Valley Regional Healthcare

Community Health Needs Assessment • 2018














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

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Executive Summary

During the period January through June 2018, a Community Health Needs Assessment was completed by Valley Regional Healthcare in partnership with New London Hospital, Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, Visiting Nurse and Hospice for VT and NH, and the New Hampshire Community Health Institute. The purpose of the assessment was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. For the purpose of the assessment, the geographic area of interest was 15 municipalities comprising the Valley Regional Healthcare service area with a total resident population of 43,051 people. Methods employed in the assessment included surveys of community residents made available on-line and paper surveys placed in numerous locations throughout the region; a direct email survey of key stakeholders and community leaders representing multiple community sectors; a set of community discussion groups; compilation of results from other recent assessment activities focused specifically on behavioral health needs and gaps; and a review of available population demographics and health status indicators. All information collection activities and analyses sought to focus assessment activities on vulnerable and disproportionately served populations in the region including populations that could experience limited access to health-related services or resources due to income, age, disability, and social or physical isolation. The table on the next two pages provides a summary of community health needs and issues identified through these methods.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community and Key Stakeholder Surveys**	**Community Discussion Groups**	**Community Health Status Indicators**
Access to mental health services	Access to mental health care was the highest priority issue identified in combined responses of community survey and key stakeholder survey respondents. 'People in need of mental health care' was the top underserved population identified by key stakeholders.	Identified as a high and continuing priority for community health improvement by community discussion groups including parents and teachers who identified 'long term effects' of poor mental health on families as the highest priority.	About 10% of adults in the service area report 14 or more days in the past 30 days when their mental health was not good, a measure that is correlated with depression and other chronic mental health concerns as well as overall health-related quality of life
Alcohol and drug misuse prevention, treatment and recovery	Prevention of substance misuse, addiction (#2) and access to substance misuse treatment and recovery services (#5) were top issues identified in combined responses of community survey respondents and key stakeholders.	All community discussion groups identified substance misuse issues in general and the opioid epidemic in particular as having significant impacts on individual, family and or community health.	14% of adults in the service area reported binge drinking in the past 30 days. While the rate of drug overdose deaths is lower than the overall NH rate, the rate of drug overdose deaths in the VRH service area has approximately doubled since 2012.
Access to affordable health insurance, health care services and prescription drugs	Availability of affordable health insurance was the second highest priority identified by community survey respondents and the highest priority for respondents with annual household income under $50,000.	Community discussion groups also identified health care costs and affordability of insurance including co-pays and deductibles as significant barriers to health care.	The estimated proportion of people with no health insurance has declined in the VRH service area from 13% in the last community health assessment to 9.5%; a proportion still higher than the statewide estimate of uninsurance (8.4%).
Family violence and childhood trauma including bullying	Child abuse or neglect (#4) and domestic violence (#6) were top issues identified in combined responses of community respondents and key stakeholders. Bullying / Cyberbullying was also a top concern, particularly in Claremont where 79% of respondents identified this topic as a high or very high priority.	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.	The most recent statistics for Children in Out of Home Placement in the service area (6.4 per 1000 children) is higher than the overall NH rate (3.7). The rate of Civil Domestic Violence Petitions in Sullivan County (4.2 per 1000 population) is also higher than the overall NH rate (3.0).
Health care for seniors including supports for aging in place	Improved resources for senior health care was a top 10 issue identified by community survey and key stakeholder respondents.	Discussion groups identified an aging population, limited resources for seniors, and the need for more supports for elderly with handicaps who are trying to stay in their homes.	The service area population has a higher proportion of seniors (18.7% are 65+) compared to NH overall (15.8%).

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE (continued)			
Community Health Issue	**Community and Key Stakeholder Surveys**	**Community Discussion Groups**	**Community Health Status Indicators**
Availability of affordable dental care for adults	Availability of dental services was a mid-tier priority identified in surveys relative to other priorities. However, dental care was the top service that people report leaving the local area to access and the second most common service type cited for access difficulties.	Access to affordable dental care for adults was identified as 'a huge issue' by participants in all four discussion groups.	13% of adults in the service area have not visited a dentist or dental clinic in the past 5 years and the percent of adults who report having six or more of their permanent teeth removed (20%) is higher than for NH overall (16%).
Availability of primary care services	Availability of primary care services was a mid-tier priority identified in surveys relative to other priorities overall, but was a high priority for respondents ages 65+ years; 11% of all respondents cited difficulty accessing primary care services in the past year, the highest percentage for any specific service type.	Availability of primary care was not specifically identified in discussion groups, although access to care and cost of care were general discussion topics across community discussion groups.	86% of adults in the service area report having a personal doctor or health care provider, a proportion similar to NH overall (87%), as is the rate of hospital stays for ambulatory care sensitive conditions for Medicare enrollees (41 per 1,000)
Social determinants of health including affordable housing, transportation and poverty	Key stakeholders identified affordable housing as a top priority for community health improvement (#3) and lack of transportation as the top barrier to accessing services. Affordable housing was also identified as a high or very high priority for improvement efforts by 64% of community respondents.	Three of four community discussion groups identified transportation as a 'major issue'. Discussion groups also addressed issues of homelessness, home affordability, economic realities of accessing healthy foods and organized fitness facilities, and related needs for jobs and job training / educational programs that are a realistic fit for the modern economy.	About 1 in 4 people, including 1 in 3 children, in the VRH service area live in households with incomes below 200% of the federal poverty level. About 6% of households have no available vehicle and 1 in 3 households have housing costs exceeding 30% of household Income.

Valley Regional Healthcare

2018 Community Health Needs Assessment

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

The total population of the primary service area of Valley Regional Healthcare is 43,015 people according to the United States Census Bureau (2016), which is a decrease of -1.6% or about 690 people since the year 2010. The 2018 Community Health Needs Assessment Survey conducted by Valley Regional Healthcare yielded 415 individual responses of which 79% indicated being residents of towns within the primary service area or approximately 1.2% of the total adult population. (Note: An additional 16% of survey respondents did not record a zip code on the survey, many of whom are also likely to be residents of the service area). As shown by Table 1, survey respondents from the service area are represented in similar proportion overall to the service area population by town, although Claremont is relatively over-represented among survey respondents in comparison to its proportion of the overall service area population. It is also important to note that 2018 survey respondents were much more likely to be female (83% of respondents) and somewhat younger (86% under age 65) compared to the overall adult population in the service area.

Table 1: Service Area Population by Town;
Comparison to Proportion of 2018 Community Survey Respondents

	2016 Population	Zip Code*	% Service Area Population	% of Survey Respondents
VRH Service Area	**43,015**			
Claremont NH	13,022	03743	30.2%	36.6%
Newport NH	6,393	03773	14.8%	12.3%
Charlestown NH	5,001	03603	11.6%	10.3%
Sunapee NH	3,388	03782/03255/03751	7.9%	4.1%
Grantham NH	2,963	03753	6.9%	2.7%
Plainfield NH	2,584	03781 / 03770	6.0%	4.1%
Cornish NH	1,664	03745 / 03746	3.9%	4.3%
Unity NH	1,564	03773	3.6%	Included in Newport zip
Springfield NH	1,171	03284	2.7%	1.0%
Washington NH	1,028	03280	2.4%	1.0%
Lempster NH	982	03605	2.3%	1.7%
Acworth NH	971	03601	2.3%	0.7%
Langdon NH	865	03602	2.0%	0.7%
Croydon NH	748	03773	1.7%	Included in Newport zip
Goshen NH	707	03752	1.6%	1.0%
Other or Unknown	Springfield VT (0.7%), Lebanon NH (0.5%), Windsor VT (0.5%), Bellows Falls VT (0.5%), and 14 other locations; 15.7% did not record a zip code			21.2%

