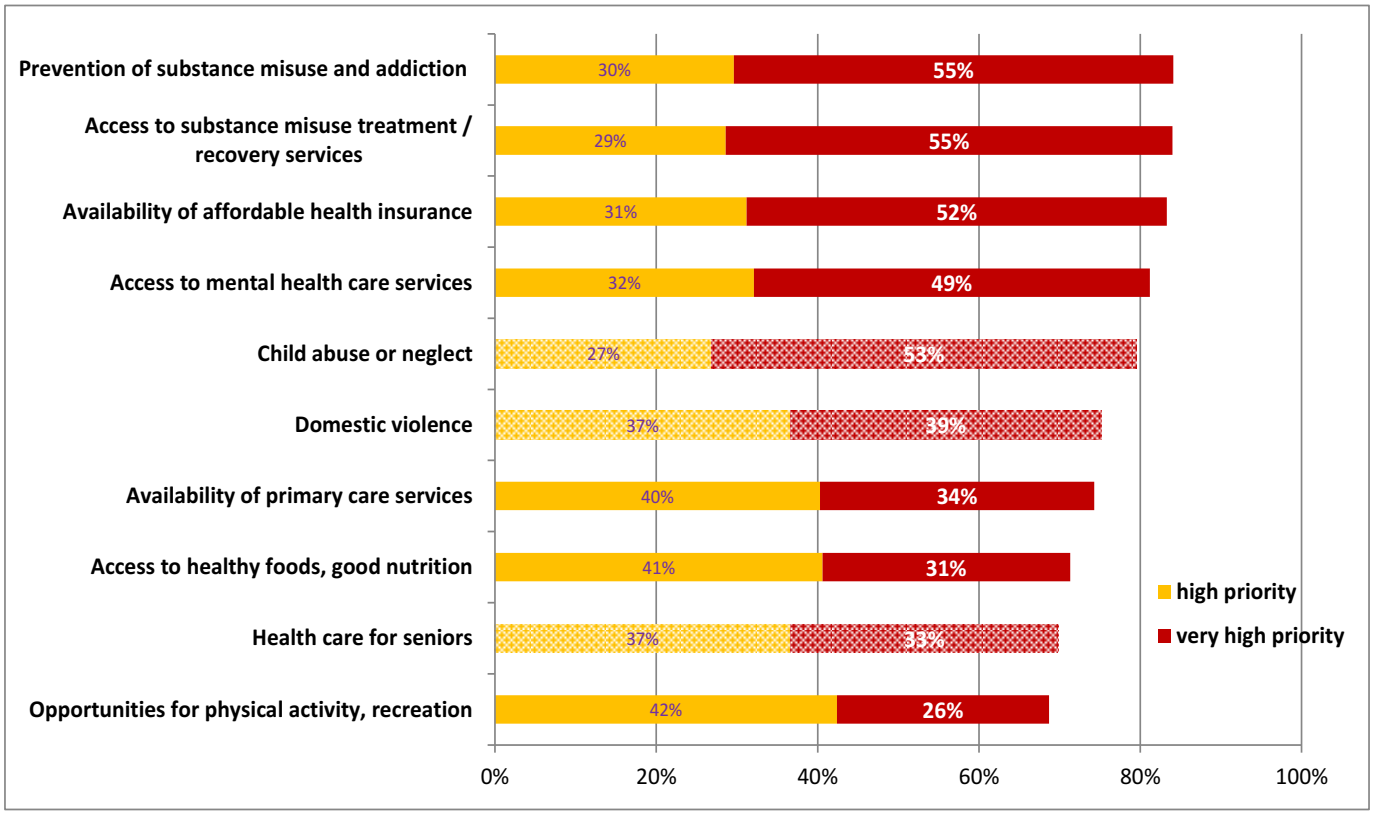
1. Most Important Community Health Issues Identified by Community Survey Respondents

Community respondents to the 2017 Community Health Needs Survey were presented with a list of 13 health-related topics that have been identified as priorities in previous community health assessments in the Central New Hampshire region. For each topic, respondents were asked to indicate the extent to which they thought it should remain a priority for community health improvement work relative to other potential priorities. A second question presented respondents with a list of 13 more topics, including and "other' write-in option, that could be considered priorities for the Central New Hampshire region. Respondents were then asked to indicate the extent to which they thought each topic should become a priority for community health improvement work relative to other potential priorities.

Table 3 on the next page displays the top priority topics for health improvement efforts identified by community respondents. The topics displayed with solid colors are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring are topics that rose to a high level priority from the second set of potential topics. The chart displays the percentage of respondents indicating the topic as a high priority or very high priority (needs are mostly unmet). Other response choices were moderate priority, somewhat low priority and low priority (needs are mostly met).

Substance misuse prevention, treatment and recovery, availability of affordable health insurance, and access to mental health services are each top priorities from prior community health needs assessments that remain among the highest priorities. Child abuse or neglect and domestic violence are two high priorities not specifically identified in prior needs assessments, although 'fragile families and reduction of family stress' is a related topic that was previously identified as a high priority for community health improvement efforts.

Figure 2: High Priority Community Health Issues; Community Respondents



The table below displays the top 5 community health improvement priorities identified by community survey respondents by age group. The percentages shown are the total percentages within each age group selecting the topic as a high priority or very high priority. Among respondents age 65 years or older, 'availability of primary care services' and 'health care for seniors' were higher on the list compared to other age groups, while 'access to substance misuse treatment and recovery services' was reported as a higher priority (relatively) by younger age groups, as was 'child abuse or neglect'.

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

18-44 years	n=126	45-64years	n=149	65+ years	n=115
Access to substance misuse treatment and recovery services	80.2%	Prevention of substance misuse and addiction	87.7%	Availability of affordable health insurance	90.8%
Prevention of substance misuse and addiction	77.6%	Access to mental health care services	87.2%	Availability of primary care services	87.1%
Availability of affordable health insurance	75.4%	Access to substance misuse treatment and recovery services	87.1%	Prevention of substance misuse and addiction	87.0%
Child abuse or neglect	74.4%	Availability of affordable health insurance	84.5%	Access to mental health care services	87.0%
Access to healthy foods, good nutrition	72.6%	Child abuse or neglect	79.6%	Health care for seniors	86.4%

The table below displays the top 5 community health improvement priorities identified by community survey respondents by income group. As with the previous table, the percentages shown are the total percentages within each age group selecting the topic as a high priority or very high priority. Among respondents with household income less than $25,000, 'availability of affordable health insurance' and 'availability of primary care services' were higher on the list (relatively) compared to other income groups. Access to mental health care and substance use treatment services were rated higher by respondents in the middle and upper income groups.

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

Less than $25,000	n=95	$25,000 to $74,999	n=129	$75,000 or more	n=143
Availability of affordable health insurance	80.0%	Access to mental health care services	90.3%	Prevention of substance misuse and addiction	90.0%
Child abuse or neglect	77.6%	Access to substance misuse treatment and recovery services	87.1%	Access to substance misuse treatment and recovery services	89.3%
Availability of primary care services	76.3%	Availability of affordable health insurance	86.4%	Access to mental health care services	86.6%
Prevention of substance misuse and addiction	75.8%	Prevention of substance misuse and addiction	85.4%	Access to healthy foods, good nutrition	80.9%
Domestic violence	75.8%	Child abuse or neglect	83.6%	Availability of affordable health insurance	80.8%

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

In addition to the survey of community residents, the 2017 Community Health Needs Assessment included a similar survey sent by direct email to key stakeholders and community leaders from around the region. A total of 51 completed responses were received (56.7% response rate) representing the following community sectors.

Table 5: Key Stakeholder Survey Respondents

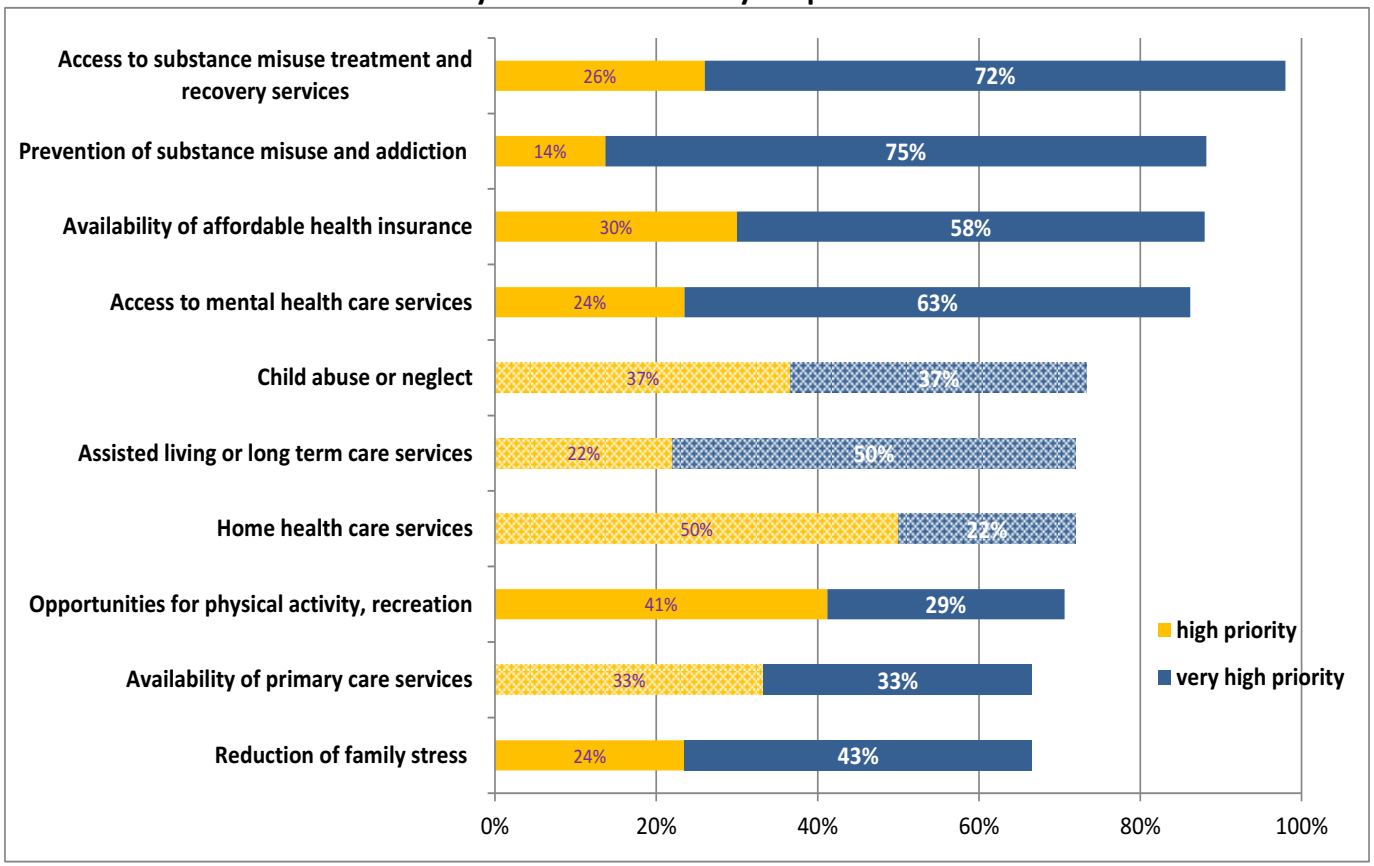
Percent of Respondents	Community Sector
25.5%	Community member / Volunteer (13 respondents)
19.6%	Business (10)
17.6%	Primary Health Care (9)
15.7%	Education / Youth Services (8)
13.7%	Municipal / County Government (7)
11.8%	Public Health (6)
11.8%	Faith organization (6)
9.8%	Fire / Emergency Medical Service (5)
9.8%	Public Safety / Law / Justice (5)
9.8%	Human Service / Social Service (5)
5.9%	Mental Health / Behavioral Health (3)
3.9%	Home Health Care (2)
3.9%	Civic / Cultural Organization (2)
2.0%	Medical Sub-Specialty (1)

Respondents to the key stakeholder survey were presented with the same two lists of health-related topics: the list of topics identified as priorities in previous community health assessments in the Central New Hampshire region; and a second list of topics (including 'other') that could be considered priorities for health improvement efforts in the region. The chart on the next page displays the results of these questions from key stakeholder responses.

The top four issues identified by key stakeholders are the same as those identified by community respondents; with even higher priority ratings for substance misuse prevention, treatment and recovery (approximately 3 of every 4 key stakeholder respondents

identified these areas as very high priority). Key stakeholders were more likely to identify assisted living, long term care and home health care as high priorities (relatively) compared to community survey respondents.

