Valley Regional Healthcare

Community Health Needs Assessment 2021









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

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Community Input on Health Issues and Priorities,

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Please direct comments or questions to:

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Partner organizations for the 2021 Community Health Needs Assessment include Valley Regional Healthcare, Dartmouth-Hitchcock, New London Hospital, Lake Sunapee Region VNA & Hospice, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, Visiting Nurse and Hospice for VT and NH with technical support from the NH Community Health Institute/JSI.

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2021 Community Health Needs Assessment

Executive Summary

During the period February through July 2021 an assessment of Community Health Needs in the Valley Regional Healthcare service area was completed by in partnership with Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, New London Hospital, Mt. Ascutney Hospital and Health Center, Lake Sunapee Region VNA & Hospice, Visiting Nurse and Hospice for VT and NH, and the New Hampshire Community Health Institute. The purpose of the assessment was to:

- Better understand the health-related issues and concerns impacting the well-being of area residents;
- Inform community health improvement plans, partnerships and initiatives; and
- Satisfy state and federal Community Health Needs Assessment requirements for Community Benefit reporting.

For the purpose of the assessment, the geographic area of interest was 15 municipalities comprising the Valley Regional Healthcare service area with a total resident population of 43,104 people. Methods employed in the assessment included surveys of community residents made available through email, distribution at COVID-19 vaccination clinics, social media and website links through multiple channels throughout the region; a direct email survey of community leaders representing multiple community sectors; a set of ten community discussion groups convened virtually across the region; and a review of available population demographics and health status indicators including summary social determinant of health characteristics of Valley Regional Primary Care Practice patients.

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 community health needs assessment also acknowledged the significant impact of the COVID-19 pandemic, which was an over-arching concern affecting both the community health needs assessment process and the content of community input. Nearly half of respondents to the community survey indicated that they were *currently* experiencing increased stress or anxiety because of the COVID-19 pandemic (most community survey responses were received in May and June 2021). The table on the next page provides a summary of the priority community health needs and issues identified through this assessment.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of mental health services	'Ability to get mental health care services' was the top priority identified by both general community and community leader survey respondents.	The rate of Self Harm-related Emergency Department visits among area residents (218 per 100K population) was similar to the rate in NH overall (196 per 100K population) in 2018. Psychiatrist FTEs per 100k population (1.8) are less than half the FTE capacity in NH overall (5.0 per 100K population).	Identified as a continuing and top priority for community health improvement by all community discussion groups including concerns for insufficient local capacity, particularly for higher levels of care, and increased need resulting from anxiety, stress and isolation impacts of COVID-19.
Cost of health care services, affordability of health insurance	Cost of health care services including health insurance and prescription drug costs were the next highest priorities identified by general community survey respondents and third highest priority identified by community leaders.	The estimated proportion of people with no health insurance (7.0%) is similar to the overall percentage in NH (5.9%). About 9% of area residents reported delaying or avoiding health care because of cost.	Community discussion participants identified health care costs and financial barriers to care as significant and ongoing concerns. It was also the third most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health'
Alcohol and drug use prevention, treatment and recovery	Prevention of substance misuse, addiction and access to substance misuse treatment and recovery services were top issues identified by both community respondents and community leaders as priorities for community health improvement.	In 2018, the rate of Drug and Alcohol Related Emergency Department Visits per 100,000 population in the region was significantly lower than in NH overall. The rate of overdose mortality is also lower than in NH overall.	Participants identified improvements in resources for substance misuse prevention, treatment and recovery, but also noted that the need is still high, there are still issues with stigma in certain settings and gaps in services for detox and recovery housing. Concerns were identified for substantial disruption of recovery support by the COVID-19 pandemic.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Socio-economic conditions affecting health and well-being such as housing affordability, access to healthy foods and affordable, dependable child care	Affordable housing, livable wages, ability to buy and eat healthy foods, and affordable, high quality child care were identified as top resources supporting a healthy community that are in need of improvement.	About 33% of households in the VRH service area have housing costs >30% of household income. The service area is also characterized by a substantial range in community wealth where median household income in lower wealth communities is less than half the median household income in higher wealth communities.	Affordability and availability of housing was a common denominator across discussion groups addressing concerns of aging, mental health and substance use recovery, jobs and economy. Disparities in access to this and other resources such as child care and transportation were described as significant problems pre-pandemic made much worse by the pandemic.
Affordability and availability of dental care services	About 25% of community survey respondents reported difficulty accessing 'dental care for adults' in the past year. Common reasons cited for access difficulties were 'cost too much', no insurance, service not available and wait time too long	Percent of 36% adults in the service area report not having visited a dentist or dental clinic in the past year (pre-COVID statistic)	Issues related to dental care and health care provider availability including turnover, choice, wait time and cost were common response topics on open-ended question about 'one thing you would change to improve health'
Prevent child abuse and neglect	Prevention of child abuse and neglect was the 5th most frequently selected community health priority by community leader survey respondents (36%) and was also top concern among the general community (selected as a top priority by 27% of survey respondents).	The most recently available statistics for substantiated child maltreatment cases per 1,000 children under age 18 show a higher rate in Sullivan County (5.3) than across NH overall (3.5). (Annie E. Case Foundation, 2016)	Discussion group participants reported concerns about the effects of parental stress, poverty and substance misuse on the health and welfare of children in the community including effects of childhood trauma on health and wellbeing later in life.

Valley Regional Healthcare

2021 Community Health Needs Assessment

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A. COMMUNITY OVERVIEW WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total population of the Valley Regional Healthcare primary service area in 2019 was 43,104 according to the United States Census Bureau (American Community Survey). The service area population has increased by approximately 0.2% or about 89 people over the last 3 years since the last Community Health Needs Assessment. Table 1 displays the service area population distribution by municipality, as well as the proportion of residents who are under 18 years of age and the proportion who are 65 and older.

Compared to New Hampshire overall, the service area population has proportionally more seniors (about 21% are 65+ compared to about 18% in NH overall). A substantial range is observed for this statistic within the region from about 15% of Langdon and Croydon residents aged 65+ to about 30% of residents in Springfield, Unity and Acworth.

TABLE 1: Service Area Population by Town and Hospital Service Area

	2019 Population	% Total Service Area Population	% Under 18 years of age	% 65+ years of age
Acworth	906	2%	10%	31%
Charlestown	5,019	12%	20%	21%
Claremont	12,977	30%	21%	18%
Cornish	1,783	4%	20%	29%
Croydon	863	2%	17%	16%
Goshen	702	2%	20%	24%
Grantham	2,945	7%	18%	22%
Langdon	712	2%	24%	15%
Lempster	923	2%	24%	19%
Newport	6,374	15%	19%	19%
Plainfield	2,555	6%	19%	19%
Springfield	1,084	3%	14%	30%
Sunapee	3,449	8%	20%	20%
Unity	1,613	4%	9%	30%
Washington	1,199	3%	12%	26%
Valley Regional Healthcare Service Area	**43,104**	**100%**	**18.9%**	**20.8%**
State of New Hampshire	1,348,124		19.3%	17.5%

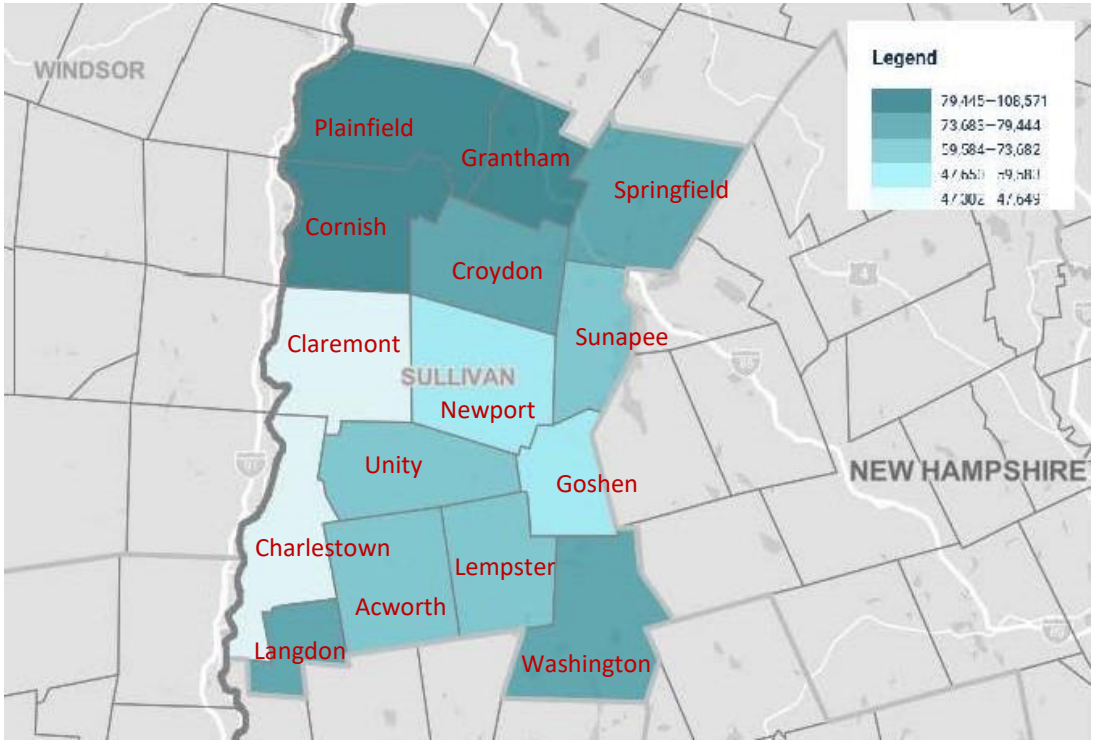
Table 2 displays additional demographic information for the municipalities of the Valley Regional Healthcare service area. As displayed by the table, the region has substantially lower median household income compared to New Hampshire overall. There is also a substantial range within the region on this measure with the highest median household income community (Grantham) having more than double the median household income in the lowest income communities (Charlestown and Claremont). The percent of people living below the federal poverty level also varies across the region from about 2% of the population of Grantham living in poverty compared to 16% in Claremont and 18% in Langdon. The map on the next page displays the distribution of median household income across towns in the service area.

TABLE 2: Selected Demographic and Economic Indicators

	Median Household Income	% with income under 100% Poverty Level	% family households with children headed by a single parent	% population with a disability
Charlestown	$47,302	15%	57%	14%
Claremont	$47,649	16%	49%	17%
Newport	$54,816	12%	41%	17%
Goshen	$59,583	14%	48%	10%
VRH Area	**$61,312**	**11.7%**	**38.7%**	**13.6%**
Acworth	$68,438	4%	17%	12%
Unity	$69,702	10%	56%	12%
Lempster	$70,156	8%	33%	14%
Sunapee	$73,682	8%	25%	7%
Croydon	$75,521	10%	33%	10%
New Hampshire	**$76,768**	**7.6%**	**28.3%**	**12.8%**
Washington	$78,224	3%	14%	8%
Langdon	$79,125	18%	14%	8%
Springfield	$79,444	7%	11%	9%
Cornish	$82,083	10%	15%	9%
Plainfield	$85,313	5%	24%	8%
Grantham	$108,571	2%	29%	12%

Figure 1 – Median Household Income by Town, Valley Regional Healthcare Service Area

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



Median household income ranges from $47,302 in Charlestown to $108,571 in Grantham.

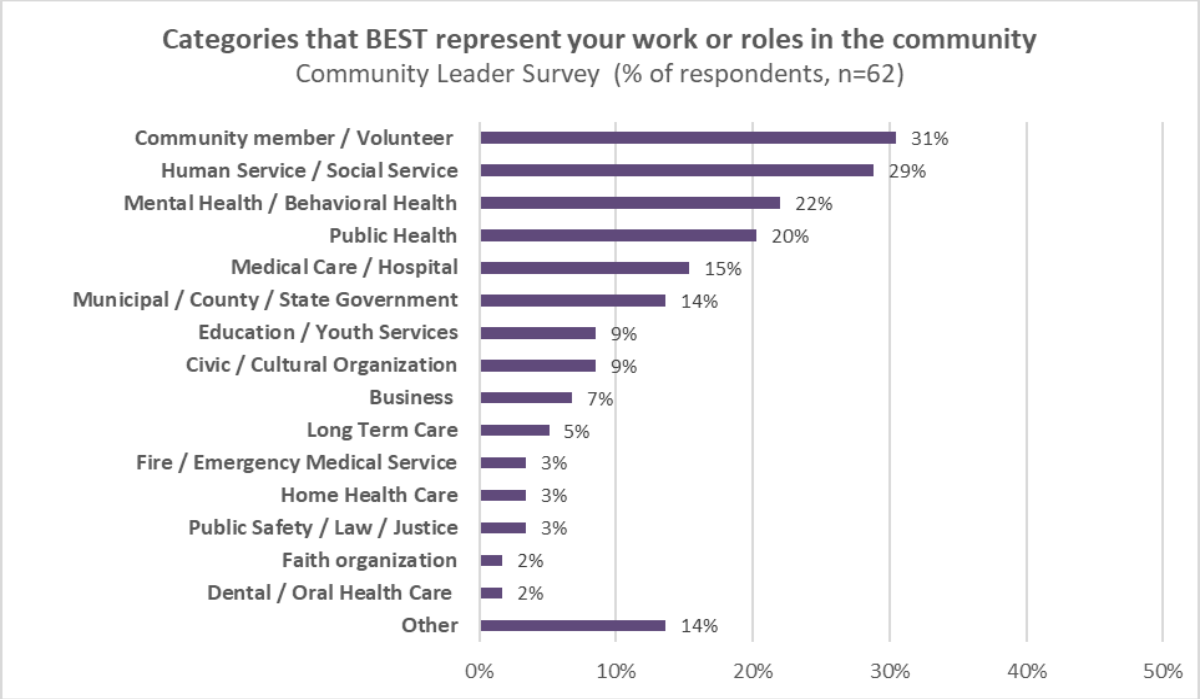
B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and July 2021, the Community Health Needs Assessment committee fielded two surveys: one with targeted distribution to community leaders and one broadly disseminated to residents across the region. The survey instruments were designed to have many questions in common to facilitate comparisons and contrasts in the analysis.

The community leader survey was distributed via unique email link to 352 individuals in positions of leadership in agencies, municipalities, business, civic and volunteer organizations serving the combined service areas of the partner organizations ranging from the Greater Claremont area to the New London area and to the Upper Valley communities of New Hampshire and Vermont. The survey distribution list was developed by the planning committee. With the understanding that some organizational leaders may be more familiar with some areas of the wider region than others, the survey instrument asked respondents to identify 'the areas you primarily serve or are most familiar with'. Of the 352 partners invited to participate in the Community Leader Survey, 207 people completed the survey (59% response).

Of the 207 respondents to the Community Leader survey, 62 (30%) indicated being familiar with the Greater Claremont area. The results included in this assessment report from the community leader survey are specific to that group of 62 respondents. Figure 2 displays the range of community sectors represented by these individuals. (Note: Respondents could identify as representatives of more than one sector).

| Figure 2 |



The community resident survey was distributed by the partner organizations through email distribution lists, distribution at mass vaccination clinics, and other social media communication channels, as well as promoted through posters and fliers with links and QR codes posted around the region.

A total of 569 community members completed the Community Resident Survey, representing all 15 towns of the Valley Regional Healthcare primary service area as well as a number of other communities. Table 3 below displays the grouping of respondents by community. Among respondents who provided information on their current local residence, more than half are residents of Claremont. The most common locations outside the service area were Springfield, VT (about 2% of respondents), Weathersfield, VT (<1%), and Lebanon, NH (<1%).