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

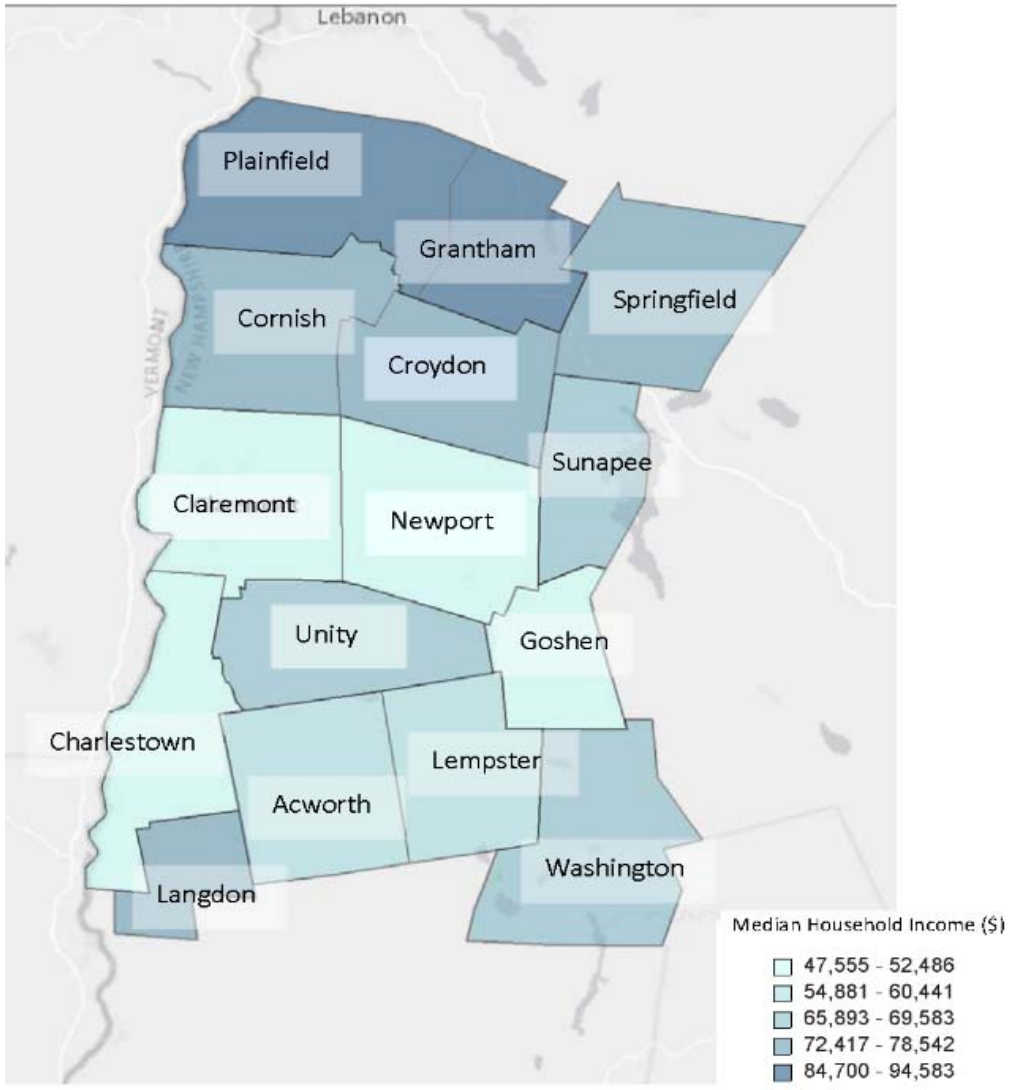
Table 2 below displays additional demographic and economic information for the towns of the Valley Regional Healthcare service area. On this table, municipalities are displayed in order of median household income with comparison to the median household income in the region and state overall. As displayed by the table, the median household income in the VRH service area overall is similar to the median household income in New Hampshire. The proportion of households with incomes under 200% of the federal poverty ranges from 2.9% (Grantham) to 34.8% (Charlestown). Figure 1 following this table displays a map of the service area with shading depicting the median household income by town in 5 categories from low to high median household income.

Table 2: Selected Demographic and Economic Information

	Median Household Income	% with income under 200% Poverty Level	% family households with children headed by a single parent	% population with a disability
Grantham NH	$94,583	2.9%	34.4%	9.2%
Plainfield NH	$84,700	14.8%	22.2%	8.1%
Cornish NH	$78,542	15.8%	36.0%	10.0%
Springfield NH	$75,347	17.1%	28.5%	7.4%
Langdon NH	$75,000	18.5%	10.7%	11.9%
Croydon NH	$72,417	20.0%	37.9%	10.4%
Washington NH	$69,583	20.9%	30.9%	9.8%
New Hampshire	**$68,485**	**21.7%**	**29.1%**	**12.3%**
Unity NH	$67,045	21.3%	34.6%	12.4%
Sunapee NH	$65,893	18.0%	43.5%	11.7%
Lempster NH	$60,441	27.1%	32.4%	17.4%
VRH Service Area	**$59,007**	**25.5%**	**42.3%**	**14.4%**
Acworth NH	$54,881	21.0%	45.9%	12.7%
Newport NH	$52,486	29.5%	52.8%	18.1%
Goshen NH	$51,029	28.3%	57.4%	16.0%
Charlestown NH	$50,568	34.8%	39.7%	15.1%
Claremont NH	$47,555	32.6%	48.6%	17.5%

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

2012-2016 American Community Survey; Map source: American Factfinder



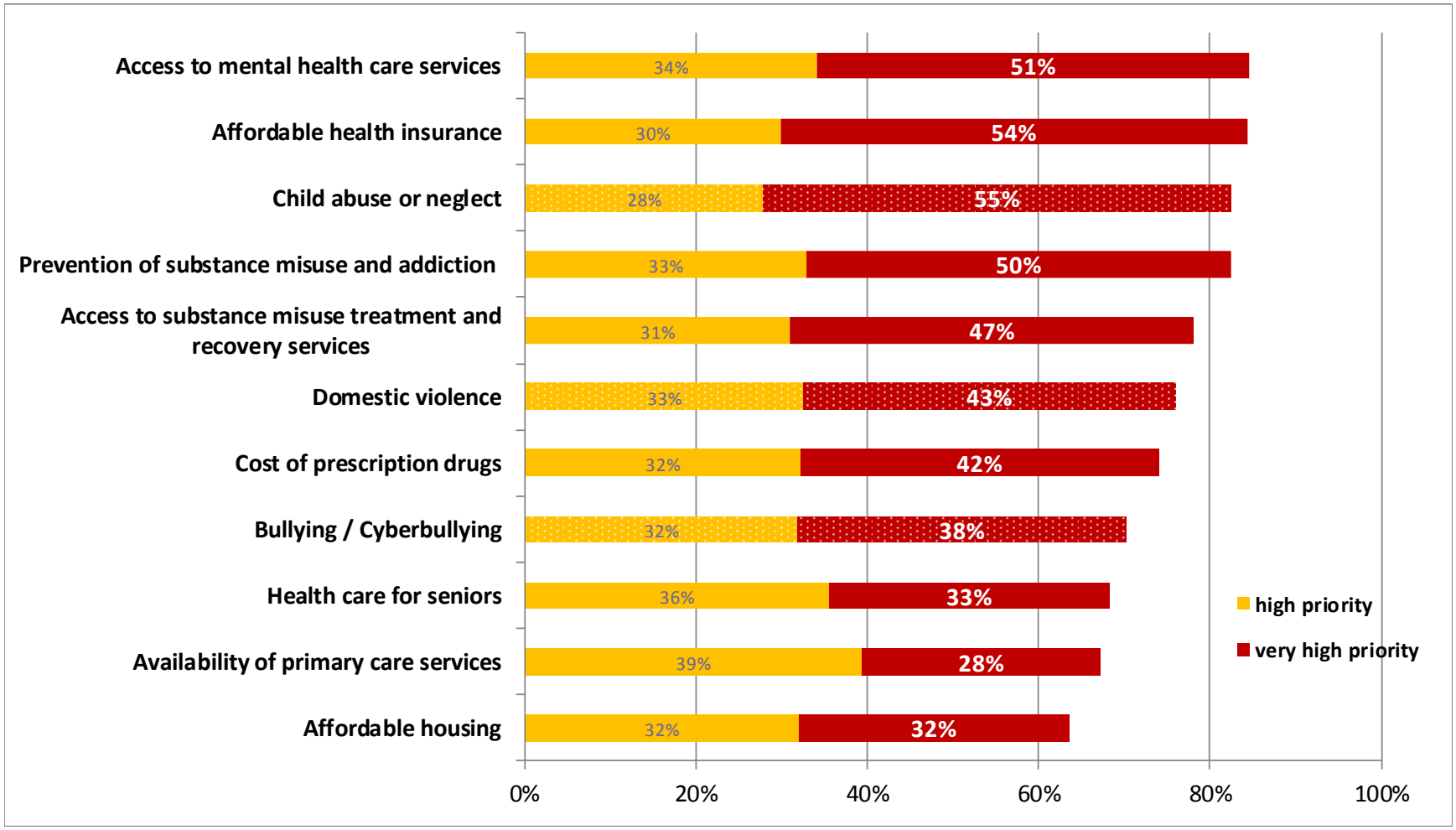
1. Most Important Community Health Issues Identified by Community Survey Respondents

Community respondents to the 2018 Community Health Needs Survey were presented with a list of 14 health-related topics that have been identified as priorities in previous community health assessments in the greater Upper Valley region of New Hampshire and Vermont including the VRH service area. For each topic, respondents were asked to indicate the extent to which they thought it should remain a priority for community health improvement work relative to other potential priorities. A second question presented respondents with a list of 14 more topics, including an "other' write-in option, which could be considered priorities for the region. Respondents were again asked to indicate the extent to which they thought each topic should become a priority for community health improvement work relative to other potential priorities.