Figure 3: Community Health Improvement Priorities
Key Stakeholder Survey Respondents



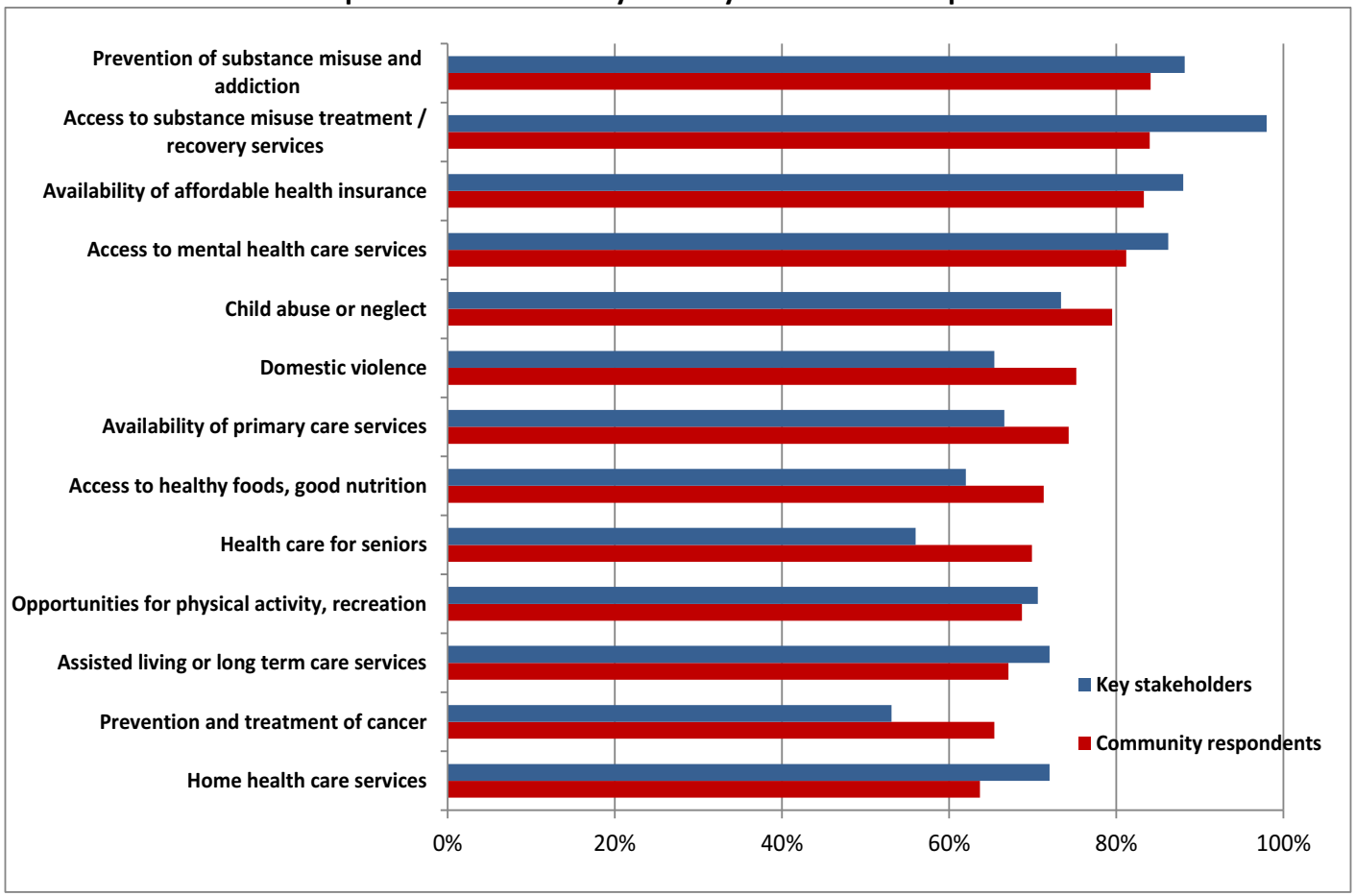
Low Priority	Somewhat Low Priority	Moderate Priority	High Priority	Very High Priority

Needs are Mostly Met ⟷ Needs are Mostly Unmet

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

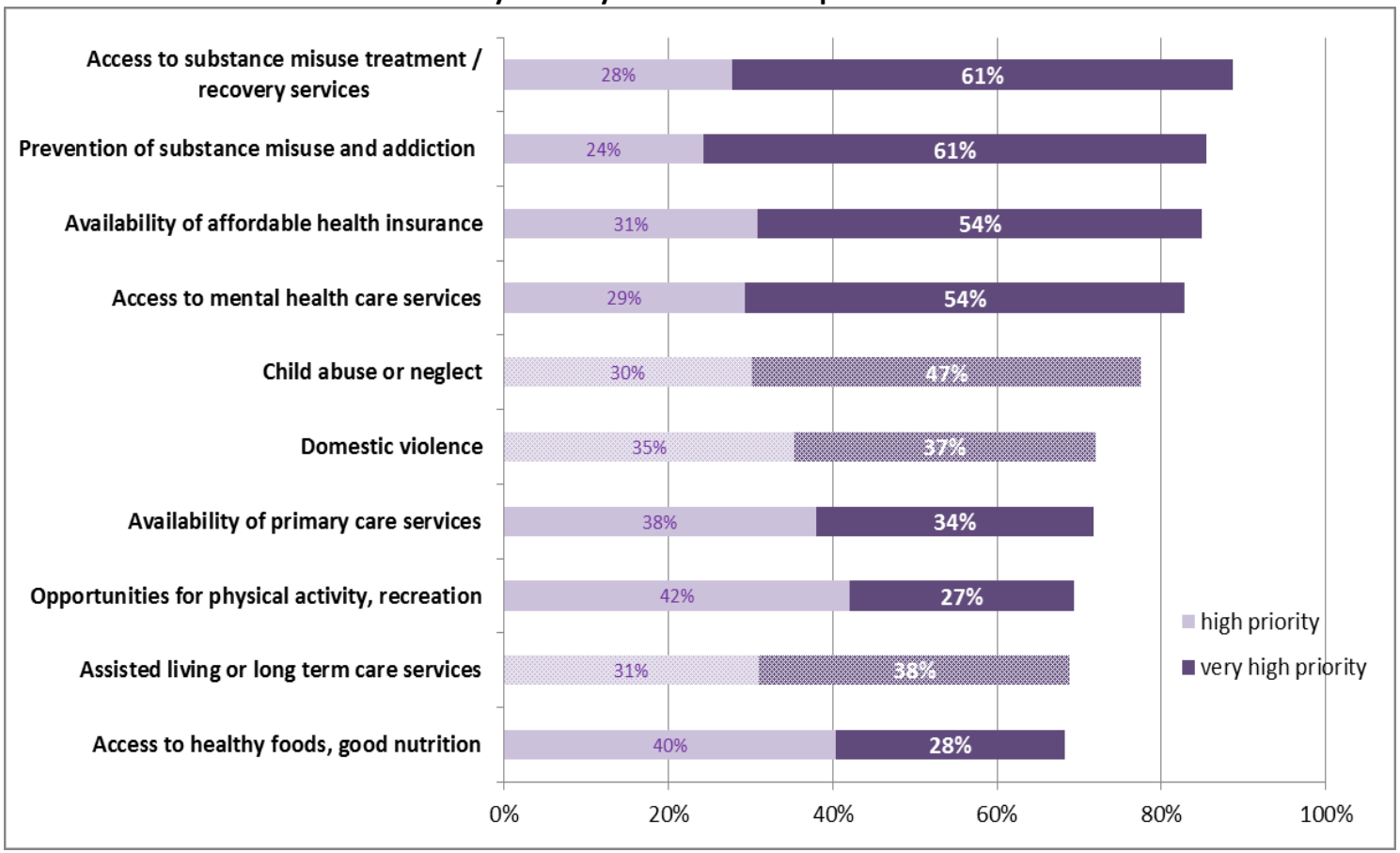
The chart below displays a comparison of the responses between community and key stakeholder surveys for the highest priority community health issues. Blue bars on the chart display the percentage of key stakeholders selecting the topic as high priority or very priority and red bars display the results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

Figure 4: Community Health Improvement Priorities
Comparison of Community and Key Stakeholder Respondents



The chart below displays the combined results from the questions on community health improvement priorities from the perspective of community and key stakeholder survey respondents. The response percentages from community respondents were given double weight in the computation of combined responses. The top 10 community health priorities are displayed. As in previous charts, bars depicted with solid color are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring (child abuse or neglect, domestic violence, assisted living or long term care services) are topics that rose to a high priority from the second set of potential topics.

Figure 5: Community Health Improvement Priorities
Community and Key Stakeholder Responses Combined

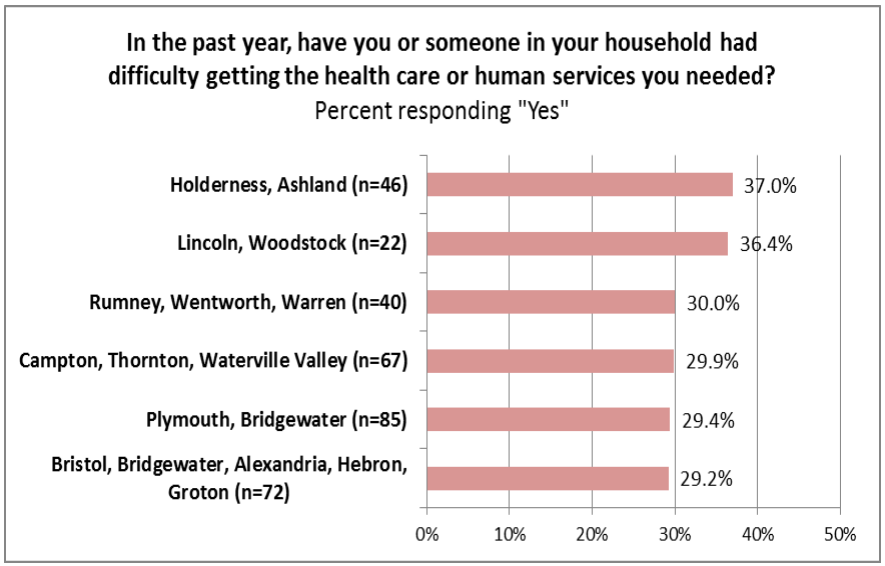


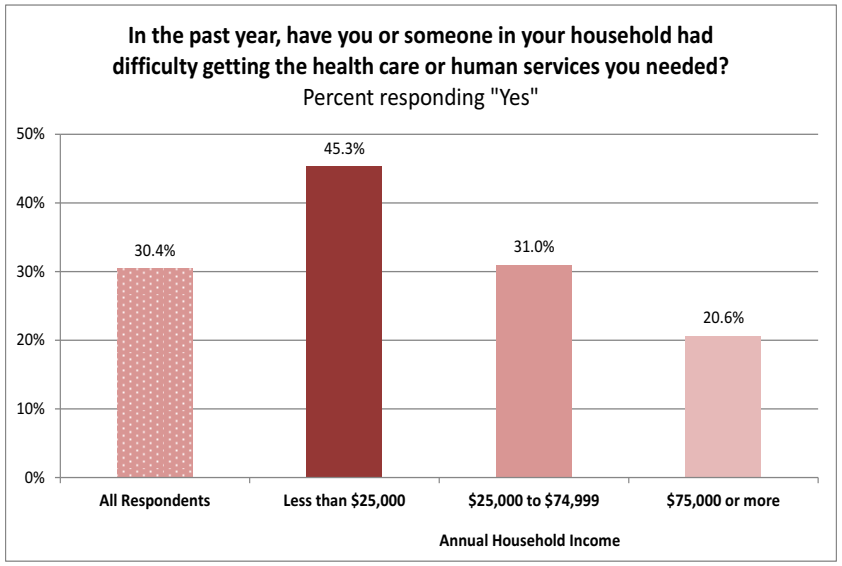
4. Barriers to Services Identified by Community Survey Respondents

Respondents to the FY2017 Community Needs Assessment Survey were asked, "In the past year, have you or someone in your household had difficulty getting the health care or human services you needed?" Overall, 30.4% of survey respondents indicated having such difficulty. As Figure 6 displays, there is a significant relationship between reported household income category and the likelihood that respondents reported having difficulty accessing services. Figure 7 examines responses to this question by sub-region within the CNHHP service area. In general, the proportion of respondents indicating difficulty accessing services was similar across the region.

Figure 6: Access to Services
Community Survey Responses

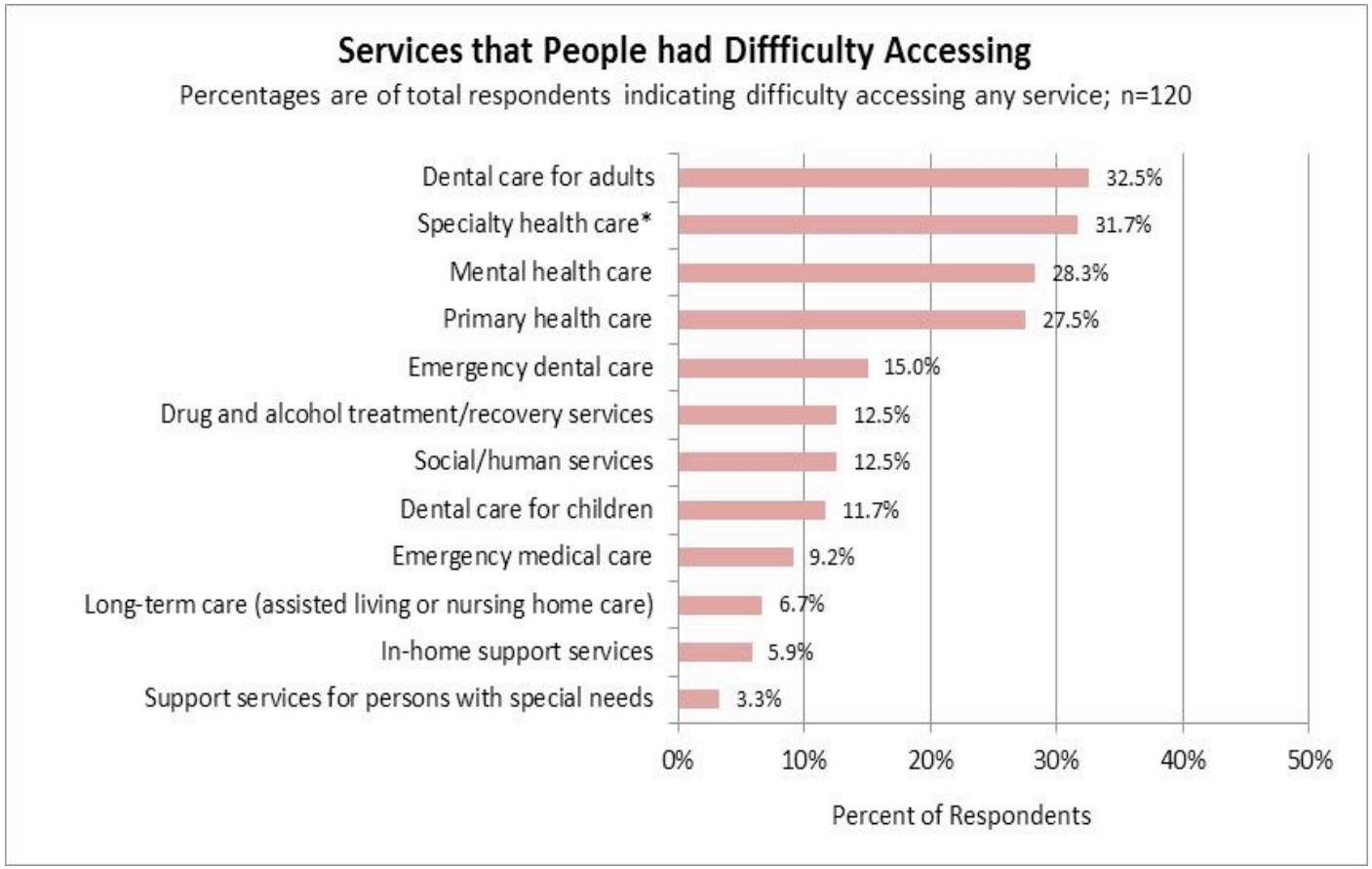
Figure 7: Access to Services
by sub-region