Compared to the regional demographics overall, community survey respondents were proportionally more likely to be female and over 65 years of age. Approximately 32% of respondents have household income of less than $50,000, 39% have income of $50,000 up to $100,000, and 19% reported household income of $100,000 or more. About 10% of respondents did not provide household income information. Table 4 below displays selected characteristics of respondents to the community survey.

| Table 4 |

Age < 65 years	Female	Black, Indigenous and People of Color	Current military service or veteran
73%	68%	6%	12%
Household Income < $50K	**Currently Uninsured**	**Currently has Medicaid coverage**	**Hard to do some Daily Tasks without help**
32%	4%	12%	9%

| Table 3 |

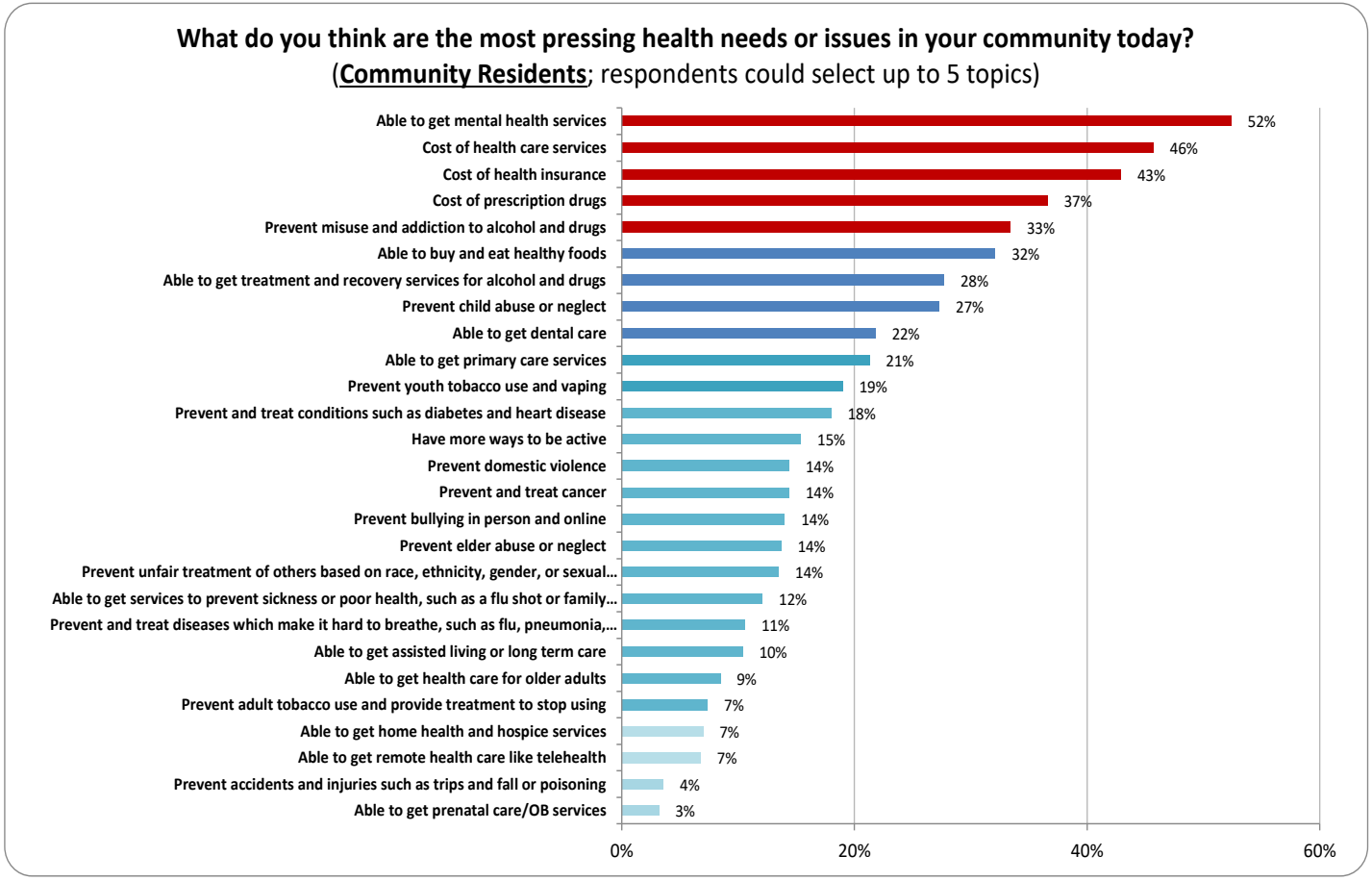
Town	# of respondents	% of total*
Claremont	246	52%
Charlestown	57	12%
Newport, Croydon, Unity (03773)	56	12%
Cornish	10	2%
Sunapee	9	2%
Goshen	6	1%
Plainfield	6	1%
Grantham	5	1%
Springfield	3	1%
Langdon	3	1%
Lempster	3	1%
Acworth	2	<1%
Washington	2	<1%
Other locations	62	13%

*Percent of respondents who provided information on the location of their residence. About 17% of respondents did not provide this information.

1. Priority Community Health Issues

Respondents to the community leader and general community resident surveys were asked to select the top 5 most pressing health needs or issues in the community from a list of 27 potential topics (plus an open-ended 'other' option). On the survey instrument, the topics were organized into 6 overall conceptual groups with 'plain language' descriptions as follows: Prevent Poor Health or Injury, Make Health Care Services Easier to Get, Address Costs of Care, Prevent and Treat Substance Misuse, Prevent and Treat On-going Conditions, Prevent Abuse and Violence. Survey respondents could select any of the individual topics from across the different topic groups.

| Figure 3 |



As displayed by Figure 3, 'Able to get mental health services' was the most commonly selected health need by respondents to the general community survey (52% of respondents selected this as a top 5 issue). The related issues of 'cost of health care services' (46%), cost of health insurance (43%), and cost of prescription drugs (37%) were the next 3 of the top 5 issues identified overall; followed by

'prevent misuse and addiction to alcohol and drugs' (33%). Ability to 'buy and eat healthy foods' was the final need or issue selected by more than 30% of respondents (32%). When the analysis is limited only to respondents who reported their residence to be one of the 15 towns in the primary Valley Regional Healthcare service area, the top concerns were the same:

- Able to get mental health services (selected by 54% of service area respondents)
- Cost of health care services (45%)
- Cost of health insurance (44%
- Cost of prescription drugs (39%)
- Able to buy and eat healthy foods (34%
- Prevent misuse and addiction to alcohol and drugs (33%)

Table 5 displays the top priorities by age group. The most frequently selected needs or issues were similar across age groups although respondents under the age of 45 were somewhat more likely to prioritize "Able to buy and eat healthy foods" and "Prevent child abuse or neglect'. Older respondents were more frequently selected 'Cost of prescription drugs' and 'Prevent misuse and addiction to alcohol and drugs' among the top 5 most pressing community health needs or issues.

| Table 5: Top Priorities by Age Group |

Age 18-44 (n=151)		Age 45-64 (n=200)		Age 65+ (n=128)	
Able to get mental health services	62%	**Able to get mental health services**	57%	**Cost of health care services**	50%
Cost of health care services	45%	**Cost of health insurance**	53%	**Cost of prescription drugs**	43%
Cost of health insurance	39%	**Cost of health care services**	46%	**Able to get mental health services**	41%
Able to buy and eat healthy foods	38%	**Cost of prescription drugs**	40%	**Cost of health insurance**	34%
Prevent child abuse or neglect	36%	**Prevent misuse and addiction to alcohol and drugs**	36%	**Prevent misuse and addiction to alcohol and drugs**	31%

The chart below displays the results from the Community Leader survey on the same question with the same response options. Community Leaders also identified 'Able to get mental health services' as the top health need with 71% of respondents selecting this issue. Community leaders also identified substance misuse prevention and cost of health care services as Top 5 issues, along with ability to get substance misuse treatment and recovery services and prevention of child abuse or neglect.

| Figure 4 |

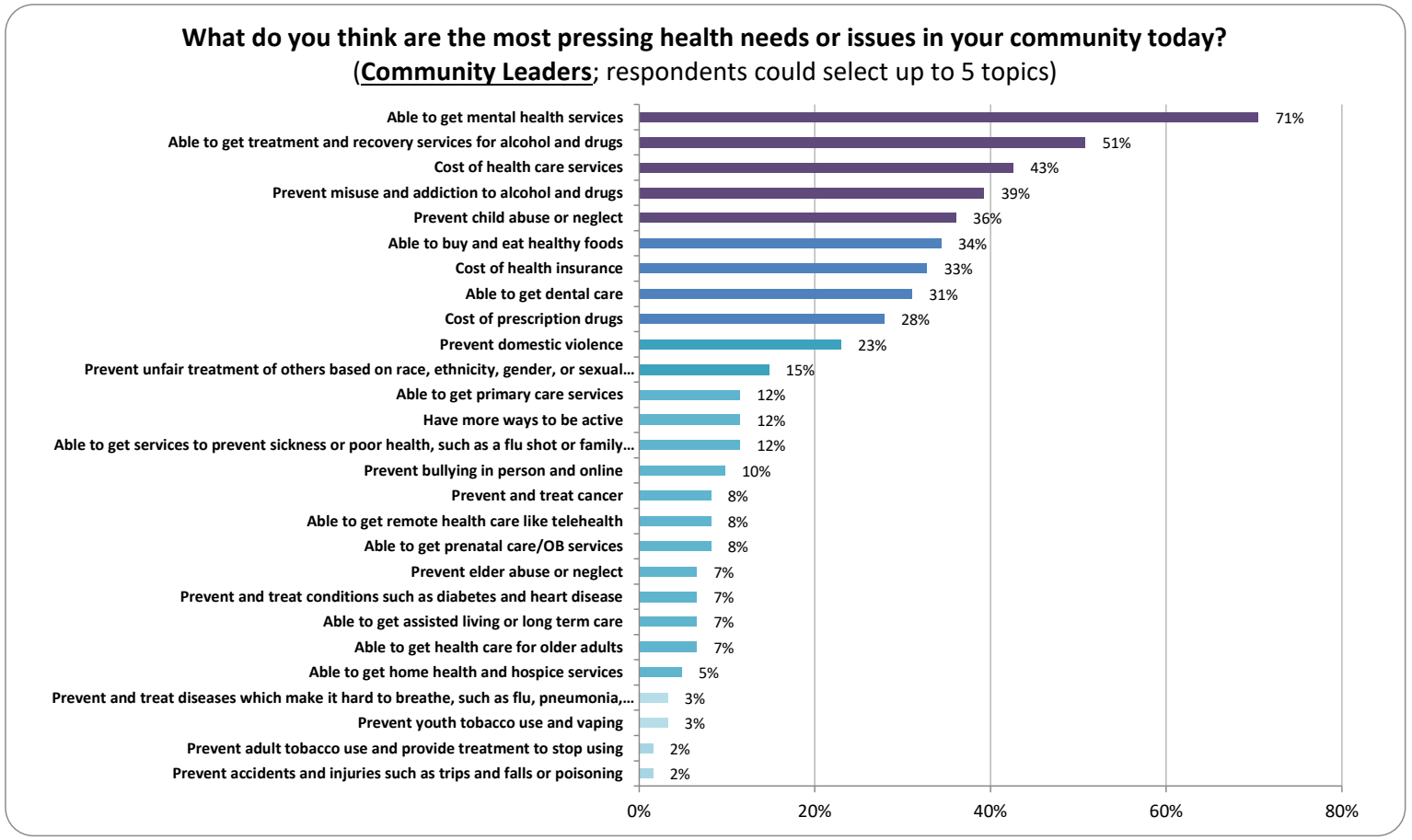
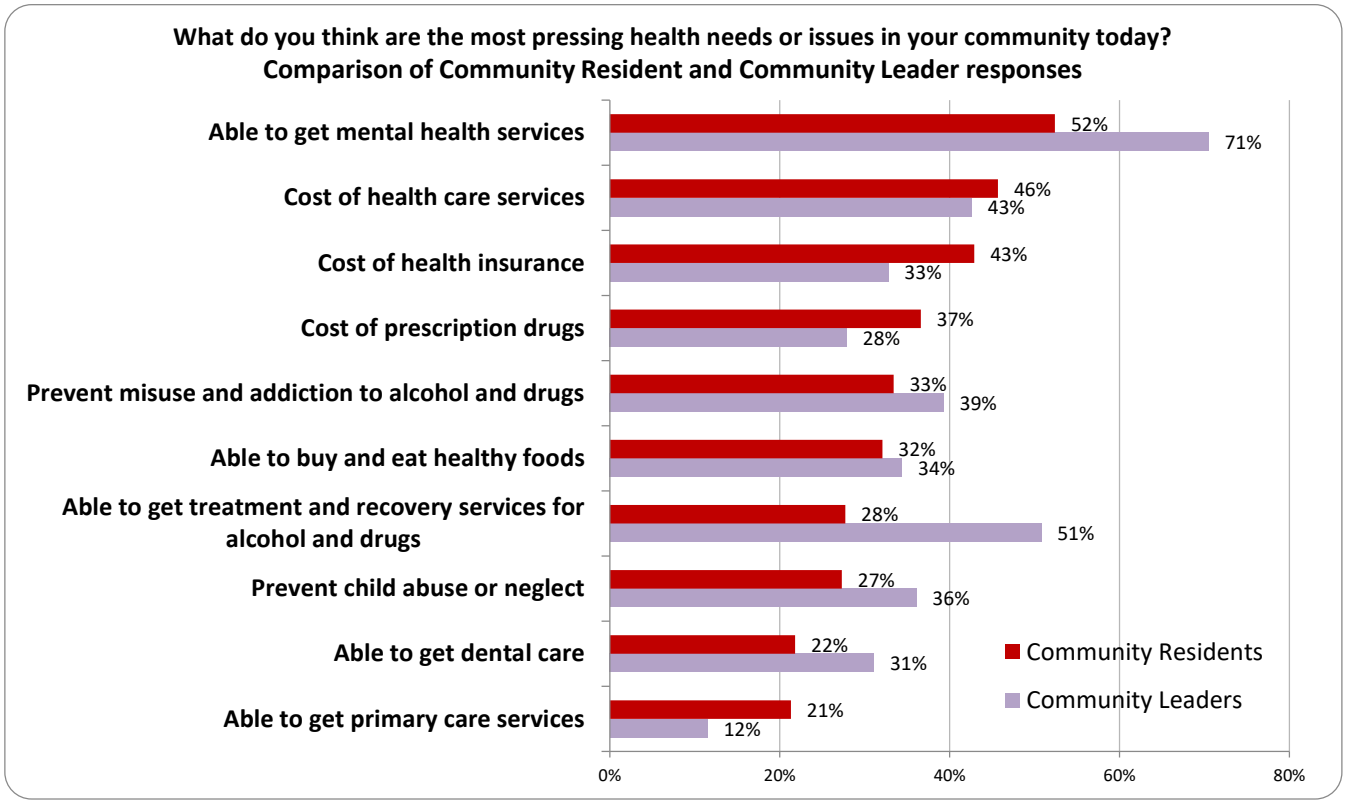


Figure 5 displays a comparison of the top 10 most pressing health issues selected by Community Resident survey respondents compared to the responses from Community Leaders on the same topics. Nine (9) of the top 10 issues identified were the same between the two groups of respondents. The one topic selected by Community Resident respondents ahead of other issues compared to Community Leader respondents was 'Able to get primary care services', while 'Prevent domestic violence' was a top 10 issue among Community Leaders (23% of Community Leaders and 14% of Community Residents selected domestic violence as a top community health issue).