Chart 1 on the next page displays the top priority topics for health improvement efforts identified by community respondents. The topics displayed with solid colors are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring are topics that rose to a high level priority from the second set of potential topics. The chart displays the percentage of respondents indicating the topic as a high priority or very high priority (needs are mostly unmet). Other response choices were moderate priority, somewhat low priority and low priority (needs are mostly met). The median percentage for all 28 items (half above, half below) with respect to the combined percentage of high and very high priority responses is 59%, ranging from 31% (preventing accidents and injuries) to 85% (access to mental health care services).

Access to mental health services, affordable health insurance and substance misuse prevention, treatment and recovery are each top priorities from prior community health needs assessments that remain among the highest priorities. Child abuse or neglect and domestic violence are two high priorities not specifically identified in prior needs assessments, although 'strengthening and supporting families' is a related topic that was previously identified as a high priority for community health improvement efforts. Another new priority identified in the community survey, bullying / cyberbullying, also addresses issues of social and behavioral interactions that an affect physical and mental health and wellbeing.

Chart 1: High Priority Community Health Issues; Community Respondents



Low Priority	Somewhat Low Priority	Moderate Priority	High Priority	Very High Priority
Needs are Mostly Met	←	→		Needs are Mostly Unmet

The table below displays the top community health improvement priorities identified by community survey respondents by age group. The percentages shown are the total percentages within each age group selecting the topic as a high priority or very high priority. In general, there is substantial similarity across age groups for the highest community health improvement priorities. Among respondents under 45 years of age, 'domestic violence' was reported as a higher priority (relatively) than other age groups, while 'cost of prescription drugs' was higher on the list for older age groups. 'Availability of primary care services' was also a top 5 priority for the respondents 65 years of age and older.

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

Under 45 years of age	n=143	45-64 years	n=176	65+ years of age	n=52
Access to mental health care services	86%	Affordable health insurance	89%	Prevention of substance misuse and addiction	86%
Child abuse or neglect	82%	Access to mental health care services	88%	Access to substance misuse treatment and recovery services	80%
Prevention of substance misuse and addiction	82%	Child abuse or neglect	84%	Affordable health insurance	80%
Affordable health insurance	81%	Prevention of substance misuse and addiction	82%	Cost of prescription drugs	80%
Access to substance misuse treatment and recovery services	77%	Cost of prescription drugs	80%	Availability of primary care services	73%
Domestic Violence	72%	Access to substance misuse treatment and recovery services	79%	Child abuse or neglect	72%

The table below displays the top seven community health improvement priorities identified by community survey respondents by household income group. As with the previous table, the percentages shown are the total percentages within each income group selecting the topic as a high priority or very high priority. Across income groups, the top seven priorities (out of 28 options) are the same. While relative order may vary, the amount of inter-item difference is small and not significant compared to the overall observation of congruence across groups.

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

Less than $50,000	n=131	$50,000 to $99,999	n=145	$100,000 or more	n=74
Affordable health insurance	85%	Access to mental health care services	88%	Prevention of substance misuse and addiction	92%
Prevention of substance misuse and addiction	82%	Affordable health insurance	86%	Access to mental health care services	91%
Access to mental health care services	81%	Child abuse or neglect	84%	Child abuse or neglect	84%
Child abuse or neglect	80%	Access to substance misuse treatment and recovery services	79%	Access to substance misuse treatment and recovery services	82%
Cost of prescription drugs	77%	Prevention of substance misuse and addiction	79%	Affordable health insurance	80%
Access to substance misuse treatment and recovery services	75%	Domestic violence	78%	Domestic violence	74%
Domestic violence	73%	Cost of prescription drugs	70%	Cost of prescription drugs	72%

The table below displays the top community health improvement priorities identified by community survey respondents from geographic sub-regions of the VRH service area. As with age and income, there is substantial similarity across groups by geography with the top seven priorities the same except for the following observations: Bullying / Cyberbullying is a higher priority relatively for respondents from Claremont, and; Newport area respondents recorded the most variation with Child Abuse or Neglect and Domestic Violence selected as top priorities along with 'Health care for seniors'.

Table 5: COMMUNITY HEALTH IMPROVEMENT PRIORITIES
BY RESIDENT LOCATION; Community respondents

Claremont	n=152	Newport, Croydon, Unity	n=51	Sullivan County 'South'	n=57	Sullivan County 'North'	n=67
Access to mental health care services	85%	Child abuse or neglect	88%	Affordable health insurance	87%	Access to mental health care services	91%
Child abuse or neglect	83%	Domestic Violence	86%	Access to mental health care services	80%	Prevention of substance misuse and addiction	90%
Affordable health insurance	83%	Access to mental health care services	84%	Prevention of substance misuse and addiction	80%	Affordable health insurance	90%
Prevention of substance misuse and addiction	83%	Affordable health insurance	82%	Cost of prescription drugs	76%	Access to substance misuse treatment and recovery services	81%
Access to substance misuse treatment and recovery services	80%	Health care for seniors	80%	Access to substance misuse treatment and recovery services	73%	Child abuse or neglect	78%
Bullying / Cyberbullying	79%	Prevention of substance misuse and addiction	78%	Child abuse or neglect	71%	Cost of prescription drugs	77%

Sullivan County 'South' includes responses from Charlestown, Acworth, Langdon, Lempster, Washington and Goshen. Sullivan County 'North' includes responses from Cornish, Plainfield, Grantham, Springfield and Sunapee.

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

In addition to the survey of community residents, the 2018 Community Health Needs Assessment included a similar survey sent by direct email to key stakeholders and community leaders from around the region. This activity occurred in conjunction with all the Community Health Needs Assessment partners with the survey going to 265 individuals across the greater Upper Valley region of NH and VT. A total of 153 completed responses were received (58%), of which 43 respondents indicated serving or being most familiar with the Greater Claremont area including Newport (respondents could indicate familiarity with or service to multiple sub-regions).

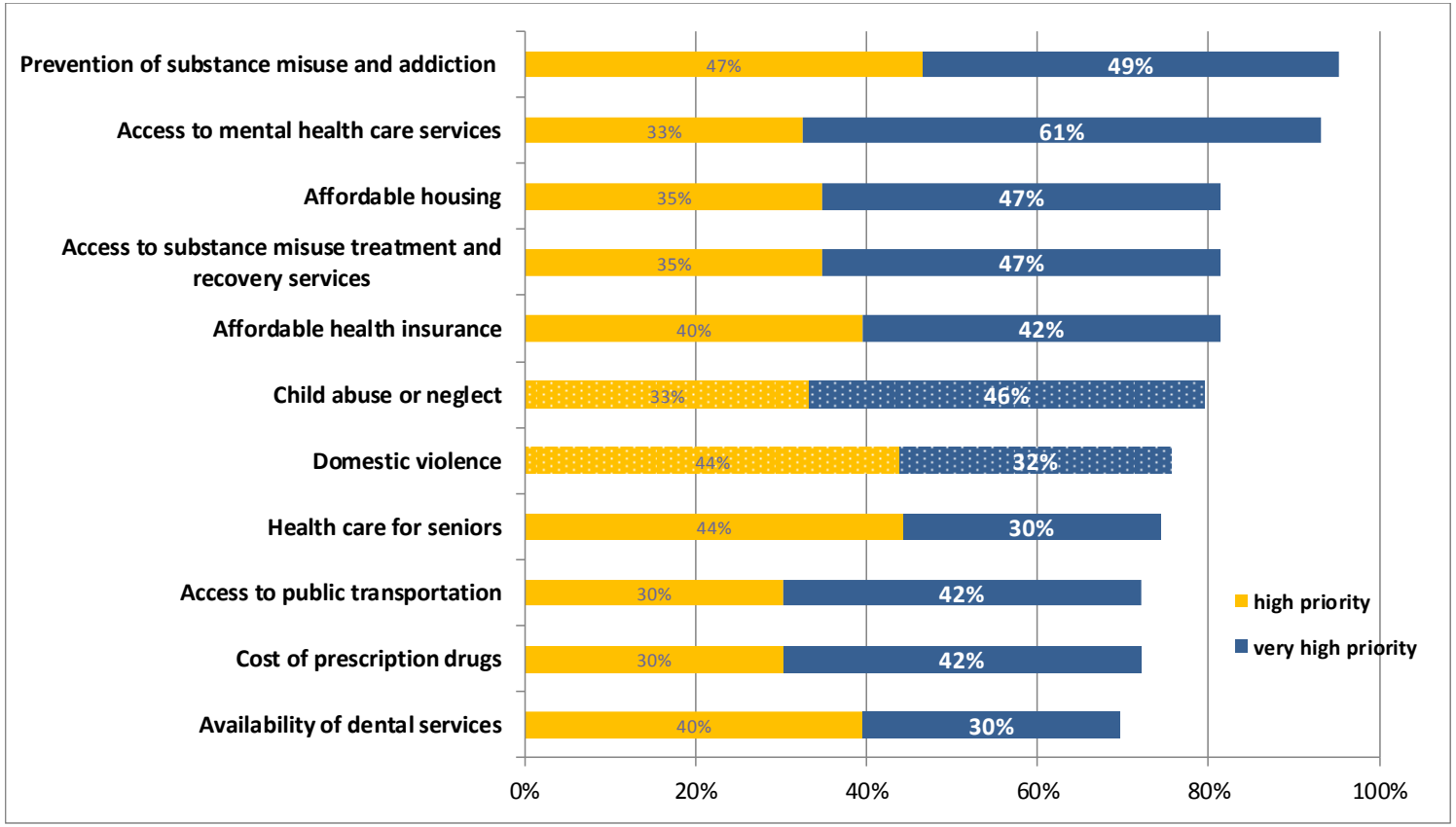
Table 6: Key Stakeholder Survey Respondents, Greater Claremont area