In the past year, have you or someone in your household had difficulty getting the health care or human services you needed?
Percent responding "Yes"
Holderness, Ashland (n=46)
37.0%
Lincoln, Woodstock (n=22)
36.4%
Rumney, Wentworth, Warren (n=40)
30.0%
Campton, Thornton, Waterville Valley (n=67)
29.9%
Plymouth, Bridgewater (n=85)
29.4%
Bristol, Bridgewater, Alexandria, Hebron, Groton (n=72)
29.2%
0%
10%
20%
30%
40%
50%


In the past year, have you or someone in your household had difficulty getting the health care or human services you needed?
Percent responding "Yes"
50%
40%
30%
20%
10%
0%
30.4%
45.3%
31.0%
20.6%
All Respondents
Less than $25,000
$25,000 to $74,999
$75,000 or more
Annual Household Income

The survey also asked people to indicate the areas in which they had difficulty getting services or assistance. As displayed by Chart 3, the most common service types that people had difficulty accessing were: dental care for adults (32% of those respondents indicating difficulty accessing any services); specialty health care (32%); primary health care (28%) and mental health care (28%). Note that percentages on this chart are of the subset of respondents who indicated any difficulty accessing services (30% of all respondents; n=120).

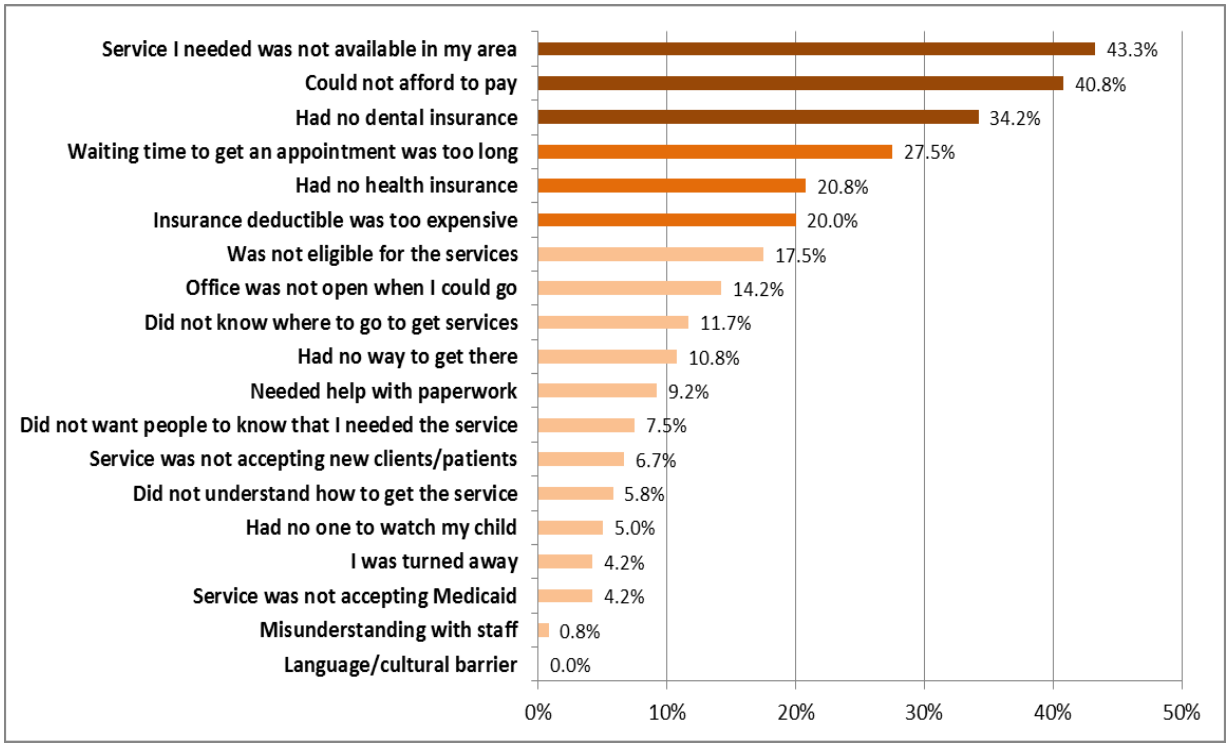
Figure 8



In a separate question, 43.9% of survey respondents indicated that 'they or someone in their household had to travel outside of the local area to get the services they needed in the past year'. In an open-ended follow-up question, orthopedic care, cancer treatment, dental care, dermatology and mental health care were the most commonly cited services for which people were traveling outside of the area. (See Appendix A for complete survey responses.)

Respondents who reported difficulty accessing services in the past year for themselves or a family member were also asked to indicate the reasons why they had difficulty. As shown on Figure 9, the top reasons cited were: 'service I needed was not available in my area' (43%); 'could not afford to pay' for the service (41%); and 'had no dental insurance' (34%). Percentages are again calculated from the subset of respondents who indicated difficulty accessing services.

Figure 9: Access Barriers
Perspectives of Community Respondents



Further analysis of these two questions addressing access to specific types of services is shown by Table 6. Among respondents indicating difficulty accessing adult dental care, the top reason indicated for difficulty accessing services was 'had no dental insurance'(76%), followed by could not afford to pay' (73%). Similarly, among respondents indicating difficulty accessing primary care services, the top reasons cited were also related to affordability and lack of health insurance. Among respondents indicating difficulty accessing specialty health care and mental health care, the top reason cited for access difficulties was 'service I needed was not available in my area (74% and 53% respectively) and 'waiting time to get an appointment' was also frequently associated with respondents indicating access difficulties in these two areas. This suggests that available service capacity is a more significant access barrier for mental health and specialty medical services (relatively) compared to dental care and primary health care where the top challenges are associated with insurance and affordability.

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

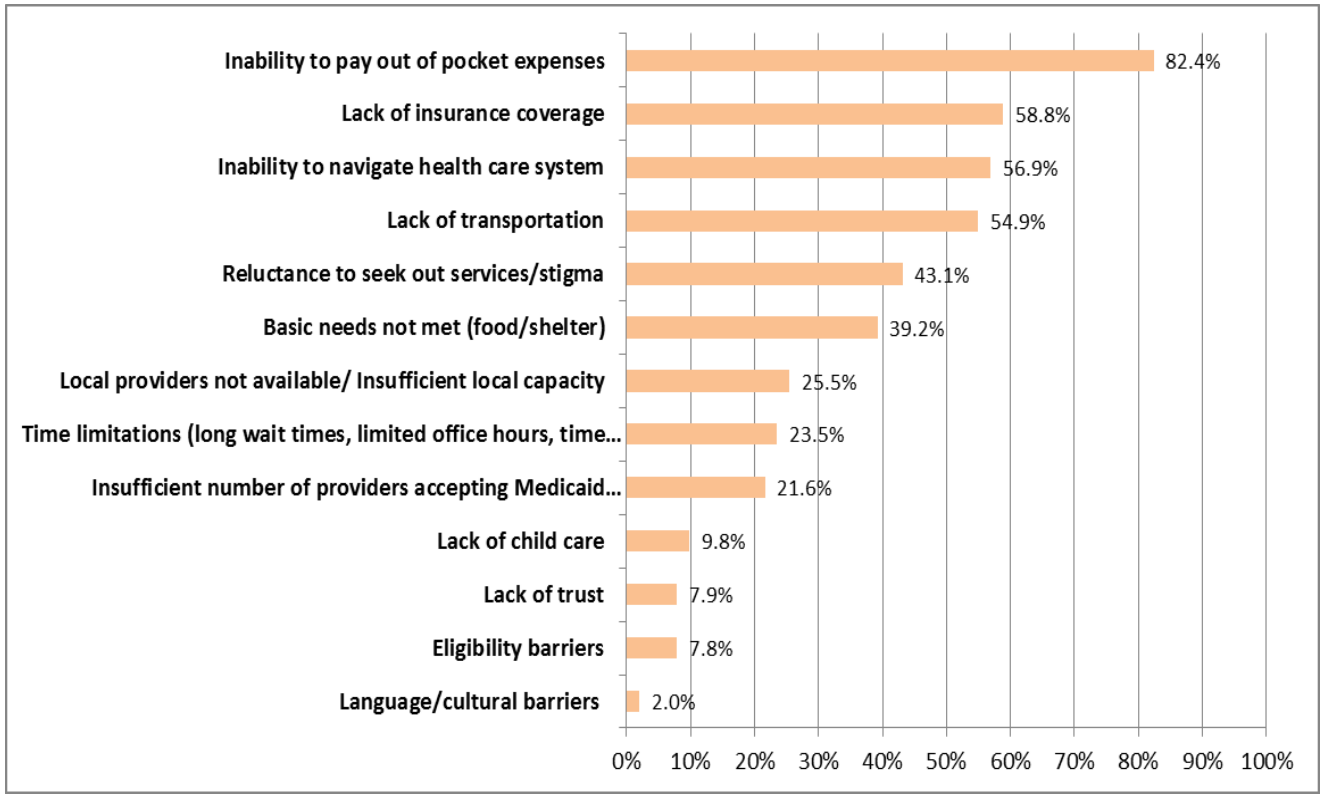
(Percentage of respondents who reported difficulty accessing a particular type of service)

Dental Care for Adults (n=41, 10.0% of all respondents)	Specialty Health Care (n=38, 9.3% of all respondents)	Mental Health Care (n=34, 8.3% of all respondents)	Primary Health Care (n=33, 8.1% of all respondents)
75.6% of respondents who had difficulty receiving adult dental care also reported they ***Had no dental insurance***	**73.7%** of respondents who had difficulty receiving specialty health care also reported the ***Service I needed was not available in my area***	**52.9%** of respondents who had difficulty receiving mental health care also reported the ***Service I needed was not available in my area***	**45.5%** of respondents who had difficulty receiving primary health care also reported the ***Could not afford to pay***
73.2% Could not afford to pay	***42.1% Waiting time to get an appointment was too long***	***44.1% Could not afford to pay***	***42.4% Had no health insurance***
36.6% Service I needed was not available in my area	***28.9% Could not afford to pay***	***41.2% Waiting time to get an appointment was too long***	***36.4% Office was not open when I could go***
36.6% Had no health insurance	***21.1% Had no dental insurance***	***32.4% Insurance deductible was too expensive***	***30.3% Insurance deductible was too expensive***
29.3% Was not eligible for the service	***18.4% Insurance deductible was too expensive***	***26.5% Did not know where to go to get services***	***27.3% Waiting time to get an appointment was too long***

5. Barriers to Services Identified by Key Stakeholder Survey Respondents

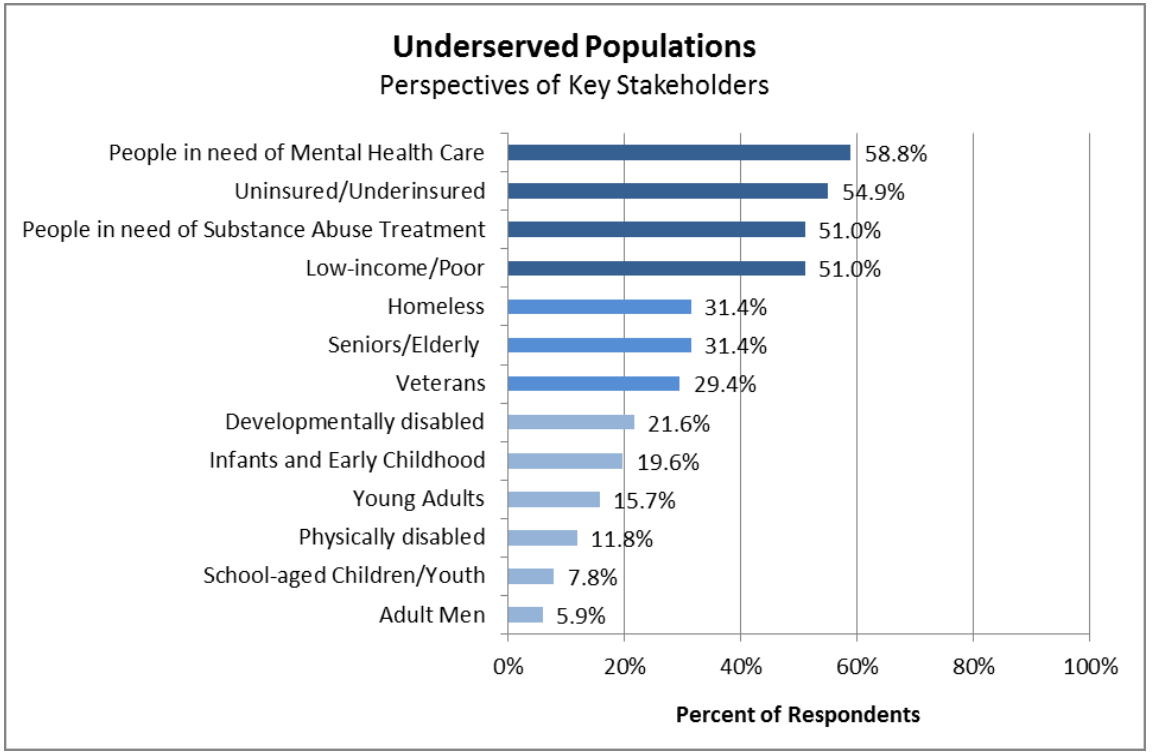
Respondents to the key stakeholder survey were also asked to identify the most significant barriers that prevent people in the community from accessing needed health care services. The top issues identified by this group were also related to affordability and insurance coverage. Other top issues included 'inability to navigate the health care system, lack of transportation, and reluctance to seek out services.