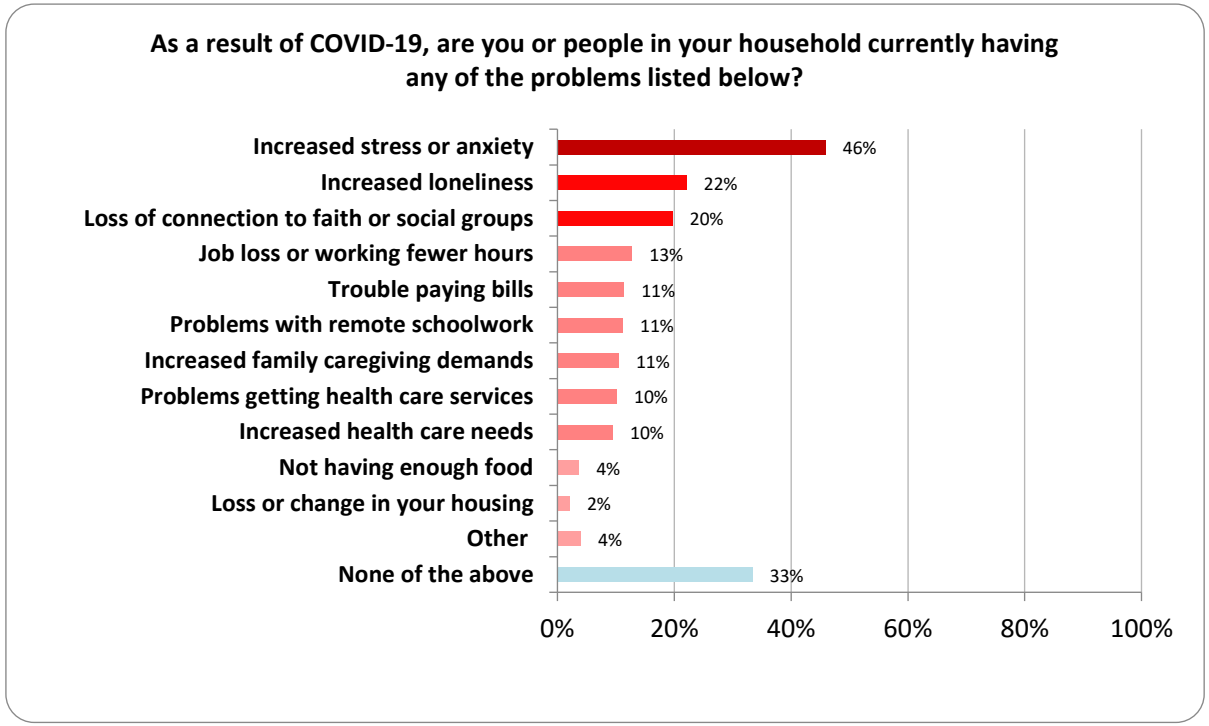
| Figure 5 |



2. COVID-19 Pandemic Impact

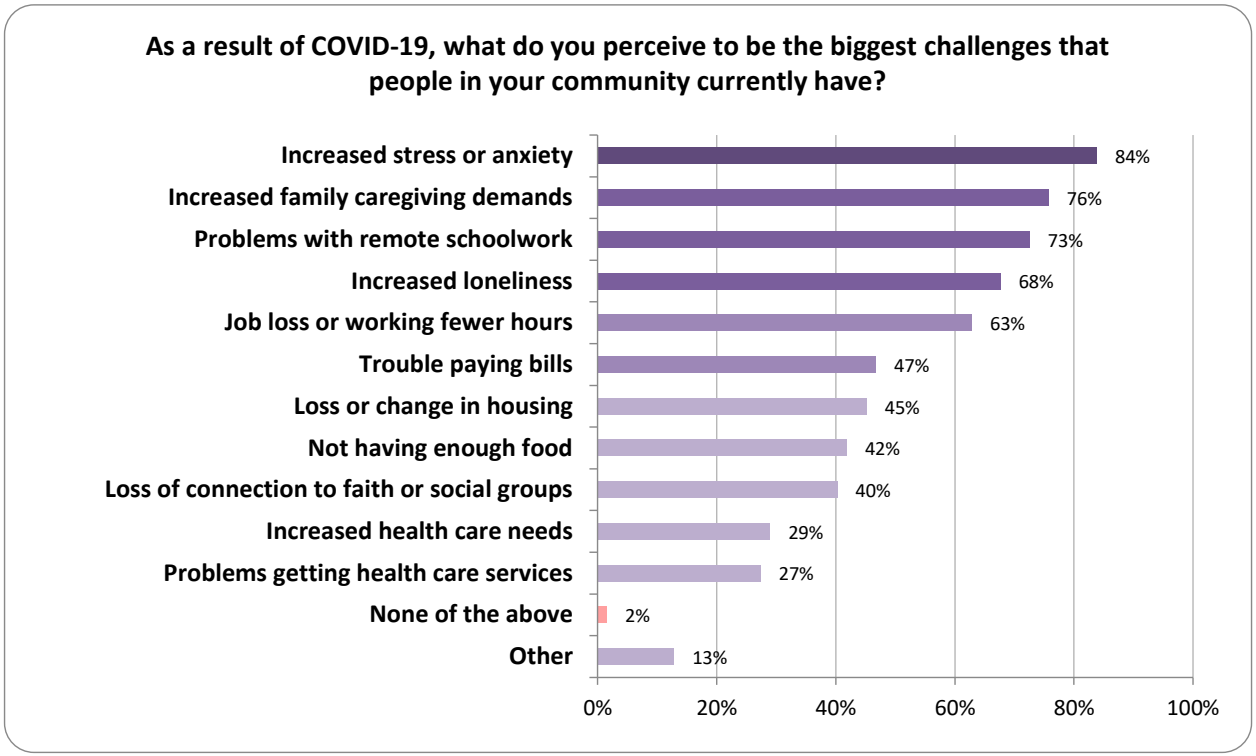
The COVID-19 pandemic has clearly had a significant impact on many community members and was an over-arching concern affecting both the community health needs assessment process and the content of community input. Consequently, the planning committee felt it important to specifically ask community members for input on how COVID-19 was *currently* affecting them or people in their household. Nearly 1 of every 2 survey respondents indicated that they were *currently* experiencing increased stress or anxiety as a result of the COVID-19 pandemic. (Most community survey responses were received in May and June 2021). About 1 in every 5 respondents were currently experiencing loneliness or loss of connection to faith or social groups. About 10% of respondents indicated problems getting health care services or increased health care needs. About one-third of respondents (33%) indicated not *currently* experiencing any of the impacts of COVID-19 listed as options on the question.

| Figure 6 |



The Community Leader survey asked a similar question about the current impact of the COVID-19 pandemic on people in the community. 'Increased stress or anxiety' was also identified by Community Leaders most frequently as the 'biggest challenge' of the pandemic; along with increased family caregiving demands and problems with remote schoolwork (respondents could select all that apply).

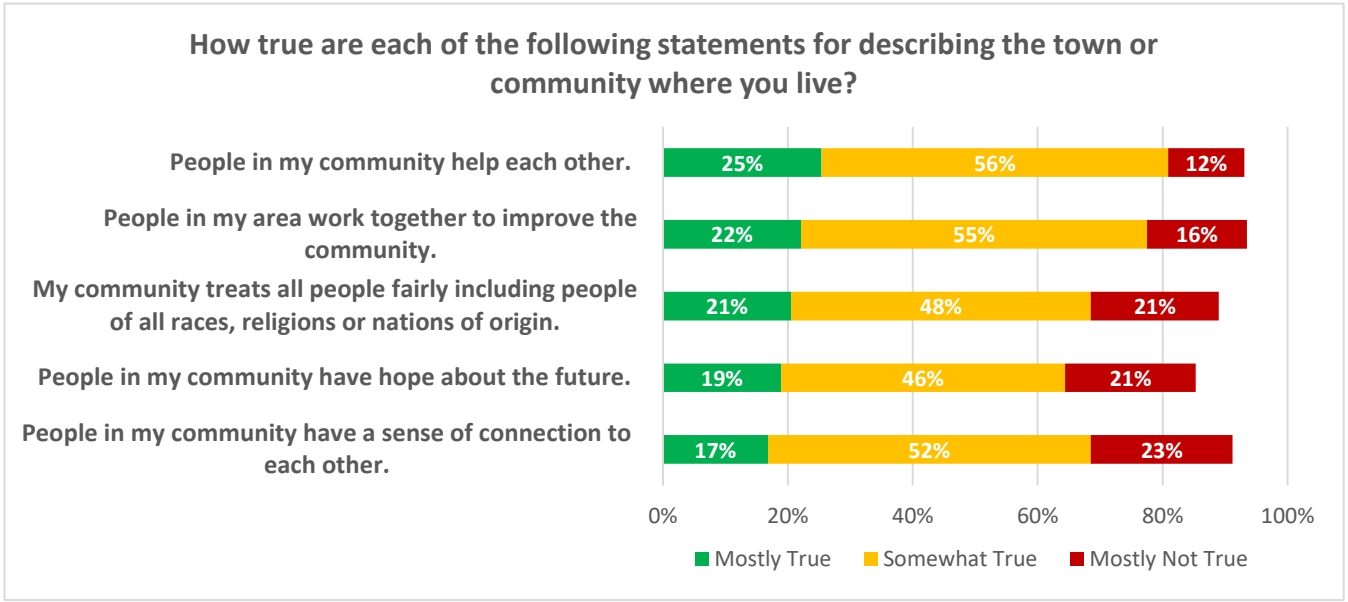
| Figure 7 |



3. Characteristics of a Resilient Community

The Community Resident survey asked people to indicate how true certain characteristics of a resilient community were for the community in which they live. As displayed by Figure 8, 25% of respondents thought the statement, “People in my community help each other” was ‘mostly true’, while most respondents (56%) thought the statement was ‘somewhat true’. Less than 20% of respondents indicated that it was ‘mostly true’ that “People in my community have hope about the future” or “People in my community have a sense of connection to each other.”

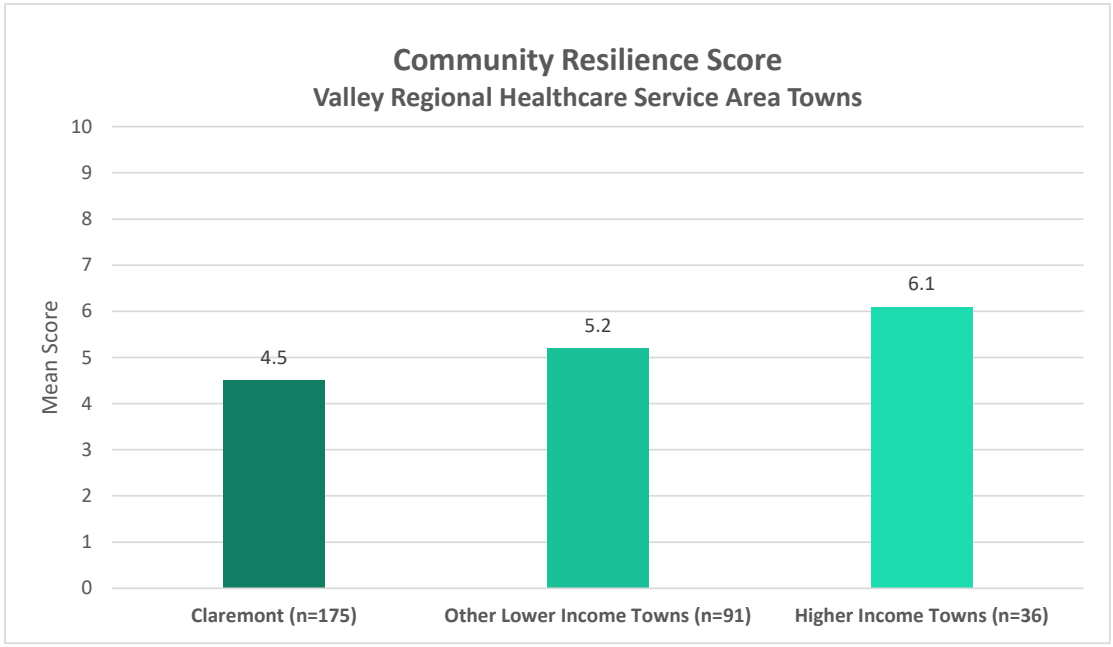
| Figure 8 |



Totals do not equal 100%. Response choice of “Don’t Know” not displayed.

Further analysis of this set of questions was conducted by calculating a composite 'Community Resilience Score' for each respondent with possible scores ranging from zero to 10 (5 questions, each question with possible values of 2, 1 or 0) where a score of 10 results when a respondent indicates that each of the 5 statements describing a resilient community are 'Mostly True'. Scores were then aggregated for 3 sets of communities within the Valley Regional Healthcare service area: (1) Claremont, (2) other service area communities with median household incomes below the overall regional median (Newport, Charlestown, Goshen); and (3) communities with median household incomes above the overall regional median (Cornish, Plainfield, Grantham, Sunapee, Springfield, Langdon, Lempster, Acworth and Washington). The chart displays the mean Community Resilience Score calculated from the responses from residents for each of these community groupings. The mean score for Claremont is significantly lower than the mean score both of the other town groupings. The 'Other Lower Income Towns' group is also significantly different and lower than the mean score for the Higher Income Towns group (One-Way ANOVA, p>.01). (Note: Responses were excluded from this analysis from respondents not reporting a residential location or who reported locations outside the VRH hospital service or who did not provide a response on all 5 questions comprising the composite score).