Percent of Respondents	Community Sector
34.9%	Human Service / Social Service (15)
20.9%	Community member / volunteer (9)
16.3%	Mental Health / Behavioral Health (7)
14.0%	Municipal / County / State Government (6)
11.6%	Home Health Care (5)
11.6%	Primary Health Care (5)
9.3%	Medical Sub-Specialty (4)
9.3%	Education / Youth Services (4)
7.0%	Business (3)
7.0%	Public Health (3)
4.7%	Public Safety / Law / Justice (2)
4.7%	Long Term Care (2)
2.3%	Faith organization (1)
2.3%	Fire / Emergency Medical Service (1)
2.3%	Dental / Oral Health Care (1)

Respondents to the key stakeholder survey were presented with the same two lists of health-related topics: the list of topics identified as priorities in previous community health assessments in the region and a second list of topics (including 'other') that could be considered priorities for health improvement efforts in the region. The chart on the next page displays the results of these questions from key stakeholder responses. The median percentage for all 28 items (half above, half below) with respect to the combined percentage of high and very high priority responses is 58%, ranging from 20% (preventing accidents and injuries) to 95%

(prevention of substance misuse and addiction). Four of the top five issues identified by key stakeholders are the same as those identified by community respondents with even higher priority ratings for substance misuse prevention and access to mental health services. Key stakeholders were more likely to identify affordable housing and access to public transportation as high priorities (relatively) compared to community survey respondents.

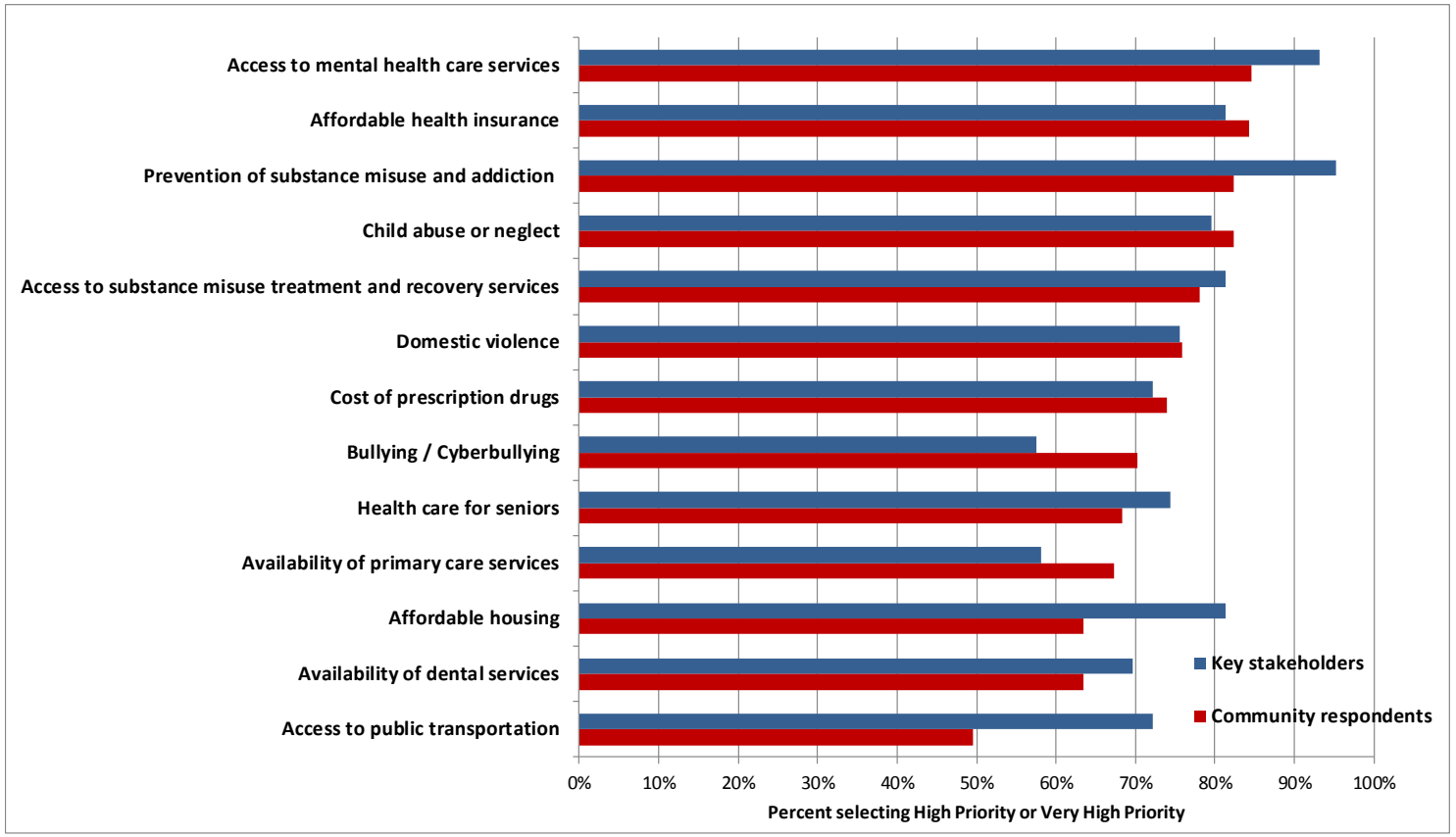
Chart 2: Community Health Improvement Priorities
Key Stakeholder Survey Respondents