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


Inability to pay out of pocket expenses
82.4%
Lack of insurance coverage
58.8%
Inability to navigate health care system
56.9%
Lack of transportation
54.9%
Reluctance to seek out services/stigma
43.1%
Basic needs not met (food/shelter)
39.2%
Local providers not available/ Insufficient local capacity
25.5%
Time limitations (long wait times, limited office hours, time...
23.5%
Insufficient number of providers accepting Medicaid...
21.6%
Lack of child care
9.8%
Lack of trust
7.9%
Eligibility barriers
7.8%
Language/cultural barriers
2.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Key stakeholders were also asked if there are specific populations in the community that are not being adequately served by local health services. About 56% of respondents indicated that there are specific underserved populations (6% responded "No" and 38% were "Not sure"). Figure 11 displays results from key stakeholder responses on specific populations thought to be currently underserved. 'People in need of Mental Health Care', 'Uninsured/Underinsured", 'People in need of substance abuse treatment' and 'Low Income/Poor' were the most frequently indicated populations perceived to be currently underserved.

Figure 11



The FY2017 Community Health Needs Assessment Survey asked people to respond to the question, ***"If you could change one thing that you believe would contribute to better health in your community, what would you change?"*** A total of 255 survey respondents (62%) provided written responses to this question. Table 7 provides a summary of the most common responses by topic theme. All comment detail can be found in the report Appendix A.

TABLE 7
"If you could change one thing that you believe would contribute to better health in your community, what would you change?"

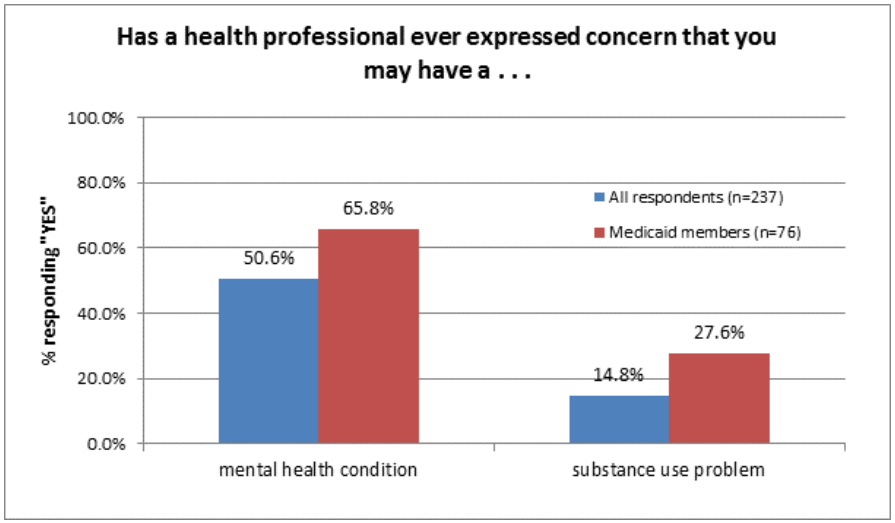
Affordability of health care/low cost or subsidized services; insurance; health care payment reform	**18.4% of all comments**
Health care provider availability including certain specialties; hours and wait time; health care delivery system improvements, quality and options	**17.3%**
Accessibility/availability of substance use treatment services; substance misuse prevention	**10.6%**
Accessibility/availability of mental health services	**8.6%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**7.1%**
Improved resources, programs or environment for healthy eating/ nutrition/food affordability;	**5.5%**
Programs/services for youth and families; healthy lifestyle education	**5.5%**
Improved job opportunities; housing; child care; economy	**5.1%**
Affordability / availability of dental services	**4.7%**
Caring community / culture; community connections and supports	**4.3%**
Improved transportation services / public transportation	**3.9%**
Senior services / assisted living / concerns of aging	**3.5%**

6. Behavioral Health Needs Survey Findings

Recognizing the continued importance of mental health and substance misuse as community identified priorities for improvement, in the fall of 2016, CNHHP member agencies partnered with other health and human service providers in the broader Lakes Region to conduct an assessment specifically focused on behavioral health needs. The results of this assessment are being used to inform the development of an Integrated Delivery Network for behavioral health care services in the region, as well as CNHHP's specific community health improvement efforts. One aspect of this assessment was a consumer survey of area residents targeted to high need locations and populations with a particular emphasis on reaching populations covered by Medicaid. A total of 237 consumer surveys were completed; 32% of respondents were Medicaid members within the last 12 months, 42% had used mental health services in the past 12 months, and 12% had used substance use services in the past 12 months. Key findings of this behavioral health needs assessment are described here.

As displayed by chart 9, about 51% of behavioral health needs survey respondents indicated that they had ever been told by a health professional that they may have a mental health condition, including about 66% of respondents who also reported having been eligible for Medicaid in the past 12 months. About 15% of respondents indicated having been told they may have substance use problem including about 28% of Medicaid members.

Figure 12



As displayed by Chart 10, about 42% of behavioral health needs survey respondents indicated that they had received some type of mental health services in the past 12 months including about 58% of respondents who had been eligible for Medicaid in the past 12 months. About 12% of respondents reported receiving services for substance use in the past 12 months including about 24% of Medicaid members.

Figure 13

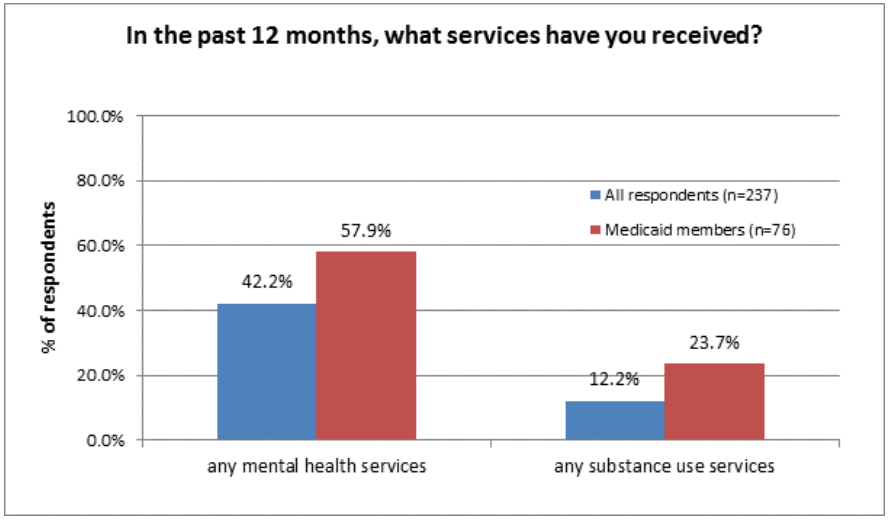
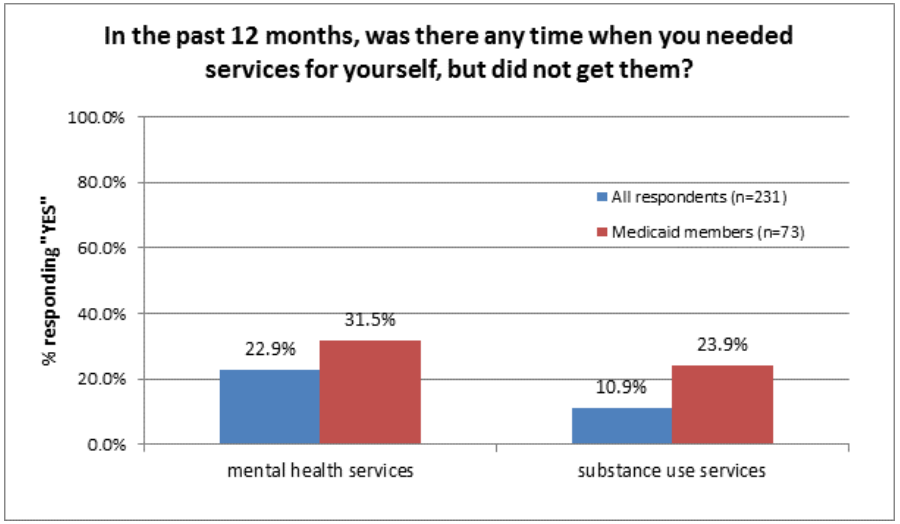


Figure 14

About 23% of behavioral health survey respondents indicated having difficulty getting the mental health services they needed in the past 12 months (Chart 11), including about 32% of Medicaid members; while 11% indicated they had difficulty getting the substance use services they needed including about 24% of Medicaid eligible respondents.



Further analysis of these results shows that of those respondents who did receive some type of mental health services in the past 12 months, about 29% also indicated having difficulty getting the mental health services they needed. Among respondents who received no mental health services in the past 12 months, nearly 1 in 5 (about 19%) indicated a need for mental health services that they did not get. These findings may reflect different challenges to receiving services such as waiting lists (e.g. respondents may have had difficulty getting services initially, but eventually did so), gaps in the appropriateness or acceptability of services, financial obstacles to care and respondent readiness to seek services.

Similar findings were observed for respondents indicating difficulty accessing substance use services where nearly half of respondents (46%) who did receive substance use services in the prior 12 months also indicated difficulty in getting services they needed. Among those respondents who did not access substance use services in the prior 12 months, about 6% reported a need for services that they did not get.

Figure 15

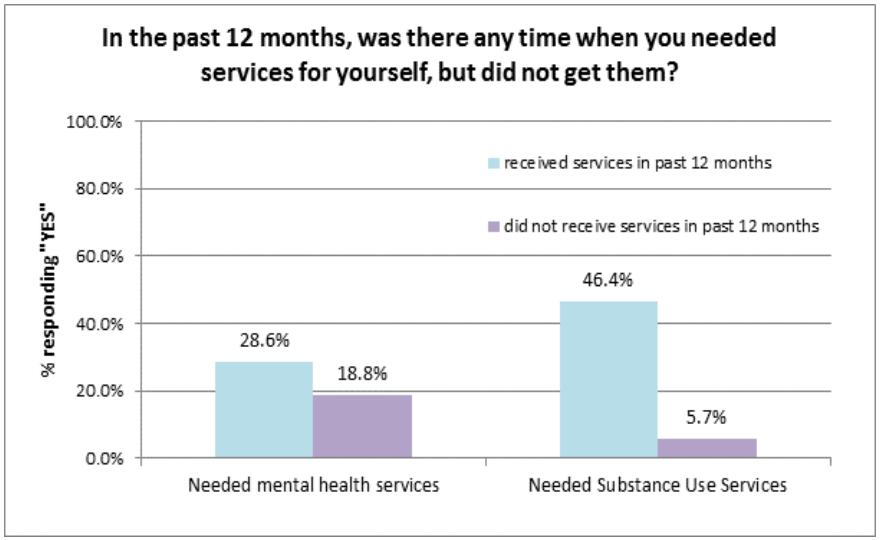


Chart 13 displays the top reasons reported for not getting needed mental health services. These are "I thought I could handle the problem without treatment" and "I did not have time (due to job, child care, or other commitments", followed by "There were no openings or I could not get an appointment" and "Health insurance did not cover the service or enough of the costs". The top mental health services that people reported having difficulty accessing (Chart 14) are individual therapy or counseling (79%) and services for co-occurring mental and substance use conditions. Taken together, these findings suggest issues of limited workforce capacity with respect to counselors / therapists as well as the need for integration of mental health and SUD services.