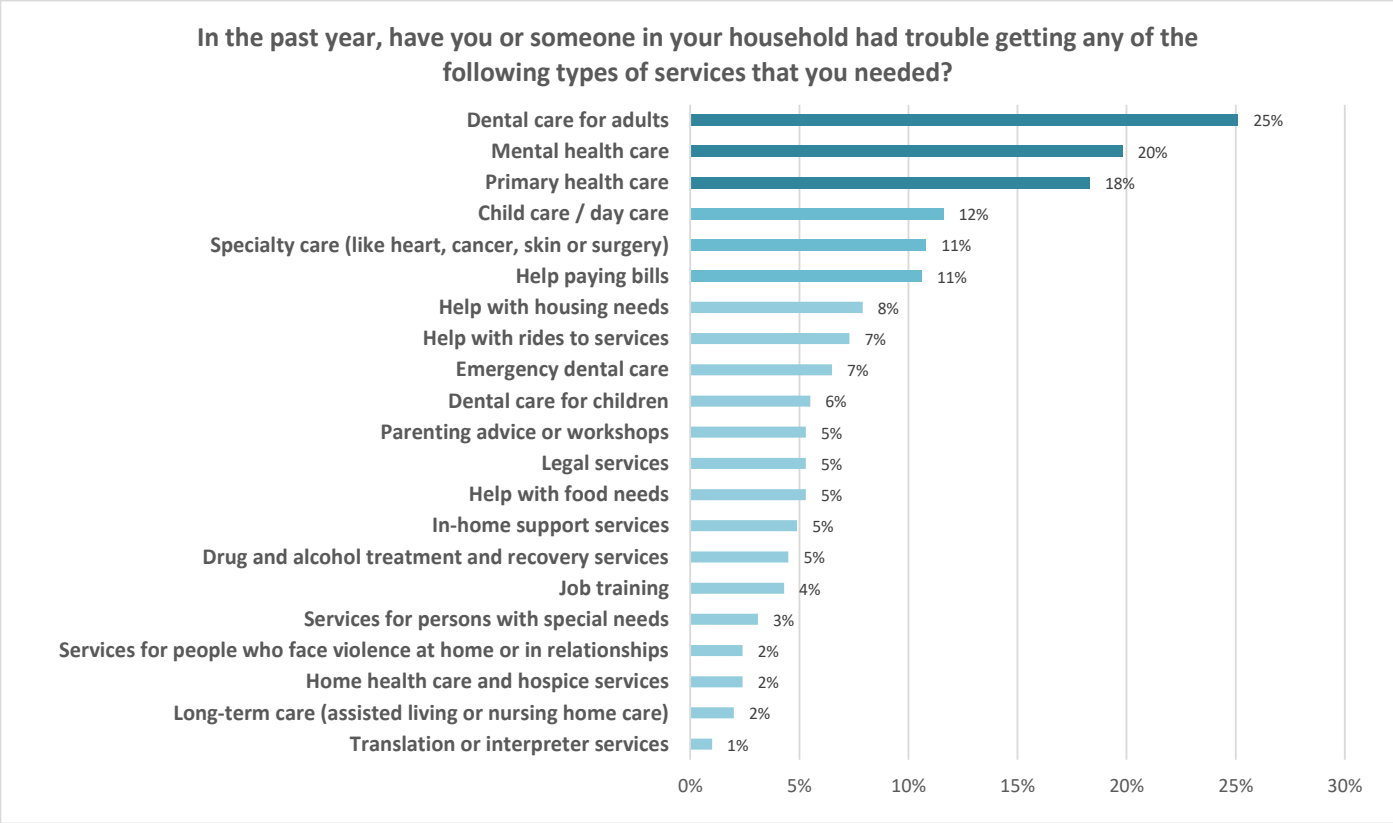
| Figure 9 |



4. Barriers to Services

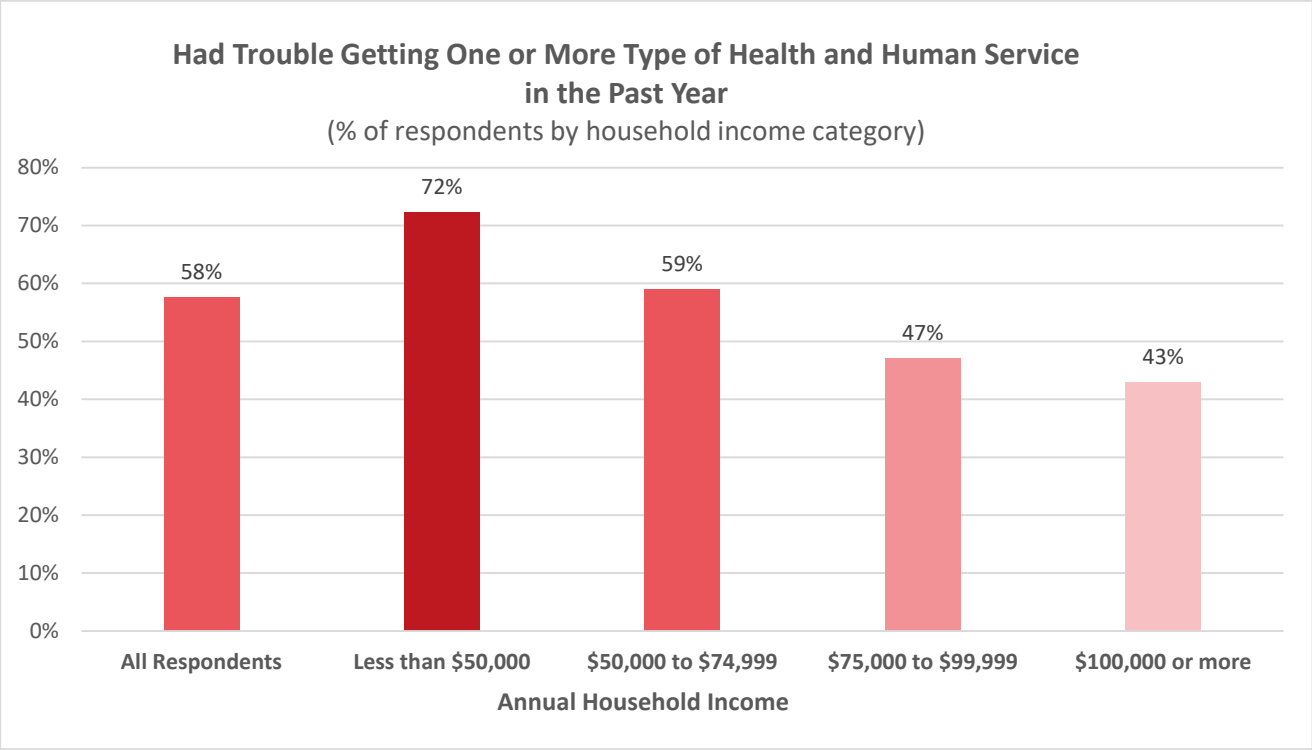
Respondents to the Community Resident survey were presented with a list of potential health and human services and asked, "In the past year, have you or someone in your household had trouble getting any of the following types of services that you needed?" As displayed by the chart below, about 25% of respondents indicating have difficulty getting 'Dental care for adults'; about 20% had difficulty getting 'Mental health care'; and about 18% had difficulty getting 'Primary health care services' over the past year. Overall, about 58% of all respondents indicated having difficulty getting at least one type of service for themselves or someone in their household over the past year. This statistic is substantially higher than in past community health needs assessments and may be reflective of the impact of COVID-19 on need, availability, and accessibility of some health and human services.

| Figure 10 |



There is a significant relationship between the likelihood that respondents reported having difficulty accessing services and household income. While a high proportion of respondents in all income categories reported difficulty accessing at least one type of service, respondents with annual income less than $50,000 were most likely to report access difficulties.

| Figure 11 |



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked a follow-up question about the reasons why they had difficulty for each type of service selected. As displayed by Table 6, among respondents who indicating difficulty accessing Dental Care for Adults or Child Care / Day Care services, the top reason reported for difficulty accessing services was 'Cost too much'. Among respondents indicating difficulty accessing Mental Health Care or Primary Health Care services, the top reason cited was 'Wait time too long'.

| Table 6: Top Reasons Respondents Had Difficulty Accessing Services by Type of Service |

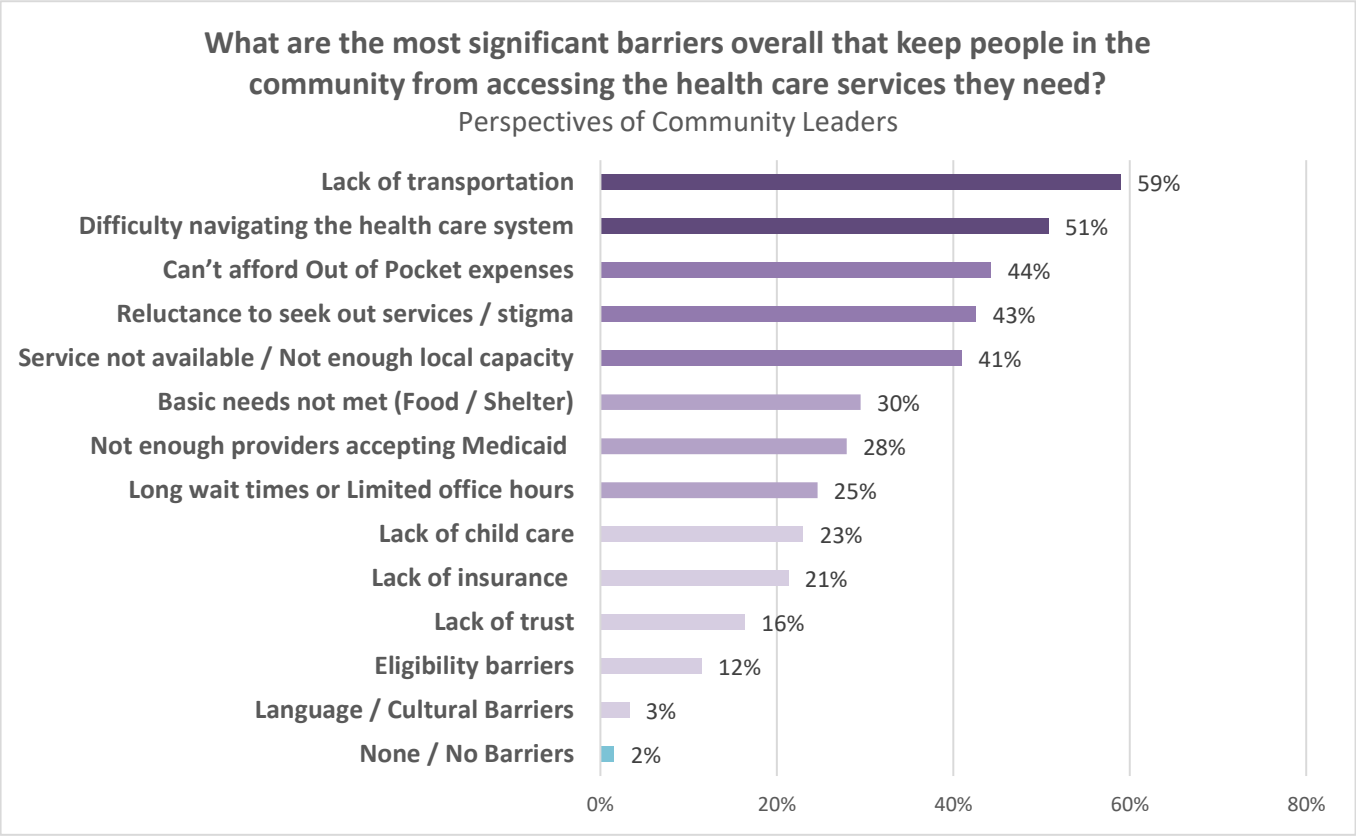
(Percentage of respondents who reported difficulty accessing a particular type of service)

DENTAL CARE FOR ADULTS (n=128, 25% of respondents)	MENTAL HEALTH CARE (n=101, 20% of respondents)	PRIMARY HEALTH CARE (n=93, 18% of respondents)	CHILD CARE / DAY CARE (n=59, 12% of respondents)
51% of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Cost too much"** as a reason	**48%** of respondents who indicated difficulty accessing Mental Health Care also selected **"Wait time too long"** as a reason	**40%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Wait time too long"** as a reason	**54%** of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason
No dental insurance or not enough dental insurance (50%)	**Service not available (46%)**	**Service not available (22%)**	**Service not available (42%)**
Service not available (24%)	**Cost too much (32%)**	**Not accepting new patients (21%)**	**Wait time too long (32%)**
Wait time too long (22%)	**Not accepting new patients (31%)**	**No health insurance or not enough health insurance (20%)**	**Not accepting new clients (26%)**

In a separate question, Community Survey respondents were asked: ***"In the past year, how often has anyone in your household missed getting health care or social services because of unfair treatment?"*** 'Unfair treatment' was further specified as "discrimination or stigma based on your race, ethnic group, gender, sexual orientation, age, disability, language, or education". Overall, 1.4% of respondents indicated that they or someone in their household had **"Often"** missed getting health care or social services because of unfair treatment, 6.4% indicated **"Sometimes",** and 92% indicated **"Never"** missing health care or social services because of unfair treatment.

Respondents to the Community Leader survey were asked to identify the most significant barriers overall that prevent people in the community from accessing needed health care services. The top issue identified by this group was lack of transportation, followed by 'difficulty navigating the health care system', 'Can't afford out of pocket expenses', and 'Reluctance to seek out services / stigma'.

| Figure 12 |

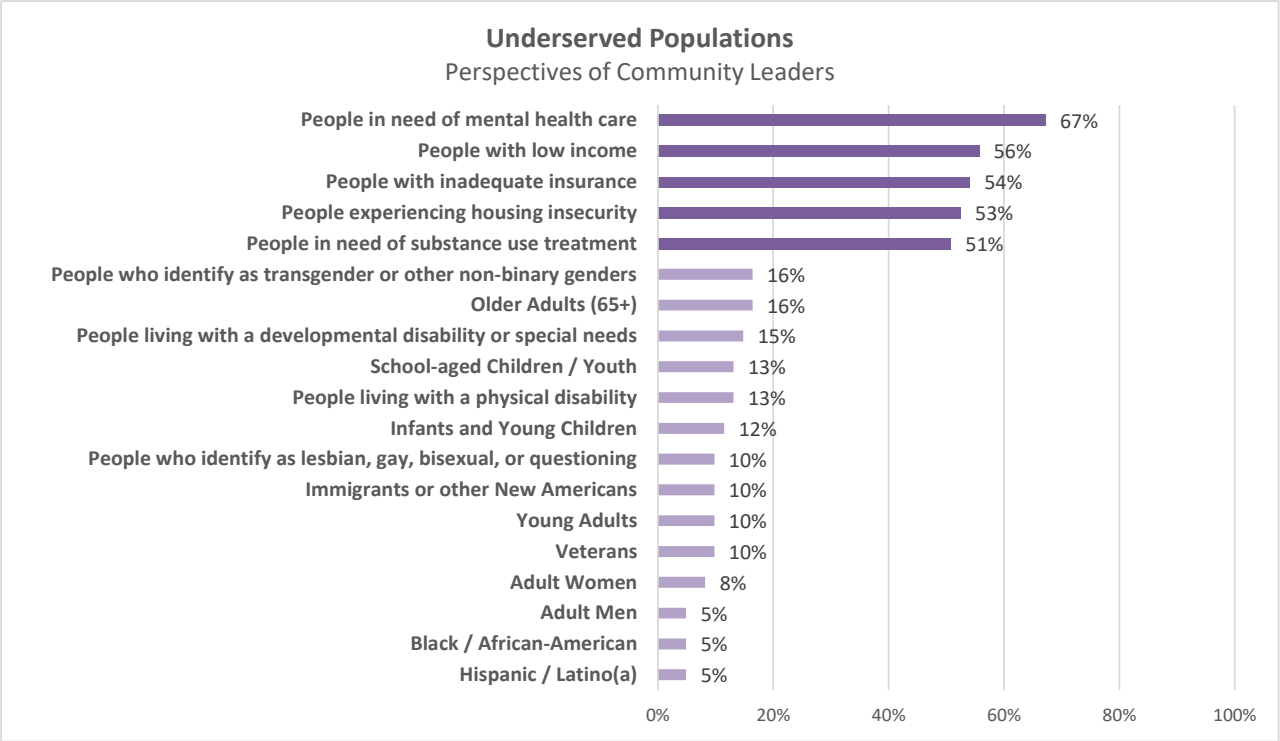


Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. As displayed by Figure 12, populations most frequently identified by Community Leader respondents as underserved were people in need of mental health care; with low income; with inadequate health insurance; experiencing housing insecurity; and people in need of substance abuse treatment.

In a related question, Community Leaders were asked, "Are there particular types of health providers, specialties or services that are needed in the community due to insufficient capacity or availability?" Nearly three-quarters of respondents (71%) responded affirmatively. By far, mental health was the most commonly cited service with insufficient capacity or availability (70% of those indicating any specific type of provider or service).