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

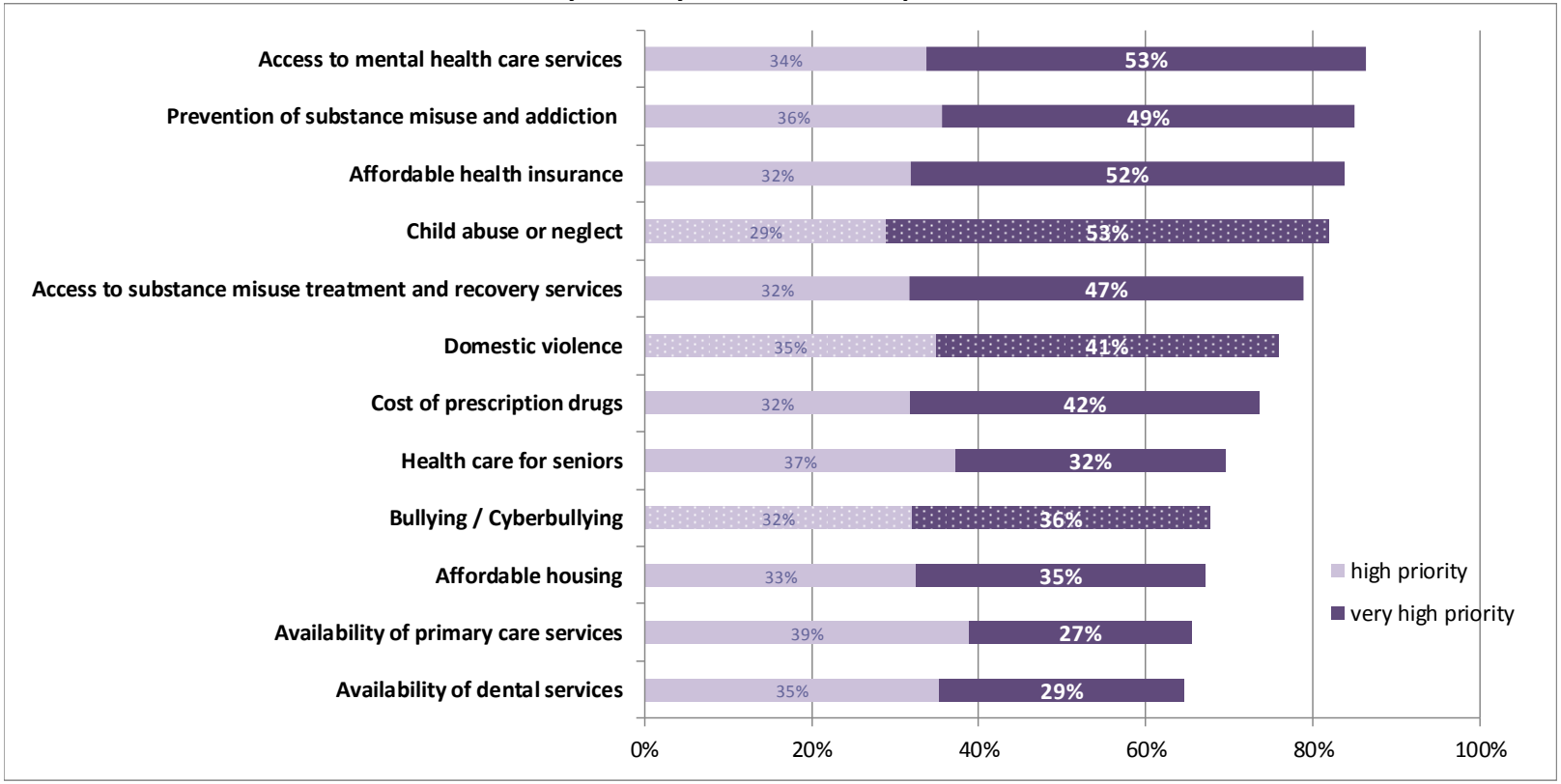
The chart below displays a comparison of the responses between community and key stakeholder surveys for the highest priority community health issues. Blue bars on the chart display the percentage of key stakeholders selecting the topic as high priority or very priority and red bars display the results from community respondents (topics are arrayed overall high to low according to the community respondent percentages). As previously noted, key stakeholder were somewhat more likely to prioritize affordable housing and public transportation, while community members were more likely to identify bullying / cyberbullying as a high priority community health issue.

Chart 3: Community Health Improvement Priorities
Comparison of Community and Key Stakeholder Respondents



The chart below displays the combined results from the questions on community health improvement priorities from the perspective of community and key stakeholder survey respondents. The response percentages from community respondents were given 80% weight in the computation of combined responses and the key stakeholder / community leader responses were given 20% weight. The top 12 community health priorities are displayed. As in previous charts, bars depicted with solid color are topics that had been identified in previous needs assessment. Those topics shown with dotted coloring (child abuse or neglect, domestic violence, bullying / cyberbullying) are topics that rose to a high priority from the second set of potential topics.

Chart 4: Community Health Improvement Priorities
Community and Key Stakeholder Responses Combined



Low Priority	Somewhat Low Priority	Moderate Priority	High Priority	Very High Priority
Needs are Mostly Met ◄			► Needs are Mostly Unmet	

4. Barriers to Services Identified by Community Survey Respondents

Respondents to the FY2018 Community Needs Assessment Survey were asked, "In the past year, have you or someone in your household had difficulty getting the health care or human services you needed?" Overall, 28.1% of survey respondents indicated having such difficulty. As Chart 5 displays, there is a significant relationship between reported household income and the likelihood that respondents reported having difficulty accessing services. In particular, respondents in the lowest income category were most likely to report difficulty accessing services (50%) and more than twice as likely to report access difficulties compared to respondents with household incomes of $50,000 or more.

Chart 5: Access to Services
Community Survey Responses

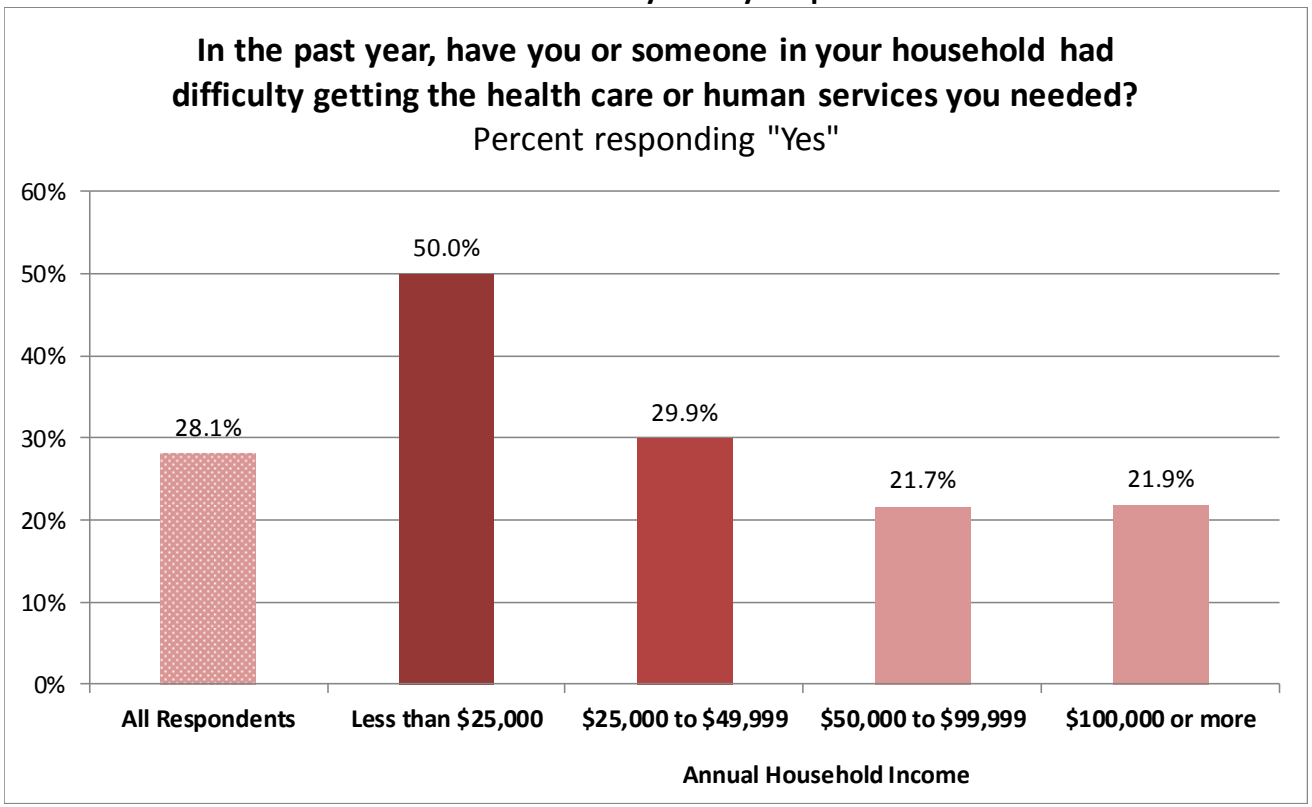
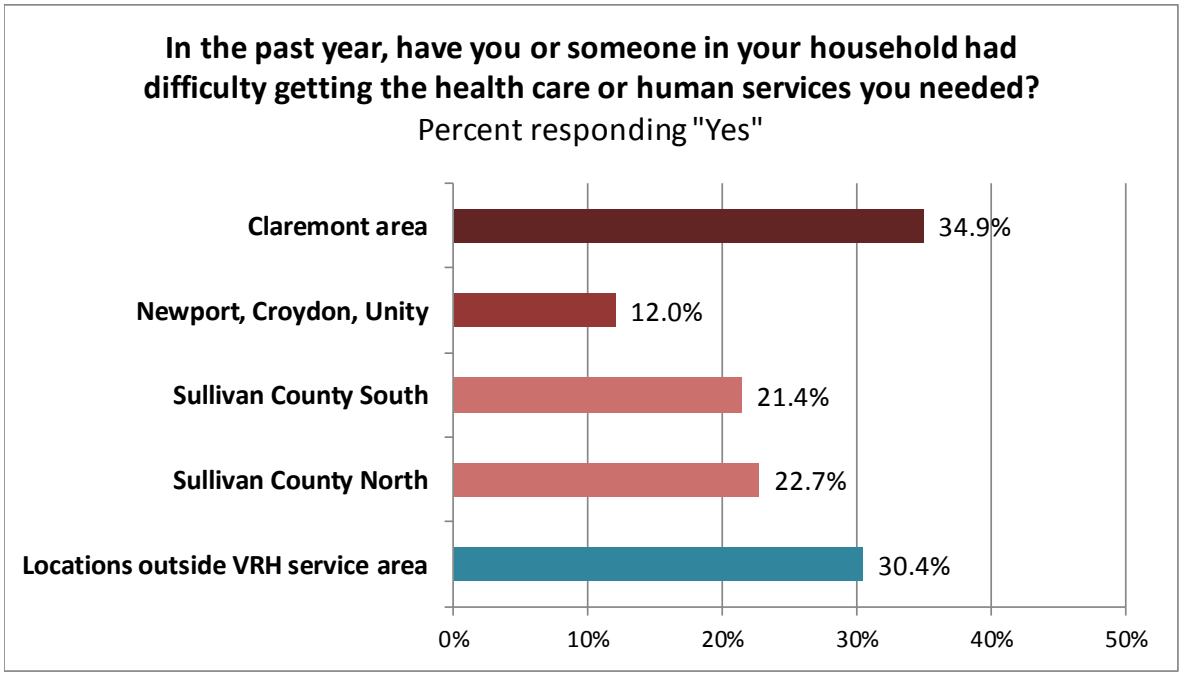