Figure 16

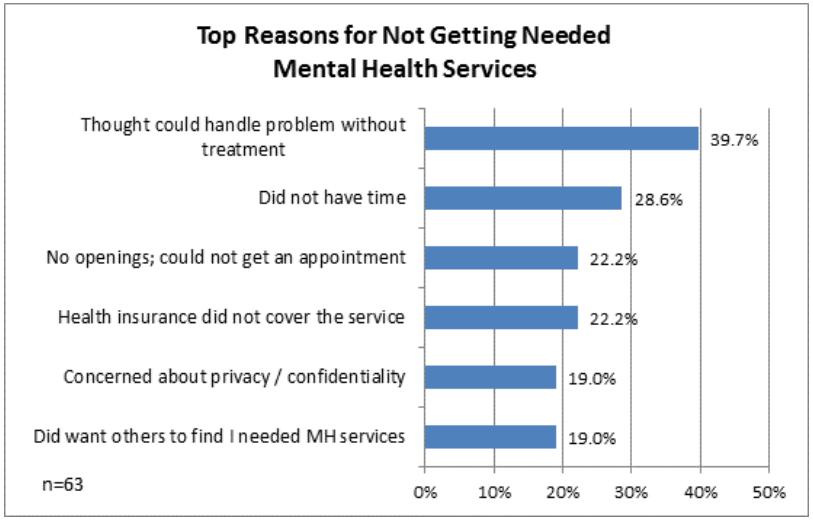
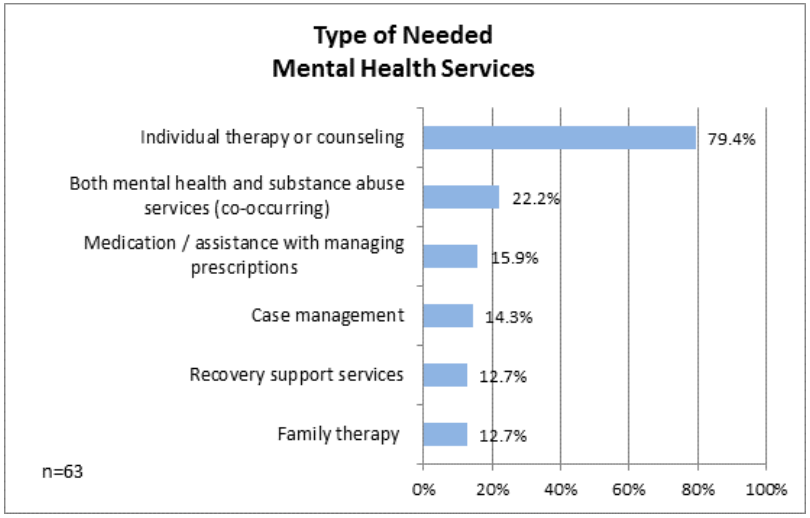


Figure 17



Reported reasons for substance use service access difficulties are similar with the top reasons being “I was not ready to stop using alcohol or drugs”, “I thought I could handle the problem without treatment”, and “There were no openings or I could not get an appointment”. However, some differences are observed for the type of services respondents had difficulty getting (Chart 16). While ‘individual therapy or counseling’ was again the top service mentioned, it was mentioned by a smaller proportion of respondents and a more diverse array of services were mentioned at higher frequency including co-occurring mental health and substance use services, peer and recovery support services, intensive outpatient treatment and opioid treatment.

Figure 18

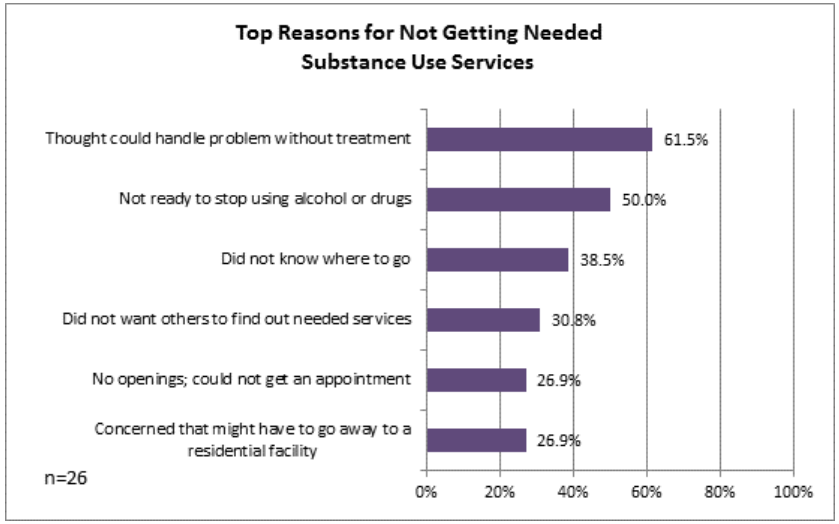
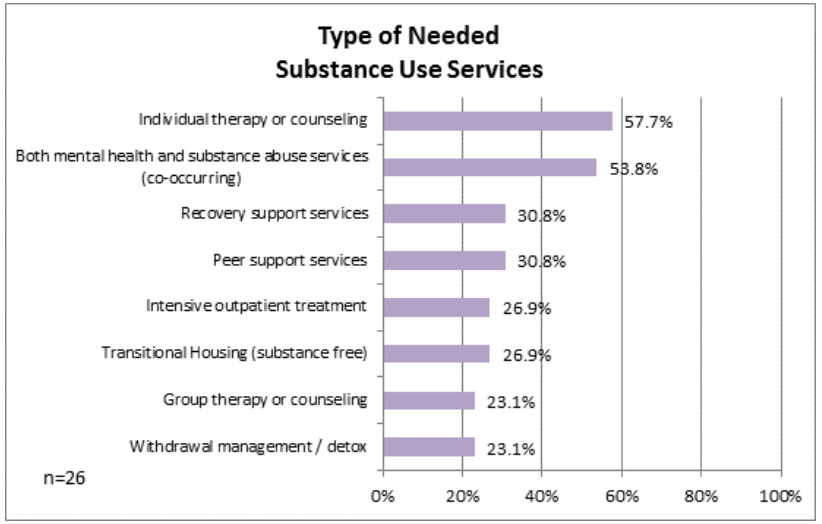
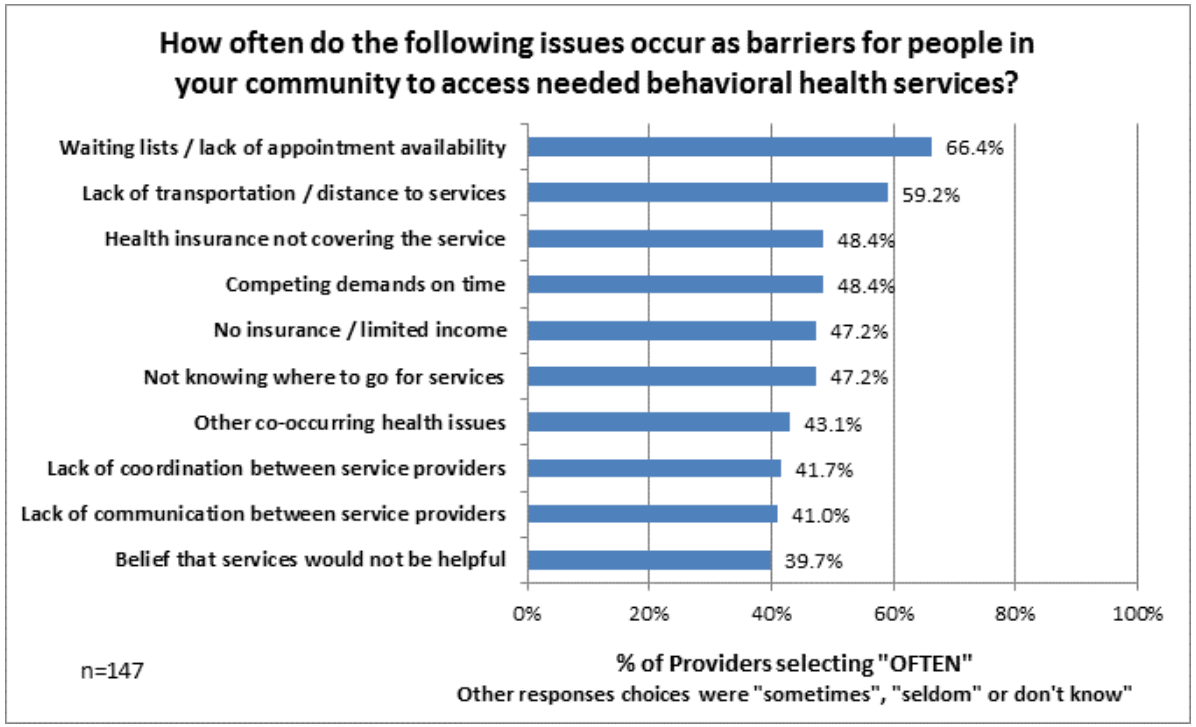


Figure 19



The focused assessment of behavioral health needs also included a survey of area health and human service providers (n=147). As displayed by Chart 17, respondents to the provider survey also reflect the observation that workforce capacity is an important concern with 'waiting lists / lack of appointment availability' cited as a top barrier to accessing behavioral health services in the region. Transportation challenges, health insurance coverage limitations and competing demands on time were also noted as substantial barriers to accessing needed behavioral health services.

Figure 20



B. COMMUNITY HEALTH DISCUSSION GROUPS

A set of three discussion groups were convened in the summer of 2017 as part of an effort by the Central NH Health Partnership to understand the health-related needs of the community and to plan programs and services that address those needs. The purpose of the discussion groups was to get input on health issues that matter to the community and thoughts and perceptions about the health of the community. Discussion groups were convened representing a variety of important community sectors and perspectives, specifically the following:

- Inter-Agency Council hosted by Whole Village (17 participants)
- Central NH Public Health Advisory Council (13 participants)
- Parent Group hosted by Whole Village (13 participants)
- Plymouth and Bristol area Senior Advisory Councils (10 participants)

1. Community Discussion Group Themes

The following paragraphs summarize the findings from the community discussion groups. See Appendix A for more detailed notes from these groups organized by topic.

1. Discussion group participants comprehended and described a comprehensive, holistic perspective on health and well-being. The contributions of health behaviors, the physical environment, programs and services, and underlying determinants of health such as housing, income and education were all discussed with respect to individual and community health outcomes.

> *"I'd say this is a health and wellness conscious community . . . . The community and the university are tied together in wellness activities through the ALLWell Center. They have an open track that invites people in. There are people from here that go down there and walk laps at lunch or after lunch. Just general access to outdoor activities here is awesome."* Senior Advisory Council Participant

2. Participants had mixed feelings about the overall health of the community. Positive factors cited include the perception of increased participation in physical activity and a number of specific community resources that promote health and wellness. However, there was also discussion of a divide in health outcomes between individuals and families with more resources, particularly income and housing, compared to those with limited resources. A number of comments also specifically cited substance misuse as an increasing problem, as well concerns about multi-generational health behaviors that contribute to poor health outcomes.

> *"When we're talking about poverty, we're not talking about the person who is struggling to find food or shelter or transportation. We are talking about the community; that this person isn't in poverty, we are in poverty."* Interagency Council Participant

3. Participants identified a wide variety of community strengths and resources that promote health including Speare Memorial Hospital, Genesis Behavioral Health, Midstate Health Center, 'Boulder Point', Pemi-Baker Aquatic & Fitness, active AA and Al Anon programs, the Plymouth and Bristol Senior Centers, the Tapply-Thompson Community Center, CADY, the ALLWell Center, the Got Lunch program, Head Start, Whole Village Family Resource Center, the physical environment and outdoor recreational activities, and farmers' markets.

4. Participants identified a range of barriers to promoting good health in the community including the need for more awareness of available resources *(. . . a single place to go that linked you into the different resources for different issues . . . that would be*

really helpful."), access to medical specialists, affordability of health care services ("*Insurance is expensive, but then once you go, it's just that much more. So you just try to stay out as much as you can."*), the need for improved access to transportation, and addressing intergenerational poverty, substance misuse and mental health.

5. With respect to what organizations could be doing better to support or improve community health, participants identified needs for improved coordination between local organizations and hospitals, better communication, social media presence and marketing of health-related opportunities, increased support and education addressing substance misuse, and more leadership for addressing long term community health issues including stronger connections with the university.

> *"I don't think we work together as a community. And I don't know what that's all about . . . I think it's just kind of the way it's always been. It just needs to change, and we just need to change it. . . . It's a hard area because we've got so many different communities coming together . . . people that have lived in the same neighborhood for many generations. And then we've got all the new people, the collegiate professors . . . we've got all different levels. I think all getting on the same bus together; we could be a really strong community. What that takes, I don't know."* Parent Group Participant

2. High Priority Issues from Community Discussion Groups

In each of the community discussion groups convened in 2017, the discussion group facilitator read top priority areas identified in the 2014 Community Health Needs Assessment and the current CNHHP Community Health Improvement Plan. These priorities were:

1. Access to affordable health care services and insurance
2. Alcohol, and drug use prevention, treatment and recovery
3. Access to mental health services
4. Healthy Eating, Active Living, obesity prevention
5. Assistance with care coordination and health system navigation
6. Support of Fragile Families & Reduction of Family Stress

Participants were then asked if they were: a) aware of any programs or activities that have focused on any of these areas; b) if they had noticed any improvements in these areas; and c) if they thought these are still the most important issues for the community to address for improving health or if there are new, different priorities. Discussion participants identified a number of programs and services intended to address: a) address health care affordability and access including the Affordable Care Act and Medicaid Expansion; b) substance misuse and mental health capacity including efforts to improve behavioral services provided throughhome health services; and c) physical activity, particularly programs for people with chronic disease through Genesis and Mid-State.

With some additions (see next page), most participants in each group expressed the overall opinion that the priorities identified in 2014 were still the most important issues to focus attention on for community health improvement. However, some participants also suggested focusing on one or a couple areas that are cross-cutting, with transportation mentioned in several groups as an example of an issue that has been a long term challenge and touches on many issues associated with access to services and quality of life.