> ***"Access for mental health services is not sufficient to meet the needs of the community, especially for people with complex, chronic or acute mental health needs."***
>
> - *Community Leader Respondent*

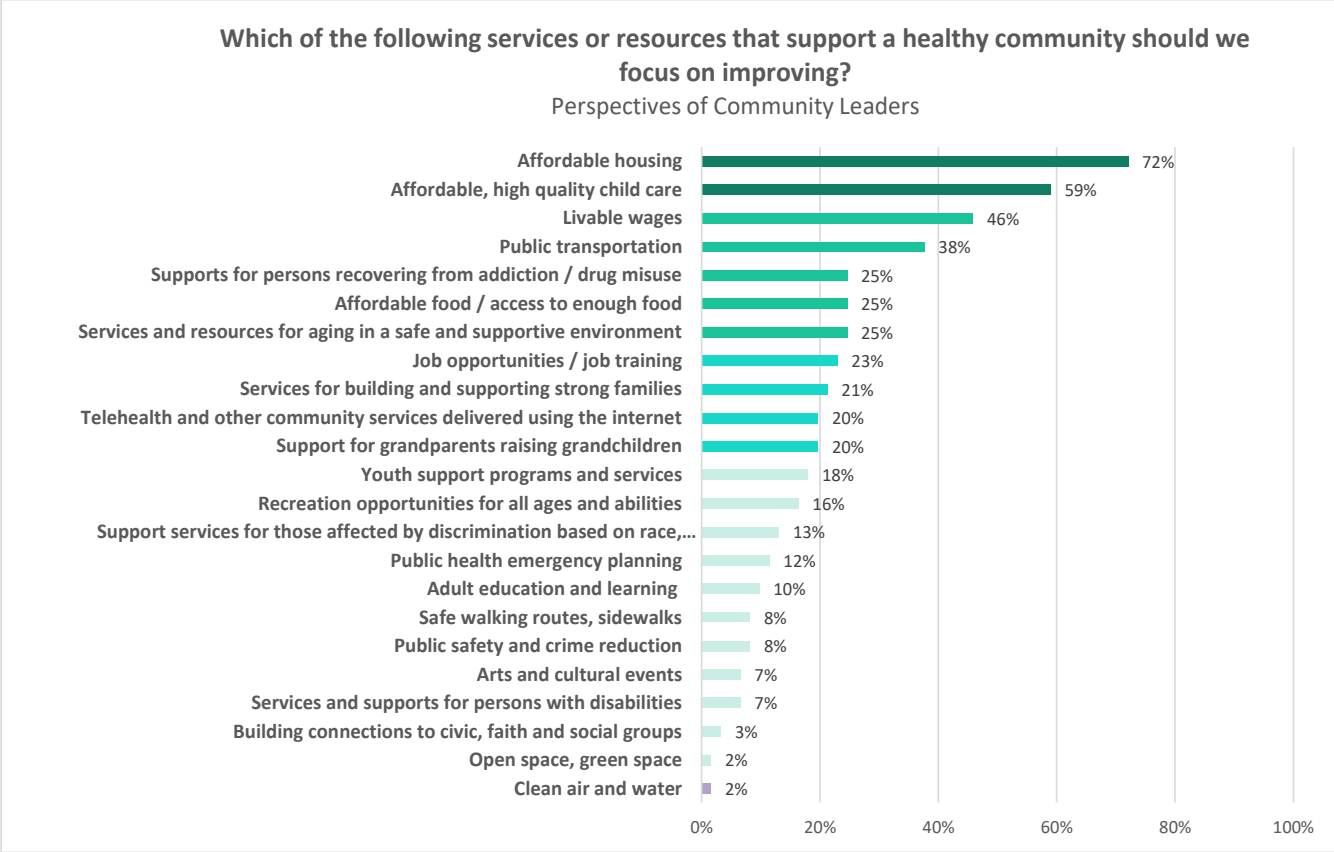
| Figure 13 |



5. Services and Resources to Support a Healthy Community

Community leaders were asked to select from a list of 23 potential topics (plus an open-ended 'other' option) the top 5 services or resources supporting a healthy community that should be focused on. Sometimes described as social determinants of health, the items included in this question generally describe underlying community attributes that indirectly support the health and well-being of individuals and families. On the survey instrument, the topics were organized into 6 overall conceptual groups described as follows: Basic Needs; Community Safety; Family Services and Supports; Infrastructure and Environment; Jobs and Economy; Welcoming Community. Survey respondents could select any of the individual topics from across the different topic groups. As displayed by the chart, Affordable Housing was identified by nearly three-quarters of community leader respondents as an area the community should focus on to support community health improvement. Other top focus areas were Affordable, high quality child care; Livable wages; and Public transportation.

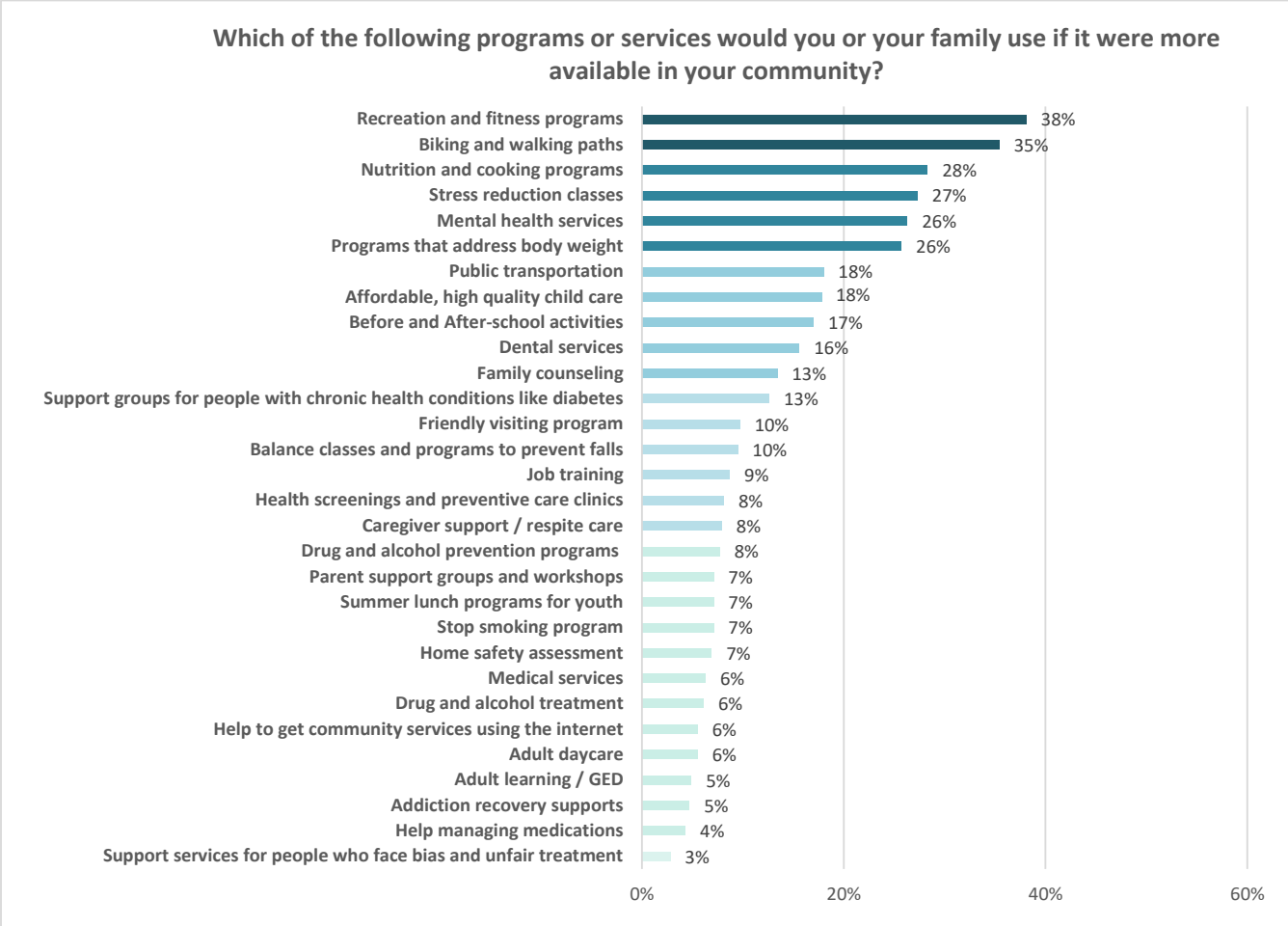
| Figure 14 |



6. Interest in Specific Community Health Programs or Services

Community members were asked a variation on the question of community services or resources to support health. Community residents were asked what **programs or services they would use if more available** in the community. The survey instrument included a list of 30 topics organized into six overall conceptual groups as follows: Services for Children and Parents; Services for Older Adults; Healthy Lifestyle Programs; Counseling and Mental Health Services; Health Care Services; Community Services and Supports. Survey respondents could select any number of individual topics from across the different topic groups. As displayed by the chart, the highest amount of interest was reported for using Recreation and Fitness programs as well as Biking and Walking Paths. Other services most frequently mentioned were nutrition programs, stress reduction classes, mental health services and programs that address body weight. The table on the next displays the top resources of interest by age group.

| Figure 15 |



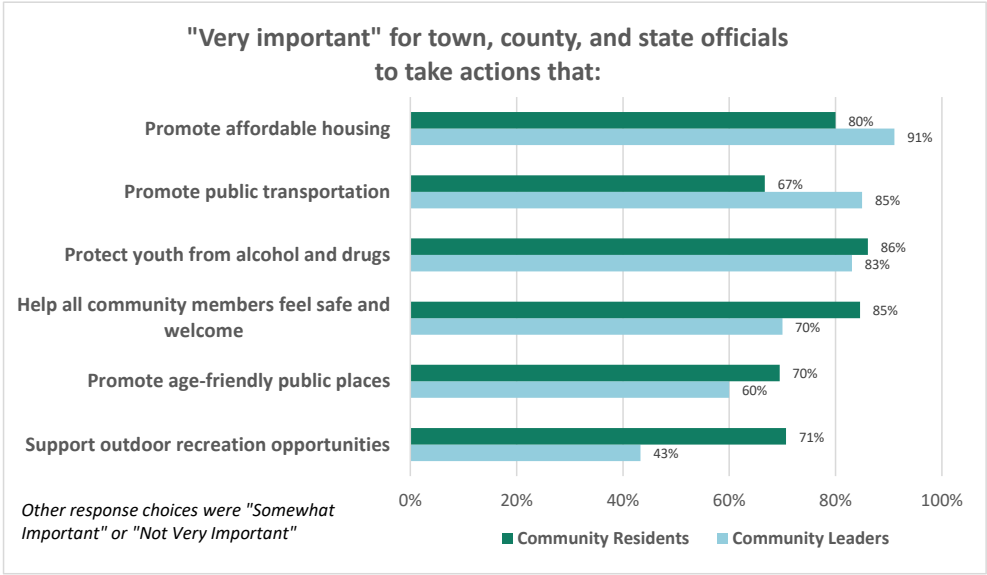
| Table 7: Top services or resources people would use if more available, by Age Group |

Age 18-44*		Age 45-64		Age 65+	
Recreation and fitness programs	46%	Recreation and fitness programs	42%	Recreation and fitness programs	26%
Mental health services	42%	Biking and walking paths	40%	Biking and walking paths	26%
Biking and walking paths	41%	Programs that address body weight	35%	Public transportation	21%
Nutrition and cooking programs	36%	Nutrition and cooking programs	31%	Nutrition and cooking programs	19%
Stress reduction classes	36%	Stress reduction classes	30%	Balance classes and programs to prevent falls	19%

*Note: Respondents age 18-44 were also substantially more likely than older age groups to indicate interest in more availability of Before and After-school activities (33%) and Affordable, high quality child care (31%).

Respondents to the community resident and community leader surveys were asked how important it is for town, county, and state officials to take certain actions associated with community health. As displayed by Figure 15, nearly all community leader respondents (91%) indicated it was "very important" for officials to take actions that 'promote affordable housing'. The actions most frequently indicated to be "very important" by community residents were 'protect youth from alcohol and drugs' (86%) and 'help all community members feel safe and welcome' (85%), as well as promoting affordable housing (80% 'very important').

| Figure 16 |



The 2021 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you believe would improve health in your community, what would you change?"* A total of 284 survey respondents (50%) provided written responses to this question. Table 8 provides a summary of the most common responses by topic theme.

TABLE 8

"If you could change one thing that you believe would improve health in your community, what would you change?"

Availability / affordability of mental health services; mental health awareness / stigma	**16% of all comments**
Health care provider availability including certain specialties; hours and wait time; health care delivery system improvements, quality and options	**15%**
Affordability of health care/low cost or subsidized services; insurance; health care payment reform	**11%**
Accessibility/availability of substance use treatment services; substance misuse prevention including tobacco	**8%**
Caring community / culture; community connections and supports	**7%**
Affordable housing; improved job opportunities; economy, taxation and welfare	**7%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**6%**
Healthy lifestyle awareness and education, prevention and personal accountability	**6%**
Improved resources, programs or environment for healthy eating / nutrition / food affordability	**5%**
Services or resources for youth and families	**4%**
Community Safety / Accessibility	**3%**
Natural Environment / Environmental Protection	**2%**
Affordability / availability of dental services	**2%**
Senior services / concerns of aging / home health care / assisted living	**1%**
Improved transportation services / public transportation; medical transportation	**1%**
COVID-19 Prevention, Policy	**1%**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

Convening community discussion groups was challenging during the 2021 Community Health Needs Assessment. Due to the ongoing Covid-19 pandemic, discussion groups had to be held virtually to protect the health and safety of participants. The Community Health Needs Assessment Committee worked with community partners to identify and recruit a variety of groups and participants intended to represent a broad cross-section of the region and different community interests. In spite of the challenging context of the ongoing pandemic, the committee and our community partners successfully convened 10 different community discussion groups representing the following sectors, attributes or topics:

- Behavioral Health Coordinators (6 participants)
- Community Health Workers (4 participants)
- Food Insecurity (2 participants)
- Regional Public Health (2 participants)
- Substance Use Recovery Coaches (7 participants)
- Medication Assisted Treatment (5 participants)
- Chamber of Commerce Directors (5 participants)
- Rural Community Residents (6 participants)
- Individuals with Complex Health Needs (4 participants)
- Seniors (6 participants)

The purpose of each of the discussion groups was to get more in-depth qualitative input on health issues that matter to the community, descriptions of ongoing challenges including the COVID-19 pandemic, observations on past community health improvement efforts, and suggestions for new or continuing areas of focus. In addition, the assessment committee worked with students from The Dartmouth Institute's Master of Public Health (MPH) program to facilitate and take notes for each community discussion group using a semi-structured discussion group guide to foster some measure of consistency and comparability across the different discussion groups. The following paragraphs summarize the main themes with illustrative quotes for some of the core questions included in the discussion guide such as the impact of the COVID-19 impact, opportunities for more effectively addressing inequities and discrimination, and resources needed to support healthy aging. Following these summary paragraphs is a table with additional information from each of the discussion groups on overall community health improvement priorities.

1. Impact of COVID-19

Many discussion group participants spoke of the social isolation, loneliness separation, and anxiety. Other impacts of COVID-19 included:

- Significant impacts on family finances, unemployment, food insecurity, juggling work, child care, remote schooling; "COVID has impacted just being able to get things done in general."
- COVID has had a big impact on family mental health; "The impact of remote schooling on child mental health seems to have been largely dismissed."
- Reduced access to care and delayed care; "I have clients who are going without routine medical care or mental health because they have no one to watch their child and they're not allowed to bring them."
- Limits or stopped a lot transportation services; has impacted seniors in particular; and also a problem with Medicaid transportation providers canceling scheduled rides with no backup causing patients to miss important visits; especially an issue for rural residents in winter

> ***"I exist in my own little castle here doing things and sometimes I get bored and I know that's not being bored; that's being depressed."***
> - *Senior Group Participant*

- Difficulties navigating virtual visit technology
- For mental health and substance use recovery, not being able to meet in support groups; not being able to have social interaction has been very detrimental to recovery.
- "Everyone is being affected multiple ways all the time . . . . There has been incredible pressure to get information out as rapidly as possible. It's been a really long year. A lot of stress. A lot of pressure."

> ***"People are isolating and people are drinking alone. People are drinking, because they don't know what else to do and this is how they are surviving the day and getting through . . . . Once they start drinking, then their decision goes off. Then that leads them to making poor decisions about using something else, or doing other things that they shouldn't be doing."***
> - *SUD Recovery Group Participant*

2. Resources to Support Aging in Place

The community discussion group participants were asked what additional community resources are needed to help people plan ahead for aging in place? Aging in place was defined as the ability to live in one's own home and community safely, independently and comfortably. Some of the ideas and suggestions included:

- A community nurse or a health coordinator in rural towns; someone who helps people navigate services or can check in on them periodically;
- More resources to help people assess and retro-fit homes for age-related safety (e.g. ramps, handrails); 'When you have your annual Medicare review, it would be helpful to have an annual at-home evaluation by the occupational therapist' was one suggestion.
- There is a need to start educating people about financial planning early on.

> ***"We don't have a consistent kind of order of operations for these discussions. When you turn 65, you come in for a welcome to Medicare visit. I feel like there should be a discussion at that point or some sort of stepping stone to say, what is your plan for aging? What do you see for yourself in the next 10 years? We have advanced care planning. I think there should be long term care planning that's deliverable in the health care setting. There's a lot of families that don't know where to even ask these questions."***
>
> - *Behavioral Health Coordinator Group Participant*

- There is a lot of discussion about workforce shortages in senior serving organizations; it was observed that it is difficult enough to find home care services in the daytime and that overnight care is a huge, incredibly challenging issue.
- Home-based, non-health care related supports such as home maintenance, cleaning, shopping and other non-health care social supports are key; and 'there are a lot of resources in the community for helping older adults remain vibrant, but much of it is for well-resourced seniors', but we have a lot of seniors in more rural communities who are struggling';
- There are lengthy wait lists - several years - for subsidized senior housing; it was observed that many seniors are not planning that far ahead.
- "Council on Aging is a great resource; can borrow medical equipment, can get rides to appointments, there are also activities that you can participate in to keep you moving forward, to keep you functioning and keep you happy."