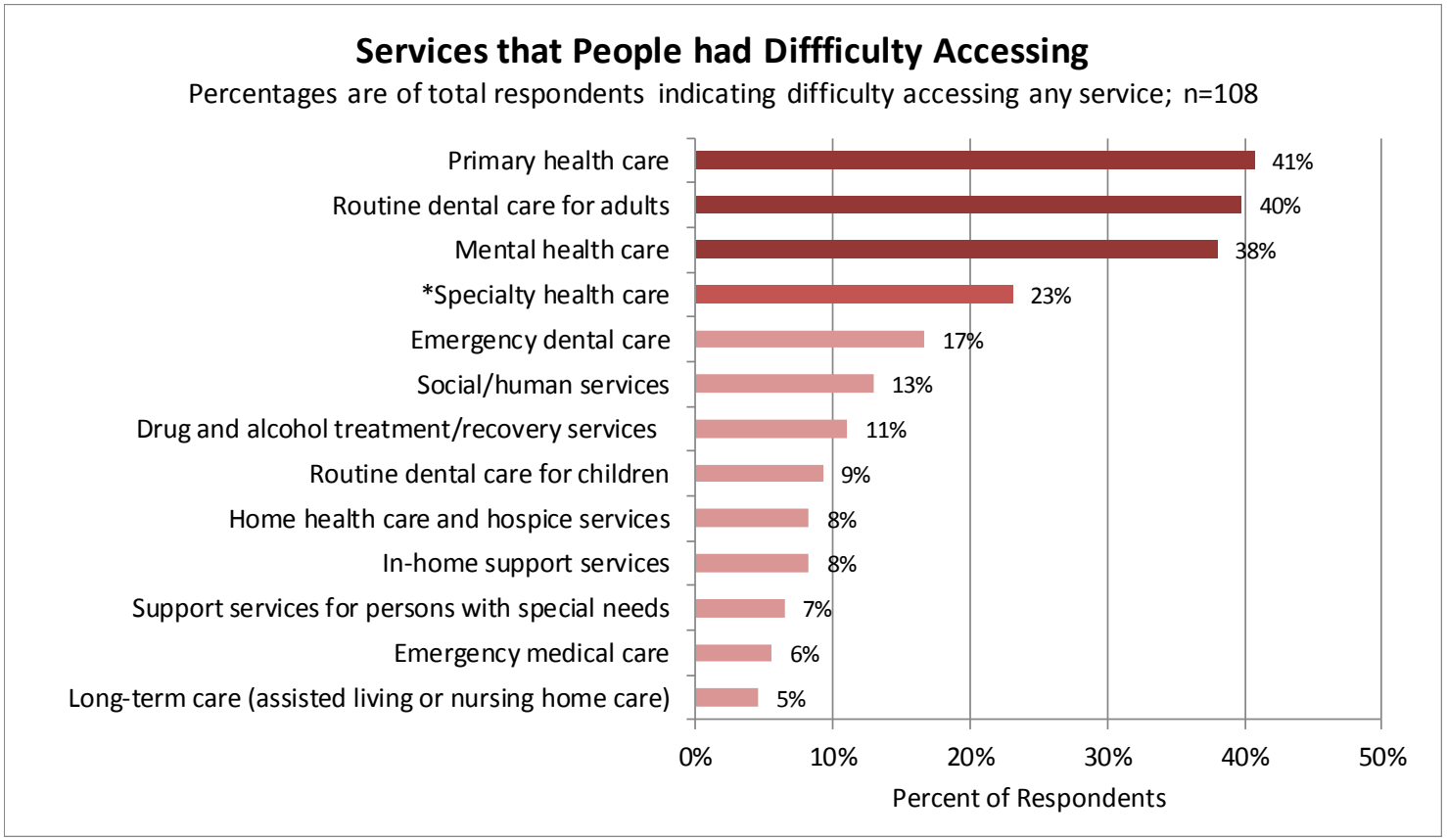
Chart 6 examines responses to this question by sub-region within the VRH service area. Within the primary service area of Valley Regional Healthcare, residents of Claremont were most likely to report difficulty accessing services, while residents of Newport / Croydon / Unity (zip code 03773) were least likely to report access difficulties. Survey respondents from communities outside the primary service area of VRH were also more likely to report having had access difficulties in the past year.

Chart 6: Access to Services by Sub-region



The survey also asked people to indicate the areas in which they had difficulty getting services or assistance. As displayed by Chart 7, the most common service types that people had difficulty accessing were primary health care (41% of those respondents indicating difficulty accessing any services); routine dental care for adults (40%); mental health care (38%); and specialty health care (23%). Note that percentages on this chart are of the subset of respondents who indicated any difficulty accessing services (28.1% of all respondents; n=108).