> *"In general for all the priorities mentioned, there has been more done, but the wave coming at us is so much bigger that it sort of swamps the increased efforts. It's not that there haven't been increased efforts in these areas, just not enough to keep up with the demand.* Interagency Council Participant

The table below displays the top overall priorities identified by each set of discussion groups. As noted on the previous page, the community discussion groups convened in 2017 generally endorsed the same set of priorities as identified in 2014. Some additional themes emerged in these discussions and are noted in this table as well.

TABLE 8 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

	Inter-Agency Council	Public Health Advisory Council	Parent Group	Senior Advisory Council
Mental Health and Substance Use	Of the clients I see in the Welfare department probably 75% at least have some connection to either MH or SU or both. A lot of times both.	I think that our community puts on a very healthy front, but sort of behind the scenes, not so much . . it's the poverty, it's the substance abuse, it's the mental illness, it's the family dysfunction, all of that. We've got people in our ERs waiting weeks trying to get services.	Professional recovery resources is what we don't have. Like, IOPs. Someone I know is in the hospital for (*a serious mental health issue*), and they couldn't find *(the person*) a bed in time so they stuck her in a room for three days and just left *(the person* there.	I think more needs to be said to teenagers maybe about the drugs. They need more information. They need to know that happens.
Social Determinants; Social connectedness	It's a global issue. Wellbeing depends on all of those supports and feeling like you are part of the community and not feeling like you are shamed because you are accessing those supports. Poverty and access are the big ones.	Talking about the isolation issue, it's not just seniors. There are a lot of young families that are very isolated and they don't have community connections, connections with friends, with neighbors.	I don't know how open we are about communication . . . in terms of what's going on, or we don't discuss a lot of things that maybe should be discussed in an open forum for our community. And I feel like that's hurting a lot of people, health-wise.	I think Bristol takes care of people, but you have to ask. . . and a lot of people that need services, they're sort of afraid to ask. Would they know who to ask? You improve the quality of life and then the other things will fall into place.

	Inter-Agency Council	Public Health Advisory Council	Parent Group	Senior Advisory Council
Provider availability; capacity; workforce shortages	There are staffing shortages in all those areas. In nursing, in social work, in mental health. There's a line out of every door. That's the frustration. It's not that we don't have people who want to help.	I think one of the good things from the community perspective is people know where to go in this community. It's easily identifiable who the providers are . . .	I had *(several)* counselors, just different ones because they either quit, or were let go, or because the empathy is not there. So, to build rapport with someone who's supposed to help you is kind of difficult when you have just such a lot of turnover. I notice my *(spouse*), every couple years (*my spouse*) got another doctor because they've fulfilled their three years. It seems hard to keep physicians in the area.	Almost everything I need is right here. I've been very pleased with the availability and quality of the healthcare service that I've gotten at Speare. One of the things that I've noticed, where I came from there was an urgent care center probably every six blocks. And there's not a lot in this whole entire area going from Bristol to Lincoln . . . Are there any?
Care coordination; Navigation; Access to information	A lot of people still also have a fear of "the system". Fear that they are going to get judged; they know they need help, or they want help or maybe they don't know they need help, but it's the fear of the system.	The insurance navigation thing that came with the ACA, basically, ACA funded folks to help patients navigate how to get insurance. And I think it was pretty successful. But that's all unwinding—	Whole Village gives you the right resources, where you need them. Especially down at the homeless shelter. They're pretty good about helping people out . . .The atmosphere here, as well as—the help is genuine when they're assisting you with anything.	People kept telling me, "There are services available. You just have to ask." And I kept saying, "Who do I ask?" Even a consolidated online source . . . If there was a single place to go that linked you into the different resources for different issues, then I think that would be really helpful.

	Inter-Agency Council	Public Health Advisory Council	Parent Group	Senior Advisory Council
Transportation	The difficult challenge in being a rural community is the transportation piece . . . as great of a connection as we feel and that sense of oneness in our community, it's difficult because we are rural and because things are so spread out . . .	Transportation plays a significant role in our rural community . . . especially in the winter months the transportation piece is a huge barrier in terms of community health and connection. I've liked the idea of tackling transportation. It comes up year after year . . .	Being stuck in subsidized housing without transportation, especially that distance down Route 25, and to be trying to arrest your own addiction or take care of your mental health issues, it feels almost hopeless in them situations. It's hard to get out, hard to follow through. Transportation goes to all those issues that you had from four years ago, don't you think? Puts them all together.	I think one of the biggest problems altogether is transportation. Even if there's something right here in town, if you don't have a car, it's not easy to get to. And I use just about every resource that there is. I finally broke down and bought myself a car to save my own sanity.
Access to health care; health care insurance	Access to healthcare has improved as a result of Medicaid Expansion. This is HUGE and has radically improved access to health care.	We've made a dent in access to health insurance. I don't know if the dent will remain.	I've got friends that can now afford insurance with Obamacare. But they don't know whether it will be available next year. That's the uncertainty. The paperwork is tremendous. Insurance is expensive, but then once you go, it's just that much more. So you just try to stay out as much as you can . . . It'd have to be something really major for me to go.	

	Inter-Agency Council	Public Health Advisory Council	Parent Group	Senior Advisory Council
Health care for seniors	Add care for frail elders as a priority. There are a lot frail elders in our community; kind of a special population.	A lot of people are drawn here that are retiring or are of retirement age. And a lot of young people are drawn to leave. And so our demographic is changing. Isolation is a huge risk factor on many levels for health . . . our elderly population struggle particularly in the winter time; and lack family supports or plans if they are sick. We spend a lot of time doing social service to help them		My top issue would be handicap accessibility. Not just for people with obvious handicaps. It's elderly people, period . . . You go into so many and there are steps and no way for them to get into a restaurant or whatever, and it makes it difficult.
Assisted Living; Long term care		One of the things that we are lacking is that there are no assisted living facilities, no nursing homes in the area. We definitely are not meeting the needs of those who are middle income or low income who couldn't afford it, even if they wanted to.		I was trying to figure out *where (a relative)* could live. (*My relative)* didn't want to be a burden. And I asked around. I didn't really find a lot of help. I ended up going all the way down to Franklin to find a place for (*my relative*) to live . . I was frustrated that there wasn't something closer. There are no residential living places that are affordable to somebody on a fixed income.
Healthy Eating, Active Living		If we could focus on an upstream model and get in their earlier, then that will help us with our children, whether it's obesity, or the exercise, and get families involved.	I think it would be helpful if we had walkable communities, like we had sidewalks, we had bike paths, that parents felt comfortable that their child could bike over to their friend's house.	I see an awful lot of people from 5 in the morning until dark walking, biking, pushing strollers. There's a lot of people out getting physical activity on a regular basis.

	Inter-Agency Council	Public Health Advisory Council	Parent Group	Senior Advisory Council
Availability of Dental Care		We still have an adult access issue regarding oral	Dental is a very, very big issue. I don't think it is as much for children, but adults. It's bad. There's no place here that has the sliding scale fee. You can't get insurance through Medicaid . . . you lose it when you're 21. So, a lot of people don't have dental insurance. And it's expensive. You see a lot of people going in the ER because they get infected teeth constantly. They just send you home, pretty much.	There are a lot of dentists here in town, but if you listen to the conversation about them, it's like "Well, don't go there, don't go there." And by the time I got done I said, "Who do you go see then?"
Injury prevention			I just think it's a safety issue (learning to swim). There's natural water in all of our communities and we don't have an easy way to address that. It's not easy, it's not affordable . . . personally, I think that's a big health issue. It's really nice to have all these pools in town and not be able to get in . . . there are so many people that haven't learned how to swim because it's not easy to.	My *(spouse)* has a hard time getting into some places because (*of a physical disability)*. I think that it wouldn't be a bad idea to have a little more emphasis on that type of thing . . . or even myself, I've had a hard time— you could trip really easy. The only thing I can think that would help me is railings . . . it's a very little thing—even a post, if it's only one step, would help.
Community Center			I've always dreamed about having a real rec center where there was a childcare facility . . . . Have us all work together as a community in this nice little rec center And teach kids how to swim, right? Our kids need to know how to swim.	

C. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2017 Community Health Needs Assessment report provides information on key indicators and measures of community health status. Some measures associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 18 town service area identified by the Central New Hampshire Health Partnership. In some instances, data are only available at the county level. In these instances, information is presented for Grafton County, because the CNHHP service area is entirely within Grafton County and comprises about 34% of the total county population.

1. Demographics and Social Determinants of Health

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

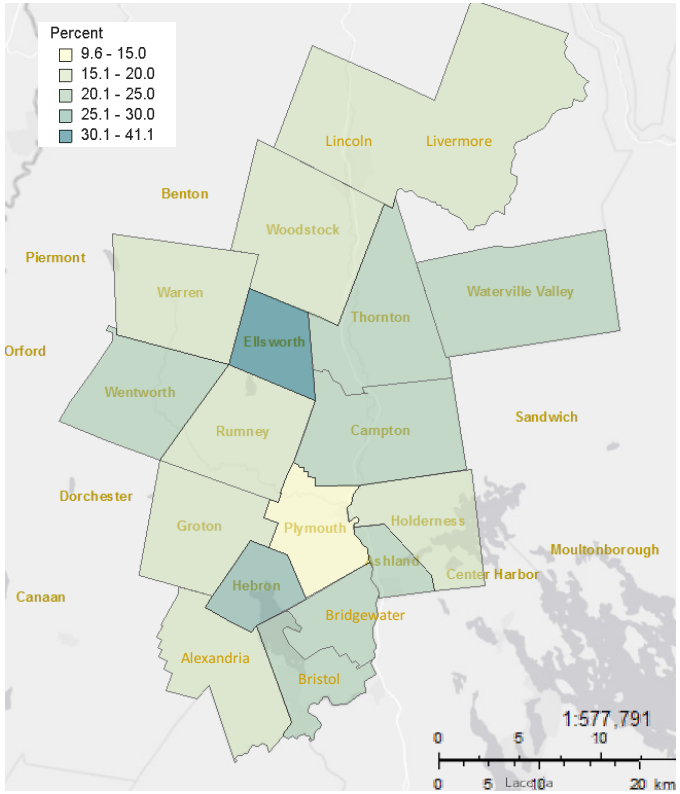
a. General Population Characteristics

According to the 2015 American Community Survey, the population of the CNHHP Service Area is older on average than in New Hampshire overall. The service area map on the next page displays the percent of the population 65 years of age and older by town. Between 2010 and 2015, the population of the CNHHP Service Area declined by almost 2%.

Indicators	CNHHP Service Area	New Hampshire
Population Overview		
Total Population	30,039	1,319,171
Over age of 65	17.7%	15.3%
Under age of 18	16.2%	20.5%
Change in population (2010 to 2015)	-1.9%	+0.6%

Data Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates and 2010 US Census.

Percent of Population 65 years of age and older
CNHHP Service Area Towns



b. Poverty

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

Area	Percent of Children in Poverty Income < 100% FPL	Percent of Children in or near Poverty Income < 200% FPL
CNHHP Service Area	11.0%	38.1%
New Hampshire	11.9%	27.6%

Data Source: U.S. Census Bureau, 2011 – 2015 American Community Survey 5-Year Estimates.

c. Education

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

Area	Percent of Population Aged 25+ with No High School Diploma
CNHHP Service Area	7.5%
New Hampshire	7.7%

Data Source: U.S. Census Bureau, 2011 – 2015 American Community Survey 5-Year Estimates.

d. Language

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

Area	Percent of Population Aged 5+ Who Speak English Less Than "Very Well"
CNHHP Service Area	0.4%
New Hampshire	0.9%

Data Source: U.S. Census Bureau, 2009 – 2013 American Community Survey 5-Year Estimates.

e. Housing

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

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

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

Area	Percent of Housing Units Categorized As "Substandard"	Percent of Households with Housing Costs >30% of Household Income
CNHHP Service Area	33.6%	32.8%
New Hampshire	34.5%	35.1%

Data Source: 2011 – 2015 American Community Survey 5-Year Estimates; Sub-standard Housing and Housing Cost Burden data accessed from Community Commons.

f. Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. The next table presents data on the percent of households that have no vehicle available.

Area	Percent of Households with No Vehicle Available
CNHHP Service Area	4.1%
New Hampshire	5.1%

Data Source: U.S. Census Bureau, 2011 – 2015 American Community Survey 5-Year Estimates.

g. Disability Status

Disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. The US Census Bureau (American Community Survey) identifies people reporting serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation. According to the 2015 American Community Survey, 13.4% of CNHHP Service Area residents report having at least one disability, a rate that is slightly higher than the overall New Hampshire rate and most likely a reflection of the proportionally older population.

Area	Percent of Population Reporting Serious Difficulty With Hearing, Vision, Cognition and/or Ambulation
CNHHP Service Area	13.4%
New Hampshire	12.1%

Data Source: U.S. Census Bureau, 2011 – 2015 American Community Survey 5-Year Estimates.