> ***"Being able to stay in one's home sometimes could just mean needing a home health aide to come in and assist with specific aspects of being at home. And while we do have some organizations in the area providing those services, we don't have enough to go around especially considering the increasing number of people who are going to need those services over the next 5 to 10 years."***
>
> - *Chamber of Commerce Group Participant*

3. Addressing Discrimination and Stigma

Community discussion group participants were asked what health care providers or other organizations serving the community could be doing better to address barriers related to discrimination or stigma. Some of the ideas and suggestions included:

- Provider education around stigma is needed, 'A Lot of Education'; and more employee engagement
- Discussing issues of race and discrimination and doing something to address them should be happening all the time, not only because of a holiday or what is happening in the news.
- More mindfulness on some basic things, such as how questions are phrased. For example, when asked about marital status, assumptions are made that responses will fit a heterosexual norm.
- Be aware of language barriers. Patients may not speak up if they are not understanding what is being said. Others may not want to speak to anyone because of fear of deportation. 'How do we work around this so patients don't fall into that situation? So we don't cause harm?'
- Perceptions of age discrimination resulting from poor communication or application of some clinical preventive service guidelines, for example colon cancer screening guidelines and protocols
- Don't assume that everyone has good internet access
- 'In general it feels like issues of discrimination and prejudice are getting better. The way you get treated is largely based on how much money you have.'
- In particular, less stigma is perceived in the community about substance use disorder, however broader education is still needed that addiction is an illness like other illnesses.
- Need for more diverse workforce in general and resources to support a more diverse population.

> ***"Some people just don't understand how difficult this is for some patients. And I wish there was a way to really impress on them that it's not as easy. You know, I've had people say, well, why don't they just get it right? Or why don't they just do this? Some more education is needed to help them understand it's just not that easy for some people."***
>
> - *Community Health Worker Group Participant*

> ***"We have discussions among the staff, especially in the last couple years about how we are received by professionals in a hospital setting. As professionals ourselves, I feel like we're extended a kind of courtesy that we have not in the past . . . . I don't think as a pure recovery coach we would have had quite the credibility that we have now."***
>
> - *SUD Recovery Group Participant*

4. High Priority Issues from Community Discussion Groups

For most of the community discussion groups convened in 2021, the discussion group facilitator read top priority areas identified in previous Community Health Needs Assessments in the region. The priorities named in the discussion groups were:

- Access to mental health services
- Cost of health care services including the cost of health insurance and prescription drugs
- Alcohol and drug misuse including prevention, treatment and recovery
- Community conditions affecting health like affordable housing, job opportunities, poverty and family stress
- Child neglect and domestic abuse

> ***"There needs to be a better system for tracking and sharing information on who has openings for mental health services. There is a lot of time wasted and missed opportunities that could be fixed more systematically with some sort of shared electronic database of available treatment slots."***
>
> - *Community Health Worker Group Participant*

Participants were then asked if they were: a) if they thought these are still the most important issues for the community to address, with recognition that COVID-19 was a major overarching concern for most people; b) if there are new, different priorities; and c) if any improvements have happened in these areas over the past several years. With some additions - - most notably transportation, affordable child care, and supportive services for aging in place - - most participants in each group expressed the overall opinion that the priorities identified previously were still the most important issues to focus attention on for community health improvement (see table on the next page).

> ***"We have been preaching transportation for I don't even know how many years. But transportation would solve, in my opinion, so many issues. At least it would be the first step."***
>
> - *Behavioral Health Coordinator Group Participant*

The table below displays overall priorities, concerns and areas of improvement identified by each set of discussion groups. As noted on the previous page, the community discussion groups convened in 2021 generally endorsed the same set of priorities as identified in 2018 with the major caveat of COVID-19 as an overarching concern with both direct impacts and exacerbating effects on pre-existing community health disparities. Some additional themes emerged in these discussions and are noted in this table as well.

TABLE 9 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Behavioral Health Coordinators	• Housing, insurance, medication costs are still major issues • Difficult to get mental health patients in higher level of care in a community setting than private practitioners can provide • Housing is a huge issue, affordability and also substandard housing	• "Transportation is the number one barrier to everything" • Food insecurity • Supportive services for aging population, in home or skilled nursing; difficult to find care for somebody to age in place; there is a workforce shortage in this service area	• Access to general mental health services has improved with the integration of behavioral health and primary care. • Wraparound services, because of the integration work; communicating with partners a lot better. • But still struggling with the actual ability to access the services needed • Access to alcohol and drug misuse, prevention, treatment, recovery has been enhanced • Prevention program in Claremont, the needle exchange program, has been a great addition. The Center for Recovery Resources has also been huge.
Chamber of Commerce Directors	• Mental health is still a major health issue that needs to be addressed and costs go hand in hand with that. • Mental health providers are very stressed right now. The whole list is still very top of mind. • Don't have good health insurance options for small businesses, for some people who are falling through the cracks.	• Can't separate the COVID epidemic from these issues. Or the current environment of social unrest. • Incorporate wellbeing as priority in the workplace. • Lack of affordable, dependable child care is another example of something that was an issue long before COVID and has been exacerbated because of COVID.	• For mental health, a lot more recognition and appreciation for services and people reaching out for those resources. A lot more acceptance in our community and lot more sharing of information on social media • Pre-pandemic substance misuse services seemed to be headed in the right direction with lots of support groups in place and counselors available. A lot of that had to pivot and has been a challenge.

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

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Medication Assisted Treatment	• Those are still important. May not be the only ones, but they are important • Health insurance: There's a real huge gap between being at the very bottom, and then actually being able to afford good insurance, there's nothing in the middle. There's really an incentive to not make more money.	• Transportation is a huge issue for people. Have to rely on relatives or a friend • Need more awareness of all things that are available and improved wrap around services. • Sometimes people have a lot of trouble navigating the systems to find the things that they need. Wrap around does happen, but still room for improvement.	• Addiction treatment has gotten way better. Easier to get, better quality, different styles. • Electronic health record has helped a lot. Don't have to tell the same story over and over. And helpful for not duplicating services or procedures.
Regional Public Health	• May be some different ordering of priorities, but these are still the most important issues. • With COVID, problems with alcohol and drugs, for example, and the related effects on children and families have just gone underground / are somewhat less visible during this time. The pandemic has probably exacerbated that.	• Dental care • Early childhood development and enrichment • Addressing health equity and health disparities • Youth vaping • Supports for seniors, aging in place • Access to reliable internet is an equity issue that has left many people vulnerable during the pandemic	• Increased funding for opioid related work has led to improved access. • Focus on behavioral health and primary care through the Integrated Delivery Network has led to some improvements in the way of care is provided and how people are able to engage in their care, particularly for Medicaid populations. • In the area of family strengthening, there has been more coalition development and coordination of care across provider groups. • The relatively strong economy helps in a broad sense to deal with issues of food insecurity and housing insecurity. • In general the region continues to benefit from strong partnerships, collaboration and cooperation

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Rural Community Residents	• They are still very relevant and very much in need of further attention. • There are probably a whole other list of other things to add to but if it's too long It's not useful	• Suicide Prevention • Aging in place with dignity and with the right supports • Transportation • Access to ambulance services in rural towns • High speed internet access ("20 years behind other communities") • Perinatal care / birthing services • Homelessness	• Haven't seen any real improvements • Participated in a similar needs assessment last year, 'don't know what became of that' • Just think there has been a lot of talk, but we don't do anything.
Individuals with Complex Health Needs	• Yes, those are still priorities although would include transportation • There's a great need for mental health services; see a lot seniors who could use some help, but they would have no idea how to reach out and get it. • Health care is expensive.	• Transportation for a lot of people is a huge barrier	• Everybody is working harder together to solve a problem. Instead of working against each other, each doing their own thing.
Seniors	• Not asked / discussed	• The COVID situation has highlighted concerns that people already had. "Something as simple as obtaining groceries. For people who can no longer drive or are disabled to the point that they have to use a walker or use a wheelchair, obtaining food and other necessary items such as prescriptions is a challenge."	• Not asked / discussed

D. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2021 Community Health Assessment report provides information on key data indicators and measures of community health status. Some measures that are 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 15 town service area identified as the Valley Regional Healthcare service area, which also corresponds to all of the communities of Sullivan County. In a few instances, data are only available at the Public Health Network region level. Regarding the latter, the Public Health Network region that most closely corresponds to the Valley Regional Healthcare service area is the Greater Sullivan County Public Health Network, which includes 12 of the 15 municipalities in the hospital service area including the City of Claremont.

This section also includes summary information associated with selected determinant of health characteristics gathered through primary care patient assessments. From 2018 to 2021, Valley Regional Primary Care Practices participated in a New Hampshire statewide healthcare project, Building Capacity for Transformation, which was launched through a federal Medicaid "1115 Waiver" to pilot cost saving initiatives. Valley Regional Healthcare partnered with area behavioral health and medical providers in a collaborative project to reach the highest feasible level of integrated care based on the approach described in SAMHSA's Standard Framework for Levels of Integrated Healthcare. The goal was to encourage mental health, substance use disorder and healthcare systems to jointly communicate and care for the patient's total wellbeing.

Medicaid patients were asked to complete a patient survey, as means to identify gaps in social determinants of health, which could affect their health outcomes. Data has been collected from Medicaid-recipient adults, youth ages 12 to 18, and parents of pediatric patients, all who sought care from primary care practices of Valley Regional Healthcare. In aggregate, this information can also help Valley Regional Healthcare and community social services organizations more strategically understand and address community needs that impact the health and wellbeing of individuals and families.

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 2019 American Community Survey, the population of the Valley Regional Healthcare Service Area is somewhat 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 2016 and 2019, the population of the Valley Regional Healthcare Service Area was essentially unchanged while the overall New Hampshire population grew by approximately 2%.

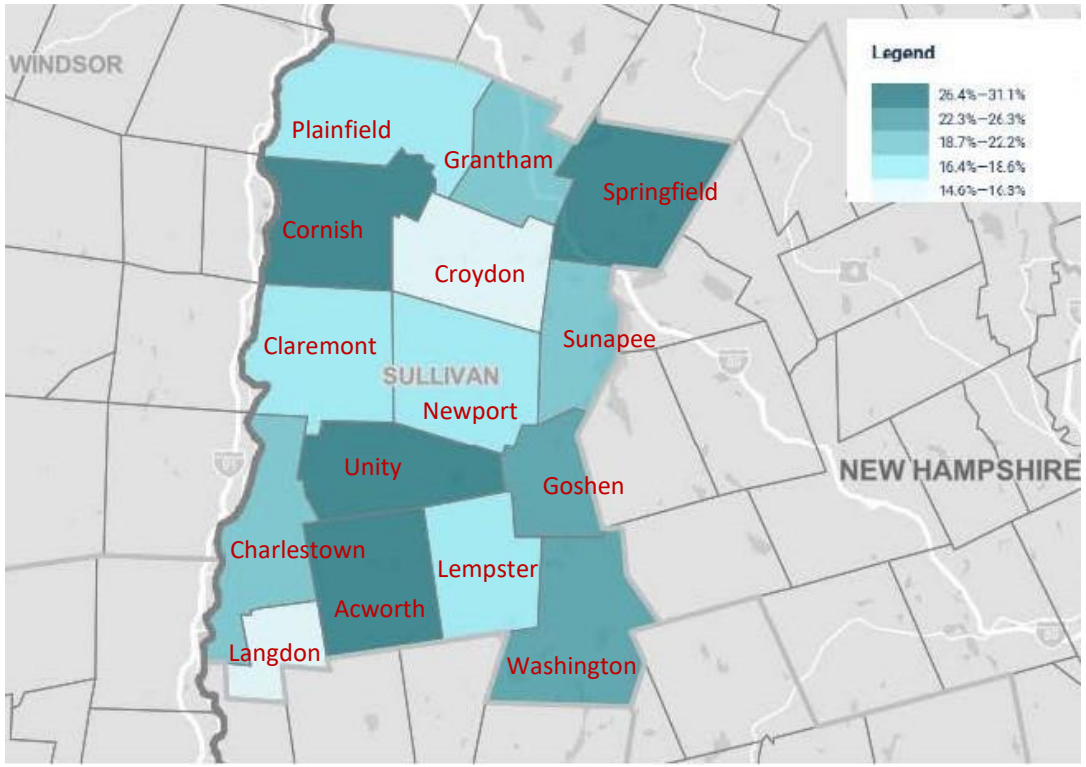
Indicators	Valley Regional Healthcare Service Area	New Hampshire
Population Overview		
Total Population	43,104	1,348,124
Age 65 and older	20.8%	17.5%
Under age of 18	18.9%	19.3%
Change in population (2016 to 2019)	+0.1%	+2.2%

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

Figure 17 - Percent of Population 65 years of age and older, Valley Regional Healthcare Service Area

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

The proportion of the population age 65 years or more ranges from 15% in Langdon to 31% in Acworth.



b. Poverty

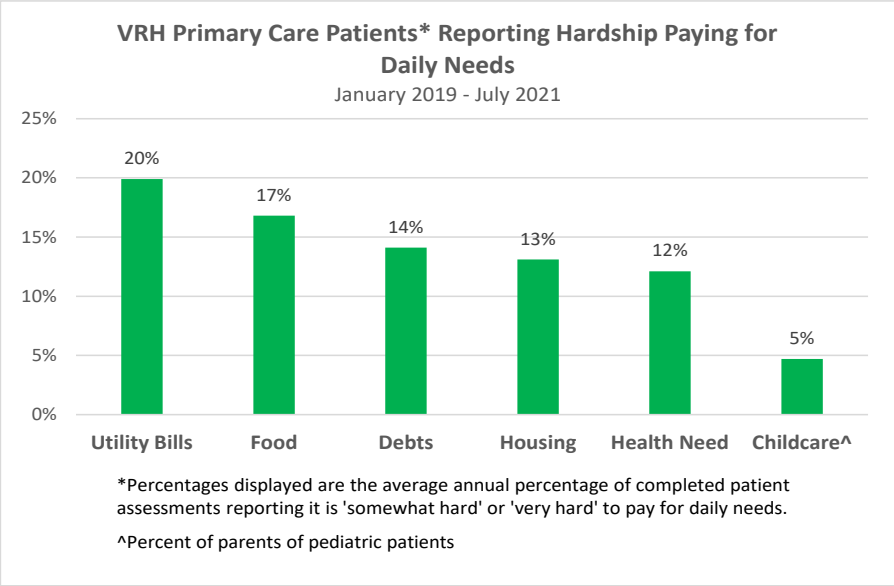
The correlation between economic prosperity and good health status is well established. Inversely, the lack of economic prosperity or poverty can be associated with barriers to accessing health care, healthy food, and healthy physical environments that contribute to good health. Information describing household income and poverty status was included in the first section of this report. The table below presents the percent of people in the VRH Service Area living in households with income below the federal poverty level and the percent of children under age 18 in households with income below the poverty level. Four communities have child poverty estimates over 20%: Croydon (24%), Claremont (26%), Cornish (27%) and Langdon (42%).

Area	Percent of people with household income below the federal poverty level (Income < 100% FPL)	Percent of children (under 18) in households below the federal poverty level (Income < 100% FPL)
VRH Service Area	**11.7%**	**16.6%**
New Hampshire	7.6%	9.2%

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

The chart on the right displays the percentage of Valley Regional Primary Care Practice patients who completed the social determinants of health screening survey and reported difficulty paying for basic daily needs including food, housing and health care. Over the entire assessment period from January 2019 to July 2021, 1,120 adult patient and 1,165 pediatric patient screening surveys were completed.

| Figure 18 |



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 Valley Regional Healthcare 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 with a high school diploma (or equivalent) or higher level of education.