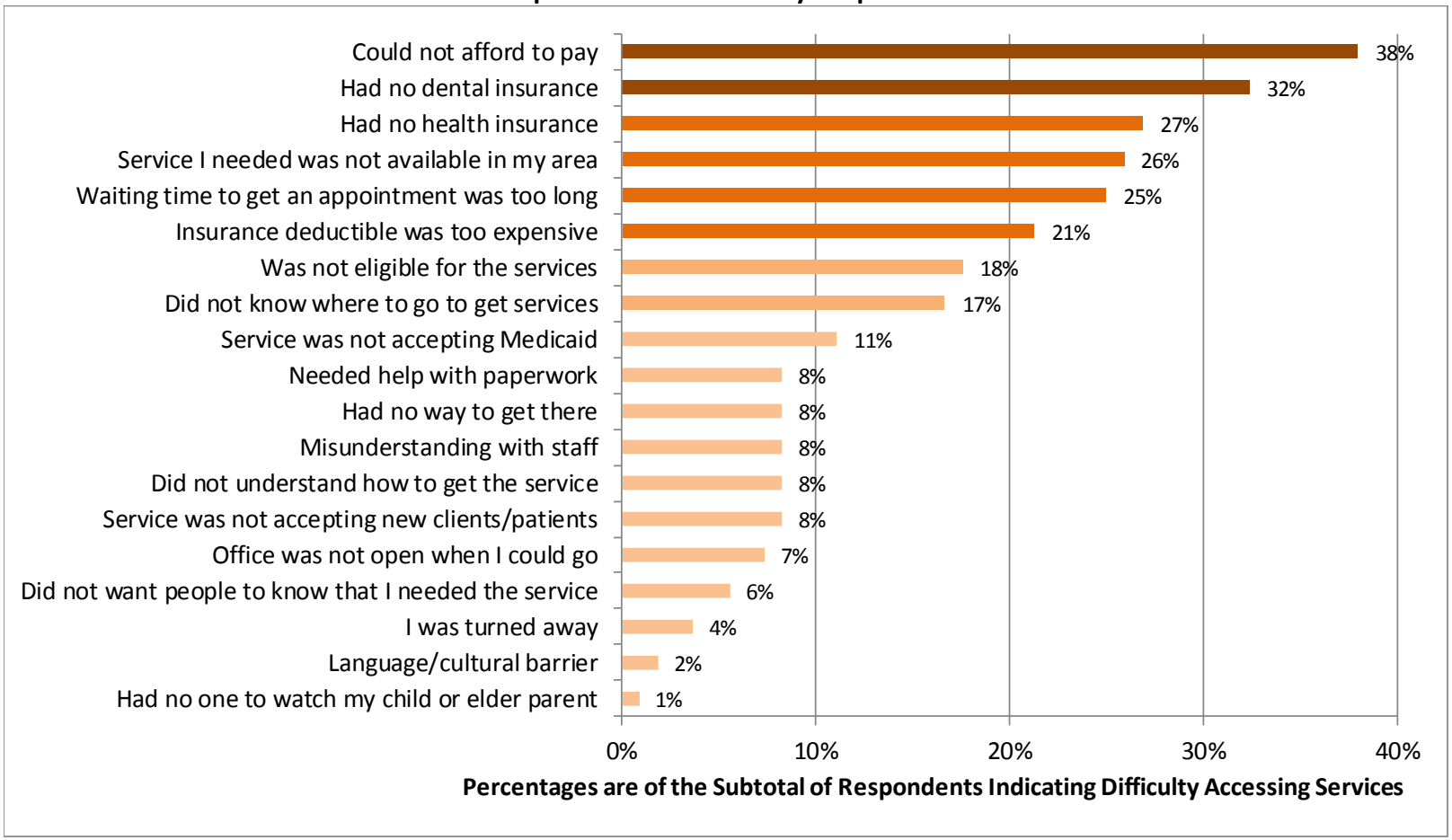
Chart 7



*Over 20 different types of specialty health care services mentioned in comments on this item. The only services with more than one respondent comment were Orthopedics, Rheumatology, Psychiatry, and Home Care.

Respondents who reported difficulty accessing services in the past year for themselves or a family member were also asked to indicate the reasons why they had difficulty. As shown on Chart 8, the top reasons cited were 'could not afford to pay' for the service (38%); 'had no dental insurance' (32%); 'had no health insurance' (27%); 'service I needed was not available in my area' (26%); and 'waiting time to get an appointment was too long' (25%). Percentages are again calculated from the subset of respondents who indicated difficulty accessing services.

Chart 8: Access Barriers
Perspectives of Community Respondents



Further analysis of these two questions addressing access to specific types of services is shown by Table 6. Among respondents indicating difficulty accessing primary health care, adult dental care or mental health care, the top reasons indicated for difficulty accessing (any) services was lack of insurance and unaffordability. Among respondents indicating difficulty accessing specialty health care, the top reason cited for access difficulties was 'waiting time to get appointment too long' and 'the service was not available in my area.

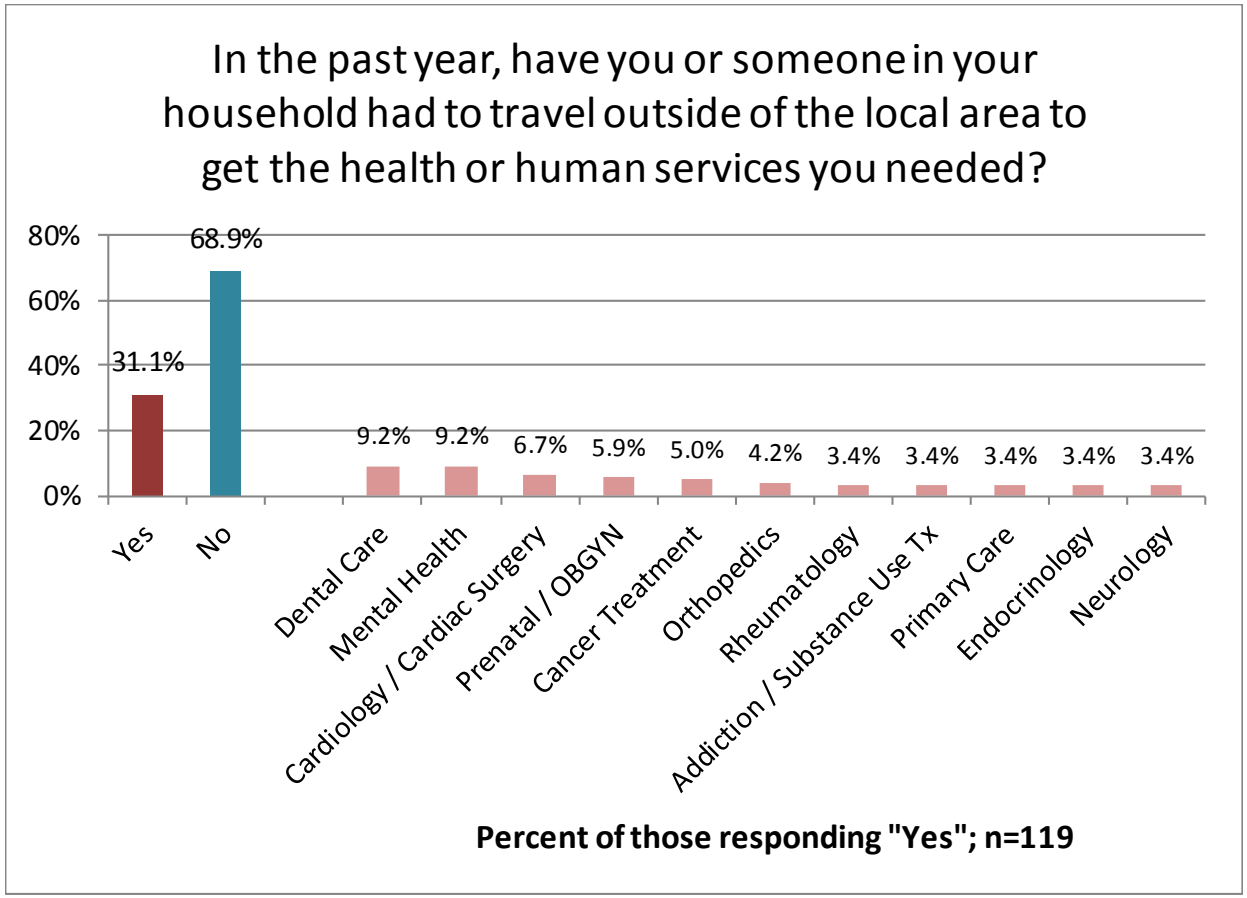
TABLE 7: TOP REASONS RESPONDENTS HAD DIFFICULTY ACCESSING SERVICES BY TYPE OF SERVICE

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

Primary Health Care (n=44, 11% of all respondents)	Routine Dental Care for Adults (n=43, 11% of all respondents)	Mental Health Care (n=41, 11% of all respondents)	Specialty Health Care (n=25, 7% of all respondents)
52% of respondents who had difficulty accessing primary health care also reported ***Could not afford to pay***	**72%** of respondents who had difficulty accessing routine dental care for adults also reported ***Had no dental insurance***	**44%** of respondents who had difficulty accessing mental health care also reported ***Could not afford to pay***	**28%** of respondents who had difficulty accessing specialty health care also reported ***Waiting time to get an appointment was too long***
41% ***Had no health insurance***	**51%** ***Could not afford to pay***	**39%** ***Had no health insurance***	**28%** ***Service I needed was not available in my area***
34% ***Insurance deductible was too expensive***	**30%** ***Not eligible for the services***	**29%** ***Insurance deductible was too expensive***	**24%** ***Could not afford to pay***
32% ***Waiting time to get an appointment was too long***	**21%** ***Service I needed was not available in my area***	**29%** ***Waiting time to get an appointment was too long***	**20%** ***Insurance deductible was too expensive***
27% ***Did not know where to go to get services***	**21%** ***Did not know where to go to get services***	**27%** ***Service I needed was not available in my area***	**20%** ***Needed help with paperwork***

In a separate question, survey respondents were asked, “In the past year, have you or someone in your household had to travel outside of the local area to get the health or human services you needed?” About 31% of all survey respondents indicated traveling outside of the ‘local area’ for health and human services in the past year. In an open-ended follow-up question, respondents were asked what type of services they had traveled outside of the area to get. Dental care, mental health care, cardiology / cardiac surgery, and prenatal / OBGYN care were the most frequently mentioned types of services.