2. Access to Care

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

a. Insurance Coverage

Table 9 on the next page displays estimates of the proportion of residents who do not have any form of health insurance coverage by municipality, as well as the proportion of residents covered by Medicare or Medicaid. It is important to note that the data source for these municipal level estimates is a 5 year span of the American Community Survey. A combination of five years of data is required to produce reasonably stable estimates on these and other measures from the survey samples. However, this particular time period spans a period of significant change in the health insurance market with the implementation of the federal Affordable Care Act and the beginning of Medicaid expansion in New Hampshire. Figures 21 and 22 following the table display 1 year estimates of uninsurance and Medicaid coverage. This analysis applies groupings of zip code tabulation areas to derive estimates at the regional and state level from the American Community Survey. These estimates are less precise, but are included to illustrate important trends in insurance coverage

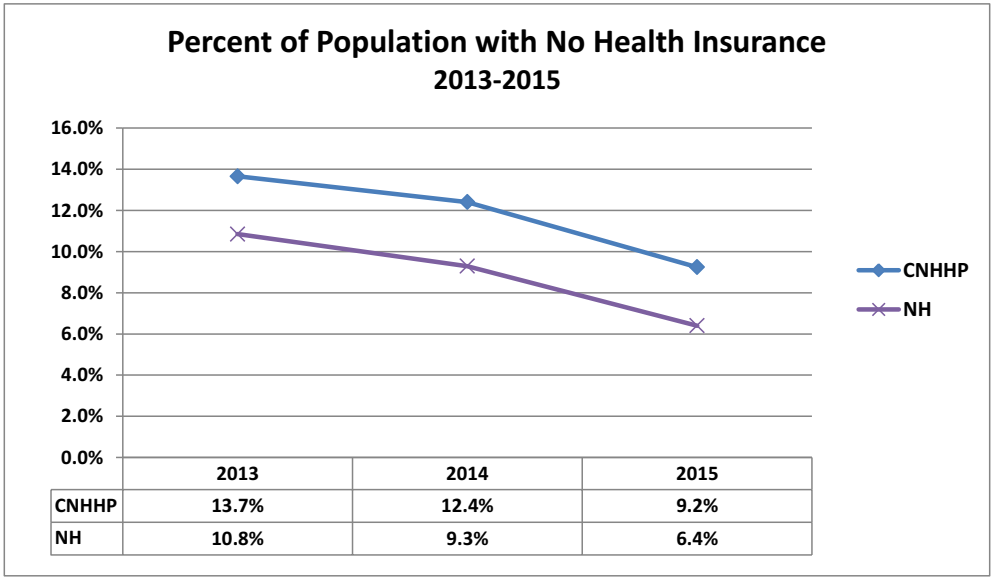
As displayed by Figures 21 and 22, the overall uninsurance rate has declined substantially in the CNHHP service area (from almost 14% to about 9%), but still exceeds the overall uninsurance rate estimate for NH (6.4%). A significant contributor to this change appears to be increases in Medicaid coverage, where estimates of Medicaid coverage increased from about 13% of the total population in 2013 to about 17% in 2015.

TABLE 9

Area	Percent of the Total Population with No Health Insurance Coverage	Percent with Medicare Coverage	Percent with Medicaid Coverage
Ellsworth	36.6%	44.6%	10.7%
Groton	31.4%	22.2%	14.3%
Ashland	21.0%	22.1%	13.9%
Alexandria	20.0%	20.5%	16.3%
Lincoln	20.0%	23.4%	19.3%
Warren	19.6%	23.5%	20.5%
Woodstock	18.6%	18.0%	8.6%
Wentworth	18.4%	25.6%	12.1%
Holderness	16.9%	18.7%	8.5%
Rumney	16.4%	18.8%	15.2%
Hebron	15.8%	29.9%	10.3%
Thornton	14.9%	23.4%	10.7%
Bristol	13.7%	22.2%	14.8%
Campton	11.9%	24.2%	6.2%
Bridgewater	9.6%	28.0%	14.0%
Plymouth	9.4%	11.4%	8.8%
Waterville Valley	2.4%	23.4%	0.0%

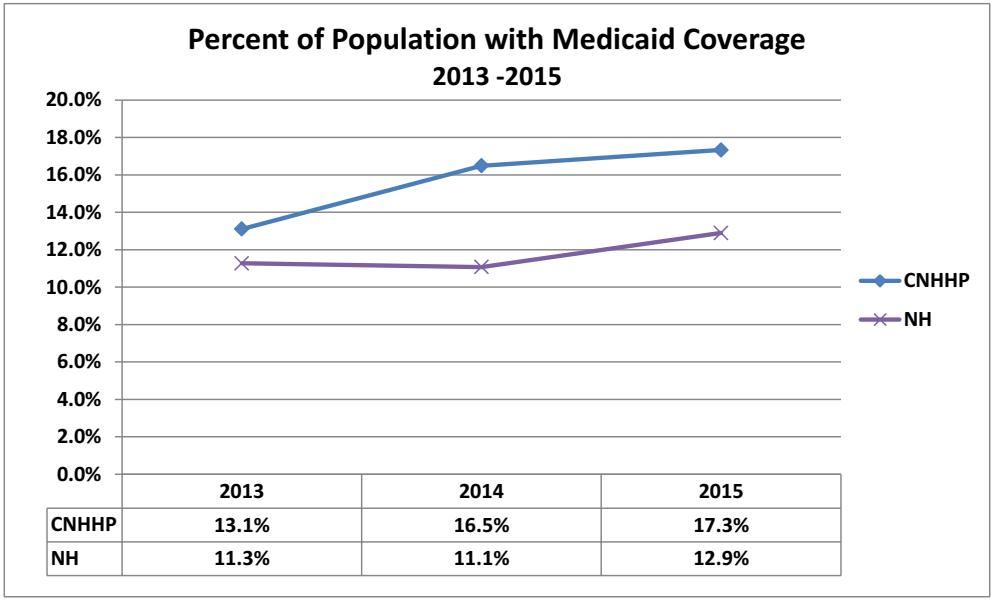
Data Source: U.S. Census Bureau, 2011 – 2015 American Community Survey 5-Year Estimates

Figure 21



	2013	2014	2015
CNHHP	13.7%	12.4%	9.2%
NH	10.8%	9.3%	6.4%

Figure 22



	2013	2014	2015
CNHHP	13.1%	16.5%	17.3%
NH	11.3%	11.1%	12.9%

b. Adults with a Personal Health Care Provider

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

Area	Percent of adults who report having a personal doctor or health care provider
CNHHP Service Area	80.6%
New Hampshire	86.8%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015.
Regional rate is not significantly different than the overall NH rate statistically.

c. Preventable Hospital Stays

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

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Grafton County	40.1
New Hampshire	44.8

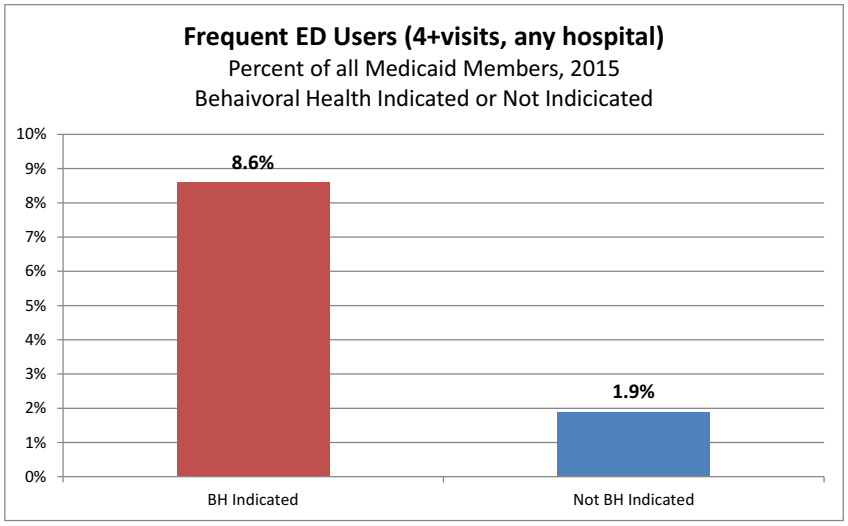
Data Source: Dartmouth Atlas of Health Care, 2014; accessed through County Health Rankings
Regional rate is not significantly different than the overall NH rate

d. Behavioral Health Care - Emergency Department Utilization and Hospital Re-admission for Behavioral Health Conditions

Overutilization or dependence on emergency departments for care of individuals with behavioral health conditions can be an indication of limited access to or capacity of outpatient mental health services. Similarly, unplanned hospital re-admissions can indicate gaps in available community and social support systems.

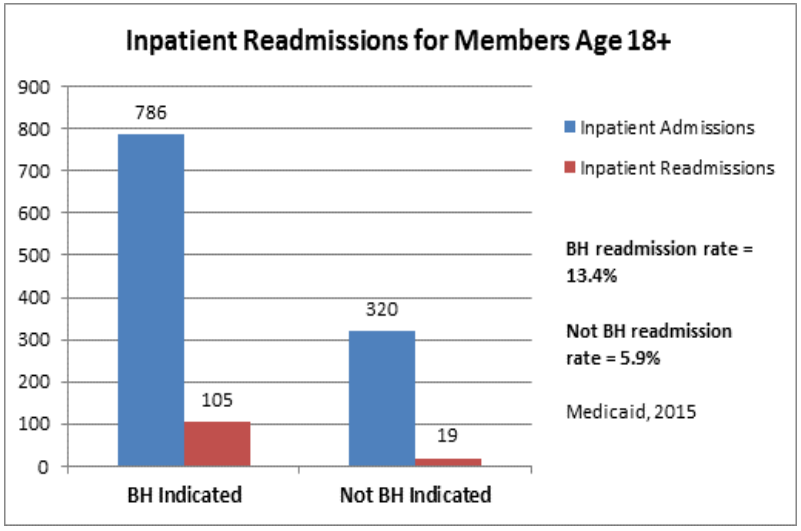
As part of the regional planning work to develop an Integrated Delivery Network for behavioral health, analyses were conducted with Medicaid claims data to compare emergency department utilization and hospital re-admissions for Medicaid members with evidence of a behavioral health condition based on claims history. Figure 23 displays the finding that Medicaid members residing in the Lakes Region of NH (including the CNHHP service area) with a behavioral health condition were over 4 times more likely to have had four or more visits to an emergency department in 2015 (8.6% of members with evidence of a behavioral health condition compared to 1.9% of members without). Similarly, the 30 day hospital inpatient readmission rate for behavioral health indicated members (13.4%) was more than double the rate for non-behavioral health indicated members (5.9%).

Figure 23



Data Source: NH Medicaid, 2015 claims data

Figure 24



e. Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past five years. A higher proportion of adults in the CNHHP service area report not having seen a dentist compared to the state.

Area	Percent of adults who have not visited a dentist or dental clinic in the past 5 years
CNHHP Service Area	17.7%
New Hampshire	11.4%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014.
Regional rate is not significantly different than the overall NH rate statistically

f. Poor Dental Health

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. In addition to highlighting needed improvements in preventive oral health care, this indicator can also highlight a lack of access to care, a lack of health knowledge, or social and economic barriers preventing utilization of services.

Area	Percent of adults who report having six or more of their permanent teeth removed
CNHHP Service Area	15.5%
New Hampshire	15.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014.
Regional rate is not significantly different than the overall NH rate statistically.

3. Health Promotion and Disease Prevention Practices

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

a. Fruit and Vegetable Consumption (Adults)

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

Area	Percent of Adults Consuming Few Fruits or Vegetables
Grafton County	69.0%
New Hampshire	71.5%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2005-2009 (most recent available).
Area estimates from Community Commons; Difference is not statistically significant

b. Physical Inactivity (Adults)

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

as obesity and poor cardiovascular health. About 1 in 5 adults in the region can be considered physically inactive on a regular basis – a rate similar to the rest of New Hampshire.

Area	Physically inactive in the past 30 days, % of adults
CNHHP Service Area	22.7%
New Hampshire	20.8%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015.
Regional rate is not significantly different than the overall NH rate statistically.

c. Pneumonia and Influenza Vaccinations (Adults)

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

Area	Adults who have received a flu shot in past 12 months and those who have ever received a pneumococcal vaccination	
	Influenza Vaccination 18 years of age or older	Pneumococcal Vaccination 65 year of age or older
CNHHP Service Area	49.0%	80.8%
New Hampshire	43.7%	76.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015.
Regional rates are not significantly different than the overall NH rate statistically.

d. Substance Misuse

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

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking more than two drinks per day on average for men or more than one drink per day on average for women), or binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Area	Engaged in Binge Drinking in Past 30 days, Percent of Adults		
	Male	Female	Total
CNHHP Service Area	18.5%	12.5%	14.7%
New Hampshire	21.7%	12.3%	16.8%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015.
Regional rate is not significantly different than the overall NH rate statistically.

Area	Heavy Alcohol Use, Percent of Adults		
	Male	Female	Total
CNHHP Service Area	NA	NA	9.8%
Grafton County	6.0%	9.8%	7.9%
New Hampshire	6.0%	6.9%	6.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2015.
Regional rate is not significantly different than the overall NH rate statistically.

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth. On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers. In the Central NH region, the rate of binge drinking among high school aged youth is similar to the overall state rate.

Area	Engaged in Binge Drinking in Past 30 days, Percent of High School Youth		
	Male	Female	Total
CNHHP Service Area	17.3%	16.0%	16.6%
New Hampshire	17.2%	16.1%	16.8%

Data Source: NH Youth Risk Behavior Survey, 2015

Regional rate is not significantly different than the overall NH rate

The misuse of prescription drugs, particularly prescription pain relievers, poses significant risk to individual health and can be a contributing factor leading to misuse of other drugs and a cause of unintentional overdose and mortality. About 17% of high school youth in the Central NH region report having ever used a prescription drug that was not prescribed to them.

Area	Ever used prescription drugs 'not prescribed to you', Percent of High School Youth		
	Male	Female	Total
CNHHP Service Area	16.3%	17.6%	16.9%
New Hampshire	14.0%	12.5%	13.4%

Data Source: NH Youth Risk Behavior Survey, 2015

Regional rate is not significantly different than the overall NH rate

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. Nearly 1 in 4 adults (24%) in the communities of the Central NH Public Health Region are estimated to be current smokers. The estimate of the percent of adults statewide who are current smokers is 17%.