Area	Percent of Population Aged 25+ with High School Diploma or Equivalency
VRH Service Area	91.2%
New Hampshire	93.1%

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"
VRH Service Area	**0.3%***
New Hampshire	1.4%

Data Source: U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates.
**Percentage estimate is significantly lower than the NH statewide estimate.*

d. Housing

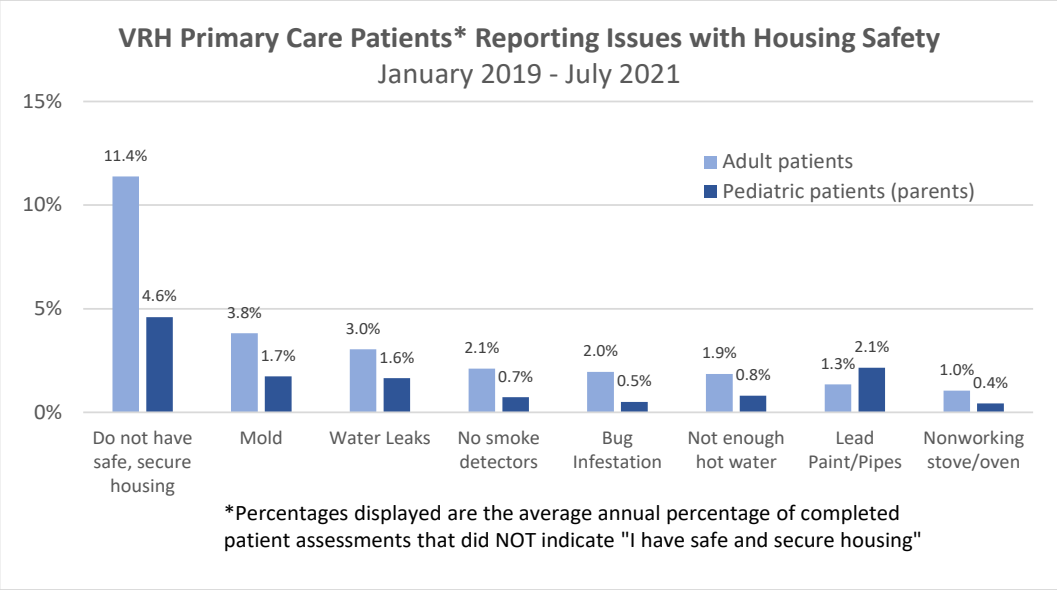
Housing characteristics, including housing quality and cost burden as a proportion of income, can influence the health of families and communities. Households that spend a high proportion of their income on housing are less likely to have adequate resources for food, clothing, medical care, or other needs. Characteristics of "substandard" housing include lacking complete plumbing facilities or kitchen facilities, and mortgage or rental costs exceeding 30% of household income. The table below presents data on the percentage of occupied housing units in the service area that have 1 or more of these characteristics.

Area	Percent of Households with Housing Costs >30% of Household Income	Percent of Occupied Housing Units Lacking Complete Plumbing Facilities	Percent of Occupied Housing Units Lacking Complete Kitchen Facilities
VRH Service Area	33.0%	0.7%	0.8%
New Hampshire	31.3%	0.5%	0.8%

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

| Figure 19 |

The chart on the right displays the percentage of Valley Regional Primary Care Practice patients who completed the social determinants of health screening survey and reported issues with inadequate housing safety or security including 2.1% of pediatric patient parents who reported housing with lead paint or pipes.



e. 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. Additionally, about 13% of Valley Regional Primary Care Practice adult patients and 4% of parents of pediatric patients reported that 'Lack of transportation' has kept them from 'medical appointments, meetings or getting daily living things'.

Area	Percent of Households with No Vehicle Available
VRH Service Area	6.0%
New Hampshire	5.1%

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

f. 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 identifies people reporting serious difficulty with six basic areas of functioning – hearing, vision, cognition, ambulation, self-care or independent living. Compared to NH overall, similar percentages of residents across age groups in the Valley Regional Healthcare service area report having at least one disability.

Percent of Population Reporting Serious Activity Limitations Resulting from a Disability		
Age Group	**VRH Service Area**	**New Hampshire**
Percent Disabled <18	**5.1%**	4.7%
Percent Disabled 18-64	**10.6%**	10.3%
Percent Disabled 65+	**30.4%**	31.4%

Data Source: U.S. Census Bureau, 2015 – 2019 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 10 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 with Medicare, Medicaid or Veterans Administration coverage.

Compared to estimates from the last community health needs assessment in 2018, the percentage of uninsured residents has decreased (9.5% uninsured estimate in 2018; 7.0% current estimate). In combination, the percentage of the population with Medicaid or no insurance coverage (25.0%) is higher than in New Hampshire overall (19.2%).

It should be noted 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. As such, the estimates may not fully reflect shorter term economic or policy conditions influencing fluctuations in insurance benefit coverage.

Table 10: Health Insurance Coverage Estimates

Area	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Acworth	13.4%	33%	8%	2%
Unity	13.2%	26%	10%	5%
Newport	12.2%	21%	20%	5%
Springfield	8.2%	31%	6%	1%
Lempster	7.8%	23%	7%	3%
Sunapee	7.1%	24%	12%	3%
Croydon	7.0%	19%	13%	4%
VRH Service Area	**7.0%**	**23.6%**	**18.0%**	**4.6%**
Charlestown	6.8%	25%	20%	5%
Langdon	6.6%	16%	16%	3%
Claremont	6.4%	23%	28%	6%
State of NH	**5.9%**	**19.1%**	**13.3%**	**2.7%**
Goshen	5.0%	26%	14%	5%
Washington	4.8%	27%	5%	7%
Cornish	3.1%	29%	12%	3%
Plainfield	2.0%	20%	11%	2%
Grantham	1.4%	22%	5%	6%

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

**Coverage alone or in combination*

b. Delayed or avoided health care visit because of cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a health care visit in the past year because of cost. A higher rate on this measure is reflective of limitations of household income or health insurance benefits inhibiting access to care. Additionally, about 11% of Valley Regional Primary Care Practice adult patients over the January 2019 to July 2021 timeframe reported 'feeling unable to afford their medications'.

Area	Percent of adults who report having delayed or avoided health care because of cost in the past year
Greater Sullivan County Public Health Region	8.9%
New Hampshire	9.3%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2017.

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

c. Physician Capacity

This indicator reports the number of Full Time Equivalent (FTE) physicians in active practice with specialties in primary care or in psychiatry. Access to high-quality, cost-effective healthcare is influenced by an adequate physician availability in balance with population needs. As displayed by the table below, the Greater Sullivan County Public Health Region has less FTE capacity of primary care physicians and psychiatrists compared to NH overall. It is likely that these ratios are influenced by the proximity of physician resources based at the Dartmouth-Hitchcock Medical Center.

Area	Primary Care FTE per 100k Population	Psychiatrist FTE per 100k Population
Greater Sullivan County Public Health Region	18.7	1.8
New Hampshire	42.3	5.0

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

d. 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
Greater Sullivan County Public Health Region	86.8%
New Hampshire	87.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2017.
Regional rate is not significantly different from the overall NH rate.

e. 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 Sullivan County is similar to the overall state rate.

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Sullivan County	34.5
New Hampshire	38.4

Data Source: Centers for Medicare & Medicaid Services, 2018; accessed through County Health Rankings
Regional rate is not significantly different from the overall NH rate

f. Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have visited a dentist, dental hygienist or dental clinic within the past year. The percentage of adults in the Greater Sullivan County Public Health Region who report not having seen a dentist is similar to the state overall.

Area	Percent of adults who visited a dentist or dental clinic in the past year
Greater Sullivan County Public Health Region	63.7%
New Hampshire	72.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2016.

Regional rate is not significantly different from the overall NH rate

3. Health Promotion and Disease Prevention

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 environmental conditions and 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. Food Insecurity

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food contributing to reduced quality, variety, or desirability of diet, disrupted eating patterns and reduced food intake. Approximatly 10% of Sullivan County households experienced food insecurity in 2019. Additionally, over the January 2019 to July 2021 timeframe about 5% of parents of Valley Regional Primary Care Practice pediatric patients indicated they 'struggle to provide fruits and vegetables' and about 3% 'struggle to provide breakfast at home'.

Area	Experienced food insecurity, past year
Sullivan County	10.1%
New Hampshire	8.8%

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

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 4 adults in Sullivan County can be considered physically inactive on a regular basis.

Area	Physically inactive in the past 30 days, % of adults
Sullivan County	**26.0%***
New Hampshire	21.0%

Data Source: Behavioral Risk Factor Surveillance System accessed via County Health Rankings, 2017.

Regional estimate is significantly different and higher than the overall NH estimate.

c. Pneumonia, Influenza and COVID-19 Vaccinations (Adults)

The indicators on the next page include the percentage of adults who self-report that they received an influenza vaccine in the past year (at the time of the survey) or have ever received a pneumococcal vaccine (age 65+). In addition to measuring the population proportion receiving preventive vaccines, these measures can also highlight access to preventive care issues or opportunities for health education including addressing concerns for vaccine safety and efficacy. This latter consideration has received significant attention in recent months due to the efforts to achieve broad distribution and administration of COVID-19 vaccines. The table on the next page includes the most recently available statistic for the proportion of Sullivan County residents aged 12 years and up who are fully vaccinated.

Area	Influenza Vaccination in the past year; 18 years or older	Pneumococcal Vaccination Ever; 65 years or older	COVID-19, Fully Vaccinated; Percent of Total Population
Greater Sullivan County Public Health Region	49.3	79.8%	
Sullivan County			49.0%
New Hampshire	44.0%	82.1%	54.1%

Data Sources: NHDHHS, Behavioral Risk Factor Surveillance System, 2017. NH Department of Health and Human Services for COVID-19 data as of September 7, 2021 via covid19.nh.gov/dashboard/vaccination Regional estimates are not significantly different from the overall NH estimates.

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	Excessive Drinking in Past 30 days, Percent of Adults
Sullivan County	19.0%
New Hampshire	20.0%

Data Source: Behavioral Risk Factor Surveillance System accessed via County Health Rankings, 2018.
Regional estimate is not significantly different from the overall NH estimate.

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth. On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers. In the Greater Sullivan County Public Health Region, the rate of binge drinking among high school aged youth is similar to the overall state rate although female high school age students in the region were somewhat more likely than males to report binge drinking behavior.

Area	Engaged in Binge Drinking in Past 30 days, Percent of High School Youth		
	Male	Female	Total
Greater Sullivan County Public Health Region	12.2%	17.2%	14.5%
New Hampshire	13.8%	14.8%	14.4%

Data Source: NH Youth Risk Behavior Survey, local and statewide samples, 2019

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 10% of high school youth in the Greater Sullivan County Public Health Region reported having ever used a prescription drug that was not prescribed to them on the 2019 Youth Risk Behavior Survey.

Area	Ever used prescription drugs 'not prescribed to you', Percent of High School Youth		
	Male	Female	Total
Greater Sullivan County Public Health Region	9.5%	10.1%	9.9%
New Hampshire	10.9%	8.9%	10.0%

Data Source: NH Youth Risk Behavior Survey, local and statewide samples, 2019

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. Smoking during pregnancy also confers significant short and long term risks to the health of an unborn child. Nearly 1 in 5 adults (21%) in Sullivan County are estimated to be current smokers, a percentage that is the same as the estimate recorded in the 2018 Community Health Needs Assessment. During the period 2015 to 2018, the rate of births where smoking was indicated during pregnancy was 21.4 per 100 births in the Greater Sullivan County Public Health Region, a rate significantly higher than for NH overall.

Area	Percent of Adults who are Current Smokers+	Smoked during pregnancy, rate per 100 births^
Sullivan County	18.0%	
Greater Sullivan County Public Health Region		**21.4***
New Hampshire	17.0%	11.0

+Data Source: County Health Rankings, 2018.

^Data Source: New Hampshire Vital Records Birth Certificate Data, NHDHHS Office of Health Statistics, 2015-2018.

Regional rate is significantly different and higher than the overall NH rate.

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 Valley Regional Healthcare Service Area is higher than the rate in New Hampshire overall.

Area	Teen Birth Rate per 1,000 Women Age Under 20
Sullivan County	**19.0***
Rest of New Hampshire (not including Sullivan County)	11.4

Data source: NH Division of Vital Records Administration birth certificate data; 2012-2016.

Regional rate is significantly different and higher than the overall NH rate.

g. Child Safety

Measures of child safety or child abuse and neglect in a community include the rate of child maltreatment victims substantiated by the NH Division of Children, Youth and Families (DCYF), as well as the rate of children in temporary, out of home placement. As displayed by the table below, the rates of child maltreatment and out-of-home placements in Sullivan County during 2016 were somewhat higher than the overall NH rates.

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Children in out-of-home placements, rate per 1,000 children under age 18
Sullivan County	**5.3**	**5.4**
New Hampshire	3.5	4.6

Data source: Annie E. Casey Foundation, Kids Count Data Center, 2016

h. Domestic Violence

Domestic violence or intimate partner violence can be defined as a pattern of coercive behaviors used by one partner against another in order to gain power and control over the other person. The coercive behaviors may include physical assault, sexual assault, stalking, emotional abuse or economic abuse. There were 359 civil domestic violence petitions filed in Sullivan County courts in 2014 and 2015 (most current data available). In New Hampshire overall, 76% of civil domestic violence petitioners in 2014 and 2015 were granted a temporary order of protection (statistics by County not known).

Area	Civil Domestic Violence Petitions, 2014 - 2015	
	Number	Annual Rate per 1,000 population
Sullivan County	**359**	**4.1**
New Hampshire	8,025	3.0

Data Source: New Hampshire Domestic Fatality Review Committee, 2014-2015 Biennial Report

4. Health Outcomes

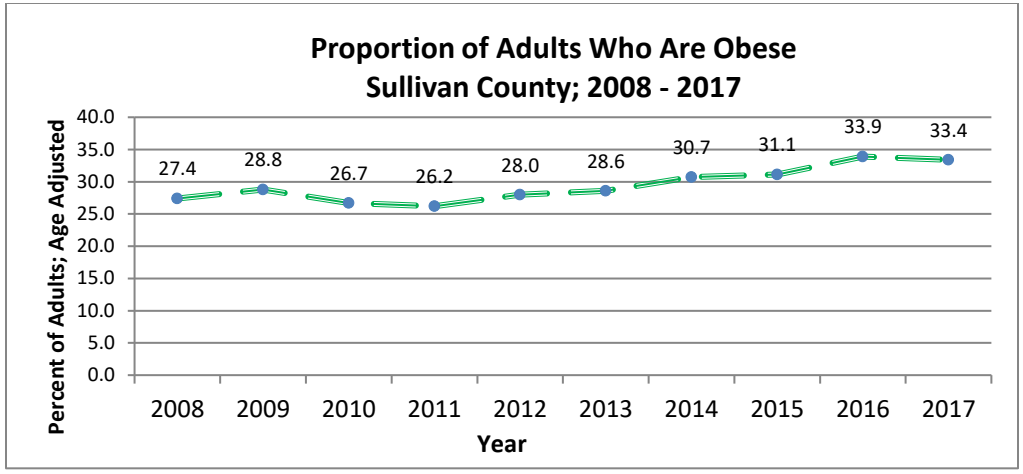
Traditional measures of population health status focus on rates of illness or disease (morbidity) and death (mortality) from specific causes. Advances in public health and medicine over the last century have reduced infectious disease and complications of child birth as major contributors to or causes 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 (BRFSS), as well as high school students (YRBS) who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese). The chart on the next page displays the increasing trend in adult obesity in Sullivan County over a ten year period from 2008 to 2017.

Area	Adults Aged 20+ Years, Percent Obese	High School Students, Percent Obese
Greater Sullivan County Public Health Region		**16.5%***
Sullivan County	**33.4%***	
New Hampshire	26.4%	12.8%

Data Sources: Centers for Disease Control and Prevention, National Diabetes Surveillance System 2017; NH Youth Risk Behavior Survey 2017; ***Regional rate is significantly different and higher than the overall NH rate.***



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

b. Heart Disease

Heart disease was the second leading cause of death between 2012 and 2016 in the Valley Regional Healthcare service area after all forms of Cancer. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance abuse including tobacco use. Over the 5 year period from 2012 to 2016, 'Diseases of the Heart' were the cause of 448 deaths in Sullivan Count.

Heart Disease Risk Factors: About 31% of adults in the Greater Sullivan County Public Health Region self-report that they have been told by a doctor that they have high blood pressure or and 36% have been told they high blood cholesterol; percentages that are similar to estimates for NH adults overall.

Area	Percent of adults who have high blood pressure	Adults told by a health professional that their blood cholesterol was high
Greater Sullivan County Public Health Region	31.3%	30.7%
New Hampshire	30.1%	32.9%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2017
Estimates are not statistically different from the overall NH estimates.

Heart Disease-Related Hospitalization: The table below displays age adjusted rates of inpatient hospitalization of residents of the Greater Sullivan County Public Health Region for hypertension and heart failure in 2018. The inpatient hospitalization rate for heart failure was significantly lower for residents of the region compared to rates among NH adults overall.

Area	Hypertension – Inpatient, age adjusted rate per 100,000 population; 18+ years of age	Heart Failure – Inpatient, age adjusted rate per 100,000 population; 18+ years of age
Greater Sullivan County Public Health Region	17.7	**246.8***
New Hampshire	30.8	320.5

Data Source: NH Uniform Healthcare Facility Discharge Dataset, HDHHS Office of Health Statistics and Data Management, 2018

***Rate is statistically different and lower 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 Valley Regional Healthcare Service Area residents was significantly lower than the overall rate for New Hampshire in the 2012 to 2016 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 Valley Regional Healthcare Service Area.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Sullivan County	**99.0**	26.6
Rest of New Hampshire (not including Sullivan County)	91.3	26.9

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

Rates are not statistically different from the overall NH estimates.

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 one in twelve adults (8%) in Sullivan County and New Hampshire overall report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes, age adjusted
Sullivan County	7.6%
New Hampshire	7.7%

Data Source: Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2017
Regional rate is not statistically different from the overall NH rate

Diabetes-Related Hospitalization: The table below displays age adjusted rates of inpatient hospitalization in 2018 of residents of the Greater Sullivan County Public Health Region for uncontrolled diabetes and long term complications of diabetes. The hospitalization rate of residents of the Greater Sullivan County Public Health Region uncontrolled diabetes was significantly lower than the overall state rate in 2018.

Area	Uncontrolled Diabetes - Inpatient, age adjusted rate per 100,000 population, 18+ years of age	Diabetes Long -Term Complications - Inpatient, age adjusted rate per 100,000 population, 18+ years of age
Greater Sullivan County Public Health Region	**6.3***	49.0
New Hampshire	24.6	55.5

Data Source: NH Uniform Healthcare Facility Discharge Dataset, HDHHS Office of Health Statistics and Data Management, 2018
Regional rate is significantly different and lower than the overall NH rate.

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus among Valley Regional Healthcare Service Area residents is similar to the overall rate for New Hampshire and is the eighth leading cause of death in the region.

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Sullivan County	19.4
New Hampshire	18.2

Data Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom, 2012- 2016
Regional rate is not significantly different from the overall NH rate

d. Cancer

Cancer is the leading cause of death in New Hampshire and in the Valley Regional Healthcare service area. 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. Over the 5 year period from 2012 to 2016, 'Malignant Neoplasms' were the cause of 490 deaths in Sullivan County.

Cancer Screening: The table below displays screening rates for colorectal cancer, breast cancer and cervical cancer. The percentage of females ages 21 to 65 receiving a Pap screening test in the past 3 years was significantly higher in 2016 than the reported percentage in overall NH.

Cancer Screening Type	Greater Sullivan County Public Health Region	New Hampshire
Had colonoscopy in past 10 years (ages 50 to 75)	63.9%	72.7%
Had mammogram past two years (women 40+)	75.1%	76.9%
Women 21 to 65 receiving Pap test in past 3 years	**95.7%***	85.1%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2016.
Regional rate is significantly different and higher 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). The incidence rate for Melanoma of the Skin was significantly higher in the VRH service area compared to the state overall between 2011 and 2015, while incidence of lung and bladder cancer was lower.

Cancer Incidence per 100,000 people, age adjusted		
	Sullivan County	**New Hampshire**
Overall cancer incidence (All Invasive Cancers)	482.9	481.9
Cancer Incidence by Type		
Breast (female)	135.0	143.4
Prostate (male)	**89.9***	109.7
Lung and bronchus	66.6	62.6
Colorectal	36.7	36.3
Melanoma of Skin	37.6	32.2
Bladder	26.6	27.4

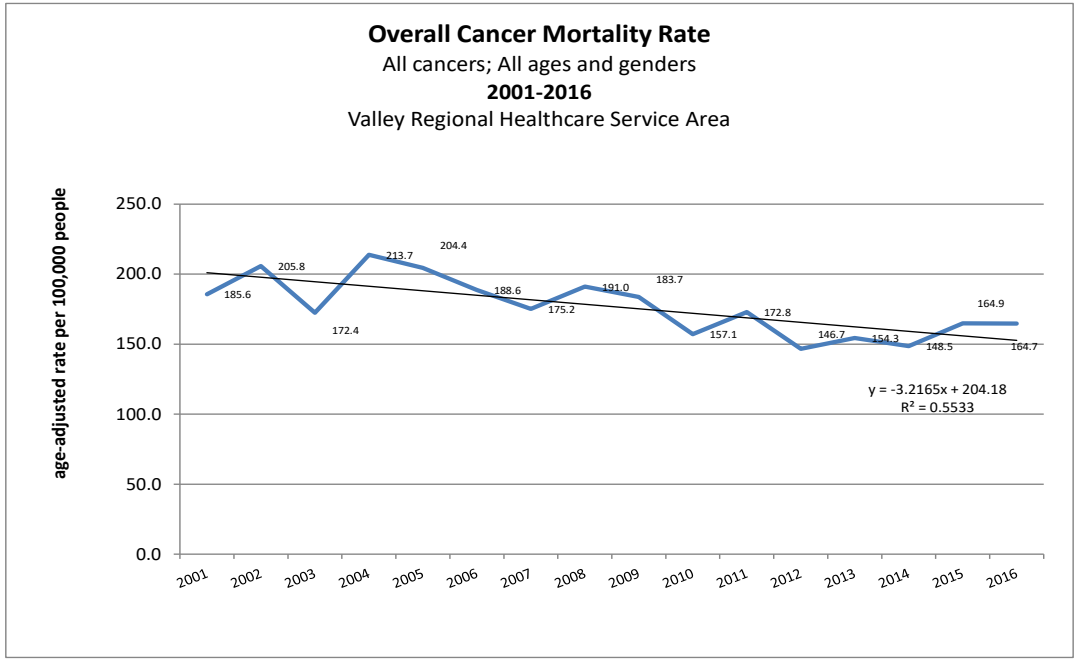
Data Source: NH State Cancer Registry, 2014 - 2018

***Rate is statistically different and lower** than the overall NH rate; other rates are not significantly different*

Cancer Mortality: The table below shows the overall cancer mortality rate and for the cancer types that account for the majority of cancer deaths. The overall cancer mortality rate and mortality rate from specific cancer types are similar to the state overall. 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 -2.4% per year since the year 2001.

Cancer Mortality per 100,000 people, age adjusted		
	Sullivan County	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	156.1	158.2
Cancer Mortality by Type		
Lung and bronchus	45.3	43.2
Prostate (male)	14.9	19.0
Breast (female)	14.3	19.1
Pancreas	10.0	10.4
Colorectal	8.5	12.5

Data Source: NH State Cancer Registry, 2012 - 2016
Regional rates are not significantly different from the 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 in NH overall. Regional rates are not available.

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Sullivan County	*Not available*	14.8%
New Hampshire	8.3%	11.8%

*Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2018
Regional rates are not statistically different than the overall NH rate

Asthma-Related Hospitalization: The table below displays age adjusted rates of inpatient and emergency department utilization for complications of asthma. The regional rate is significantly higher than for the state overall.

Area	Asthma hospital encounters, All Ages (inpatient and emergency department) age adjusted rate per 100,000 population
Sullivan County	**63.6***
New Hampshire	40.1

Data Source: NH Uniform Healthcare Facility Discharge Dataset, NHDHHS Office of Health Statistics and Data Management, 2013 - 2017
Regional rate is significantly different and higher than the overall NH rate

e. COVID-19

COVID-19 disease is caused by infection by a new strain of coronavirus (SARS-CoV-2) that had not been previously identified in humans before 2019. Coronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Severe Acute Respiratory syndrome (SARS). The virus causing COVID-19 disease is highly contagious and has caused illness and death in nearly all countries of the world (pandemic). Most people with COVID-19 have mild symptoms, but some people can become severely ill.

The first cases of COVID-19 infection in New Hampshire were reported in 2020. Since that time, there have been more than 110,000 identified cases of COVID-19 infection in New Hampshire and 1,441 deaths. The cumulative rate of COVID-19 cases in Sullivan County is the lowest among NH's 10 counties and the cumulative rate of deaths from COVID-19 in Sullivan County is the 4th lowest.

Area	Cumulative COVID-19 Cases, per 100K population	Cumulative Deaths with COVID-19 as a Contributing Factor, per 100K population
Sullivan County	5,124	48
New Hampshire	8,172	106

*Data Source: NH Department of Health and Human Services, COVID-19 Response Dashboard as of September 12, 2021

f. Intentional and Unintentional Injury

Accidents and injury are the fourth leading cause of death in the region and third leading cause of death in the state. In recent years, the epidemic of opioid and other substance misuse has been a substantial underlying cause of accidental and intentional injury and death.

Substance Use-related Emergency Department Visits, Hospitalization: The table below displays rates of emergency department (ED) visits and inpatient hospitalizations for drug and alcohol related diagnoses including acute alcohol and/or drug poisoning as well as injuries/conditions related to acute drug and/or alcohol use. Not included are visit or inpatient stays involving intentional self-harm (see table on the next page), assault or chronic drug or alcohol related conditions. In 2018, the rate of drug and alcohol-related ED visits by residents of the Greater Sullivan County Public Health Region was significantly lower than for NH overall.

Area	Drug and Alcohol Related - ED Visits, age adjusted rate per 100,000 population	Drug and Alcohol Related - Inpatient, age adjusted rate per 100,000 population
Greater Sullivan County Public Health Region	**50.6***	**8.6***
New Hampshire	140.1	24.2

Data Source: NH Uniform Healthcare Facility Discharge Dataset, NHDHHS Office of Health Statistics and Data Management, 2018

***Regional rate is significantly different and lower than the overall NH rate.**

Drug Overdose Mortality: The table below displays the rate of drug overdose mortality for Sullivan County and for New Hampshire in 2020 (as of July 2021; 2020 data not finalized). The number of drug overdose deaths in NH overall has been trending down gradually since 2017 when the rate of over overdose mortality per 100,000 population was 36.4.

Area	Overdose Deaths per 100,000 people
Sullivan County	20.5
New Hampshire	30.7

Data Source: NH Medical Examiner's Office, March 2021

Self Harm-related Emergency Department Visits and Hospitalization: The table below displays rates of emergency department visits and inpatient hospitalizations for injury recorded as intentional including self-intentional poisonings due to drugs, alcohol or other toxic substances. In 2018, the rate of ED visits involving self-inflicted harm in the Greater Sullivan County Public Health Region was not significantly differently than for NH overall.

Area	Self-Inflicted Harm - ED Visit, age adjusted rate per 100,000 population	Self-Inflicted Harm - Inpatient, age adjusted rate per 100,000 population
Greater Sullivan County Public Health Region	217.8	31.2
New Hampshire	195.9	47.3

Data Source: NH Uniform Healthcare Facility Discharge Dataset, NHDHHS Office of Health Statistics and Data Management, 2018
Regional rate is not significantly different from the overall NH rate.

Depressive Disorders: Clinical Depression (major depressive disorder) is a common and serious medical illness that can cause persistent feelings of sadness, difficulties with concentration and loss of interest daily activities. While major depressive disorder is significantly associated with self-harm and suicidal ideation, it is also highly treatable. As part of the statewide Building Capacity for Transformation project, Valley Regional Primary Care Practices implemented expanded use of a validated nine-item Patient Health Questionnaire (PHQ-9 or PHQ-A for adolescents) to screen adult and adolescent patients for potential signs and symptoms of depression. As displayed by the table below, about 1 in 4 primary care patients self-report signs and symptoms of moderate to severe clinical depression.

Percent of Adult Patients	Percent of Adolescent Patients		
PHQ-9 score of 10 or higher (screen for moderate to severe depression)	**Report feeling 'depressed or sad most days, even if you felt okay sometimes?'**	**PHQ-A score of 10 or higher** (screen for moderate to severe depression)	**Report 'in the past month have had serious thoughts about ending your life'**
27.6%	36.7%	24.8%	9.4%

Data Source: NH Building Capacity for Transformation project, Valley Regional Healthcare Primary Care, 2019-2021. Percentages displayed for each indicator are the average annual percentage of total completed patient screening instruments (adult and adolescent).

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 ten year period from 2010 to 2019, the suicide rate in the Greater Sullivan County Public Health Region was similar to the overall NH rate of suicide deaths.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
Greater Sullivan County Public Health Region	18.5
New Hampshire	17.3

Data Source: NH Division of Vital Records death certificate data, 2010-2019
Regional rate is not significantly different from the overall NH rate.

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 2017 to 2019, 597 deaths in Sullivan County occurred before the age of 75 and the average annual total of YPLL-75 was 6,080 years of potential life lost per 100,000 population. This total is not significantly different per 100,000 population from the total for NH overall.

Area	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Sullivan County	6,080
New Hampshire	6,374

Data source: National Center for Health Statistics, National Vital Statistics System accessed via County Health Rankings, 2017-2019.
Regional rate is not significantly different from the overall NH rate.

5. Comparison of Selected Community Health Indicators between 2021 and 2018

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2021) and the previous assessment conducted in 2018, as well as the most recent statewide statistic for each indicator. This comparison is provided for reference purposes and does not indicate that one estimate or rate is significantly different from another for the same measure unless indicated otherwise. For instances where there are statistically significant differences between recent estimates, the indicators are highlighted in bold font.

Table 11: Comparison of Selected Community Health Indicators between 2018 and 2021 with NH State Comparison

Community Health Indicator	Geographic Area	2018 Community Health Assessment	2021 Community Health Assessment	NH State Comparison
Access to care				
Percentage of adult population (age 18+) without health insurance coverage	VRH Service Area	9.5%	7.0%	5.9%
Have a personal doctor or health care provider, percent of adults	Greater Sullivan County Public Health Region	86.2%	86.8%	87.5%
Visited a dentist or dental clinic in the past year, percent of adults	Greater Sullivan County Public Health Region	- - -	63.7%	72.0%
Health Promotion and Disease Prevention				
Current smoking, percent of adults	VRH Service Area	19.8%	18.0%	17.0%
Physically inactive in the past 30 days, % of adults	Sullivan County	25.3%	**26.0%**	21.0%
Excessive drinking, percent of adults	Sullivan County	- - -	19.0%	20.0%
Teen Birth Rate, per 1,000 Women Age 15-19	VRH Service area	17.8	**19.0**	11.4

Community Health Indicator	Geographic Area	2018 Community Health Assessment	2021 Community Health Assessment	NH State Comparison
Health Outcomes				
Obese, percent of adults	VRH Service Area	31.7%	**33.4%**	26.4%
Ever told had diabetes, percent of adults	VRH Service Area	8.7%	7.6%	7.7%
Overdose Deaths per 100,000 people	Sullivan County	12.5	20.5	30.7
Cumulative COVID-19 Deaths per 100,000 people	Greater Sullivan County Public Health Region	- - -	48	106
Years of potential life lost before age 75 per 100,000 population, age-adjusted	Sullivan County	6,557	6,080	6,374