Area	Percent of Adults who are Current Smokers
CNHHP Service Area	24.2%
New Hampshire	17.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015
Regional rate is not significantly different than the overall NH rate statistically

f. Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rate in the Central NH Public Health region is significantly lower than the rate in New Hampshire overall.

Area	Teen Birth Rate per 1,000 Women Age 15-19
CNHHP Service Area	**8.9***
New Hampshire	12.0

Data source: NH Division of Vital Records Administration birth certificate data; 2011-2015.
***Rate is statistically different and lower** than the overall NH rate

4. Selected Health Outcomes

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

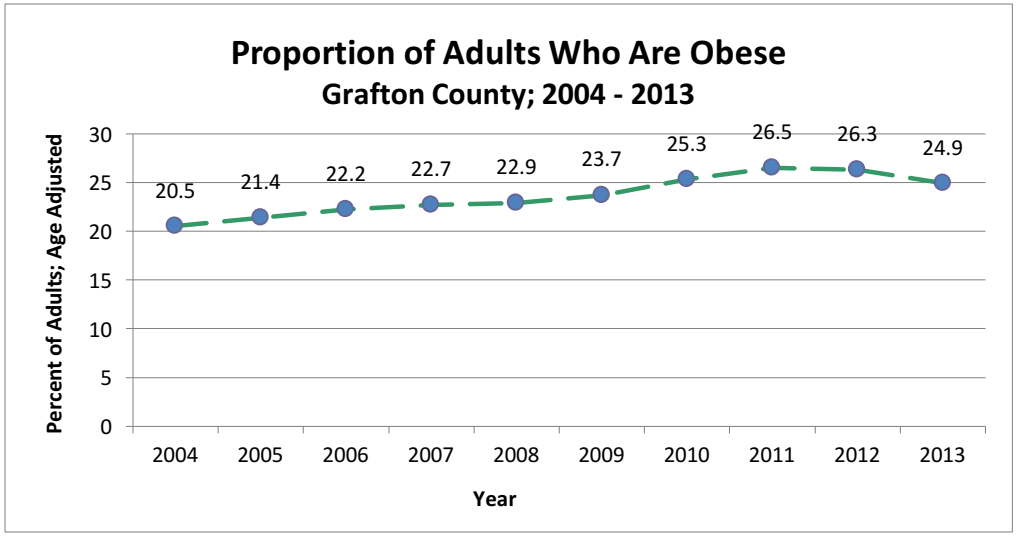
a. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) or greater than 25.0 (overweight or obese). The chart on the next page displays the trend in Grafton County since 2004 toward increasing prevalence of obesity in the adult population, although a plateau in the proportion of adults who are obese appears to have been achieved in more recent years.

Area	Percent Obese	Percent Overweight or Obese
CNHHP Service Area	**19.8%***	55.2%
New Hampshire	27.0%	63.6%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015

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



Data Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System

b. Heart Disease

Heart disease is the second leading cause of death in New Hampshire and in the Central NH Region after all forms of Cancer. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance abuse including tobacco use. In 2015, Diseases of the Heart was the cause of 50 deaths in the Central NH Public Health Region.

Heart Disease Prevalence: This indicator reports the percentage of adults aged 18 and older who have ever been told by a doctor that they have coronary heart disease or angina.

Area	Percent of Adults with Heart Disease (self-reported)
CNHHP Service Area	4.0%
New Hampshire	4.0%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2014-2015

Rate is not statistically different than the overall NH rate

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

Area	Percent of adults who have had their cholesterol levels checked within the past 5 years
CNHHP Service Area	85.3%
New Hampshire	83.0%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2015.
Rate is not statistically different than the overall NH rate

Heart Disease and Stroke Mortality: Coronary Heart Disease, a narrowing of the small blood vessels that supply blood and oxygen to the heart, is the largest component of heart disease mortality. The rate of death due to coronary heart disease among Lakes Region residents was significantly higher than the overall rate for New Hampshire in the 2011 to 2015 time period. Cerebrovascular disease (stroke), which happens when blood flow to a part of the brain stops, is the fifth leading cause of death in New Hampshire and in the Lakes Region.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
CNHHP Service Area	90.9	27.9
New Hampshire	95.9	28.7

Data Source: NH Division of Vital Records death certificate data, 2011-2015
Rates are not statistically different than the overall NH rate

c. Diabetes

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

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. About 8.0% of Central NH adults and 9.0% of New Hampshire adults overall report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes, age adjusted
CNHHP Service Area	7.7%
New Hampshire	8.6%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2014-2015.
Regional rate is not statistically different than the overall NH rate

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

Area	Percent of Medicare Beneficiaries with Diabetes with Annual Hemoglobin A1c Test
Grafton County	90.1%
New Hampshire	90.3%

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

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus among Lakes Region residents is similar to the overall rate for New Hampshire and is the seventh leading cause of death in the region.

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
CNHHP Service Area	16.5
New Hampshire	18.1

Data Source: NH DHHS Hospital Discharge Data Collection System, 2014- 2015
Rates are not significantly different than overall NH rate

d. Cancer

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

Cancer Screening: The table on the next page displays screening rates for colorectal cancer, breast cancer and cervical cancer. The United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The proportion of adults age 50 to 75 who are in compliance with the USPSTF recommendations (self-report) in CNNHP region (77.8%) is similar to the overall NH rate (74.9%). The proportion of women who report being in compliance with breast and cervical cancer screening recommendations are also similar to the overall NH rate.

Cancer Screening Type	CNHHP Service Area	New Hampshire
Percent of adults who are aged 50+ that met USPSTF colorectal cancer screening recommendations*	77.9%	74.9%
Percent of females aged 50+ who have had a mammogram in the past two years**	80.2	80.8%
Percent of females aged 18+ who have had a pap test in the past 3 years***	71.2%	78.6%

*Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2015.

**Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2014.

***Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2012 and 2014.

Regional rates are not statistically different than the overall NH rate

Cancer Incidence and Cancer Mortality: The table below shows cancer incidence rates by site group for the cancer types that account for the majority new cancer cases (incidence).

Cancer Incidence per 100,000 people, age adjusted		
	CNHHP Service Area	New Hampshire
Overall cancer incidence (All Invasive Cancers)	489.8	498.8
Cancer Incidence by Type		
Breast (female)	136.9	141.8
Prostate (male)	129.7	128.7
Lung and bronchus	59.8	67.7
Colorectal	45.2	38.2
Bladder	31.9	28.7
Melanoma of Skin	29.7	28.6

Data Source: NH State Cancer Registry, 2010 - 2014

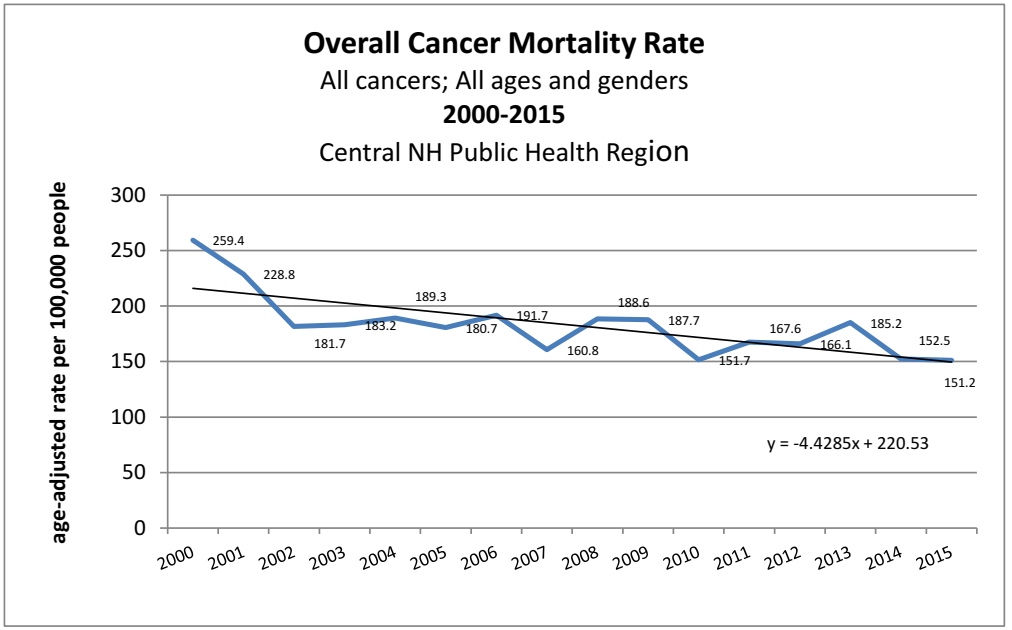
Rates are not significantly different than overall NH rate

Cancer Mortality: The table below shows the overall cancer mortality rate and for the cancer types that account for the majority cancer deaths. The overall cancer mortality rate and mortality rate from specific cancer types are similar to the state overall. As displayed by the chart at the bottom of the page, the overall cancer mortality rate in the region has been declining at a linear rate of about -4% per year since the year 2000.

Cancer Mortality per 100,000 people, age adjusted		
	CNHHP Service Area	New Hampshire
Overall cancer mortality (All Invasive Cancers)	164.5	165.1
Cancer Mortality by Type		
Lung and bronchus	41.1	45.8
Breast (female)	15.5	19.6
Prostate (male)	28.2	20.4
Colorectal	16.6	13.1
Pancreas	10.8	11.1

Data Source: NH State Cancer Registry, 2011 - 2015

Regional rates are not significantly different than overall NH rate



e. Asthma

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

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

Area	Percent of Children (ages 0 to 17) with Current Asthma*	Percent of Adults (18+) with Current Asthma**
CNHHP Service Area	3.8%	11.2%
New Hampshire	7.2%	10.1%

*Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2015

**NH DHHS, Behavioral Risk Factor Surveillance System, 2014-2015

Regional rates are not statistically different than the overall NH rate

f. Intentional and Unintentional Injury:

Accidents and injury are the third leading cause of death in the region and in the state. Of particular note in recent years, New Hampshire has been among the hardest hit states by the epidemic of opioid misuse, ranking second behind West Virginia, in the number of opioid-related deaths per capita and highest for deaths per capita from synthetic opioids like fentanyl.

Drug Overdose Mortality: As displayed by the chart to the right, the overall overdose mortality rate in the region is lower than the state overall, although the observed difference is not statistically significant.

Area	All drug overdose deaths Central NH Public Health Region, 2015 (prescription , illicit, other & unspecified drugs) Age-adjusted rate per 100,000 population
CNHHP Service Area	24.7
New Hampshire	32.6

Data Source: NH Division of Vital Records death certificate data, 2015

Rate is not statistically different than the overall NH rate

Suicide: This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care. During the period 2011 and 2015, the suicide rate in the Central NH region was similar to the overall NH rate of suicide deaths.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
CNHHP Service Area	12.9
New Hampshire	14.6

Data Source: NH Division of Vital Records death certificate data, 2011-2015

Regional rate is not significantly different than the overall NH rate statistically.

g. Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. During the period 2012 to 2014, 940 deaths in Grafton County occurred before the age of 75 and the average annual total of YPLL-75 was 5,100 years of potential life lost per 100,000 population.

Area	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Grafton County	5,100
New Hampshire	5,500

Data source: National Center for Health Statistics, National Vital Statistics System accessed via County Health Rankings, 2012-2014.
Rate is not statistically different than the overall NH rate

5. Comparison of Selected Community Health Indicators between 2017 and 2014

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2017) and the previous assessment conducted in 2014, as well as the most recent statewide statistic for each indicator. This comparison is provided for informational purposes and it is important to note the differences between the 2014 and 2017 estimates for the region and the state comparison estimate are not significantly different at a 95% confidence level for most indicators. In instances where there are statistically significant differences between recent estimates, the indicators are highlighted in bold font.

Table 10: Comparison of Selected Community Health Indicators between 2017 and 2014 with NH State Comparison

Community Health Indicator	Geographic Area	2014 Community Health Assessment	2017 Community Health Assessment	NH State Comparison
Access to care				
Percentage of adult population (age 18+) without health insurance coverage	CNHHP Service Area	13.5%	9.2%	6.4%
Do not having a personal doctor or health care provider, percent of adults	CNHHP Service Area	14.1%	19.4%	13.2%
Have not visited a dentist or dental clinic in the past 5 years, percent of adults	CNHHP Service Area	14.3%	17.7%	11.4%
Health Promotion and Disease Prevention				
Current smoking, percent of adults	CNHHP Service Area	21.2%	24.2%	17.0%
Physically inactive in the past 30 days, % of adults	CNHHP Service Area	21.0%	22.7%	19.0%
Binge drinking, percent of adults	CNHHP Service Area	20.7%	16.6%	16.8%
Teen Birth Rate, per 1,000 Women Age 15-19	CNHHP Service Area	10.6	**8.9**	**12.0**

Community Health Indicator	Geographic Area	2014 Community Health Assessment	2017 Community Health Assessment	NH State Comparison
Health Outcomes				
Obese, percent of adults	CNHHP Service Area	25.1%	19.8%	27.0%
Ever told had diabetes, percent of adults	CNHHP Service Area	9.2%	7.7%	8.6%
Current asthma, percent of adults	CNHHP Service Area	18.3%	11.2%	10.1
Coronary Heart Disease Mortality, per 100,000 people, age-adjusted	CNHHP Service Area	151.8	90.9	95.9
Cancer Incidence, All sites, per 100,000 people, age-adjusted	CNHHP Service Area	509.6	489.8	498.8
Cancer Deaths, All Sites, per 100,000 people, age-adjusted	CNHHP Service Area	171.9	164.5	165.1
Years of potential life lost before age 75 per 100,000 population, age-adjusted	Grafton County	4,956	5,100	5,500