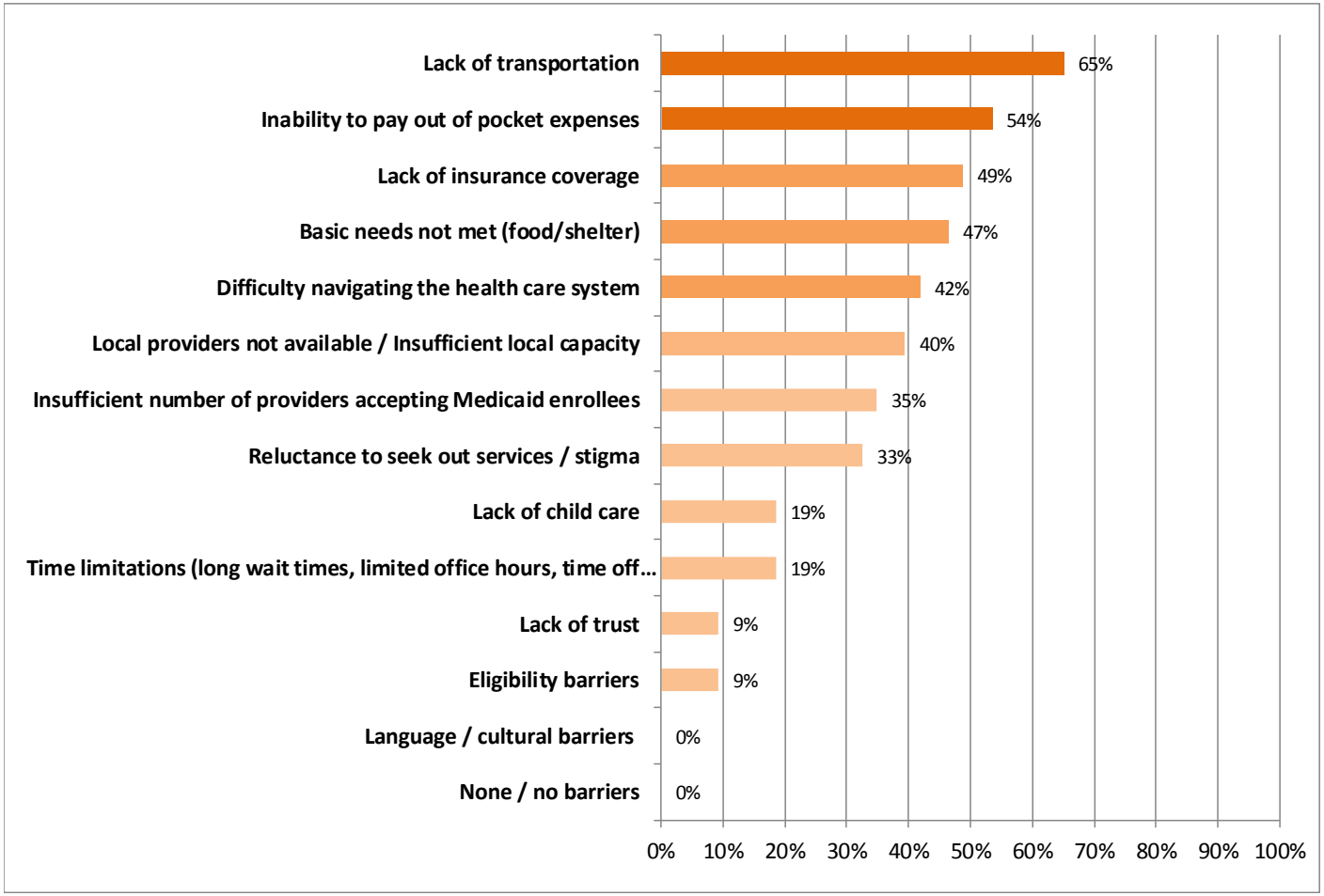
Chart 9



5. Barriers to Services Identified by Key Stakeholder Survey Respondents

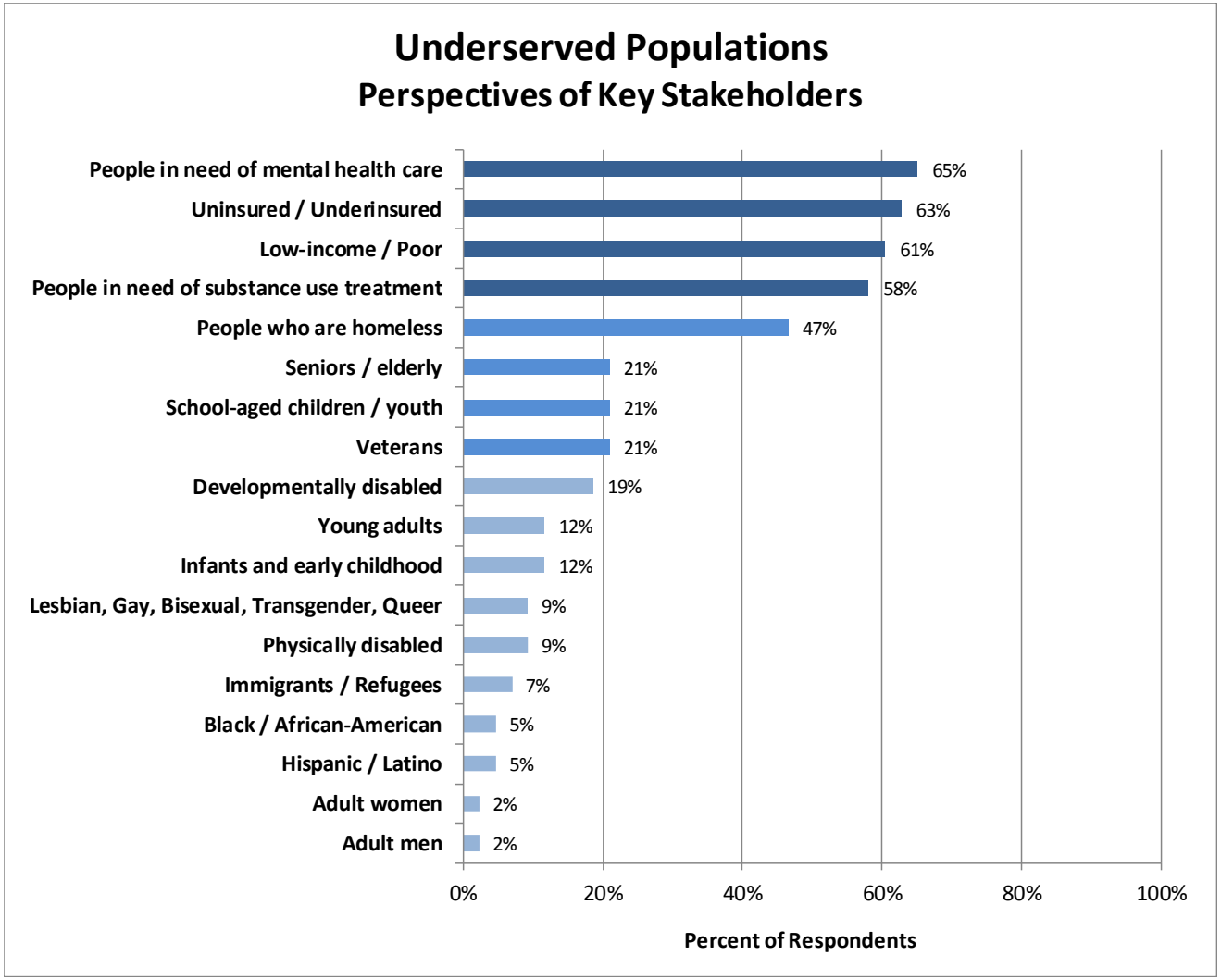
Respondents to the key stakeholder survey were also asked to identify the most significant barriers that prevent people in the community from accessing needed health care services. The top issue identified by this group was 'lack of transportation', followed by out of pocket expenses, lack of insurance coverage, and 'basic needs not met'.

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



Key stakeholders were also asked if there are specific populations in the community that are not being adequately served by local health services. Chart 11 displays results from key stakeholder responses on specific populations thought to be currently underserved. 'People in need of Mental Health Care', 'Uninsured/Underinsured", 'People in need of substance abuse treatment', and 'Low Income/Poor' were the most frequently indicated populations perceived to be currently underserved.

Chart 11

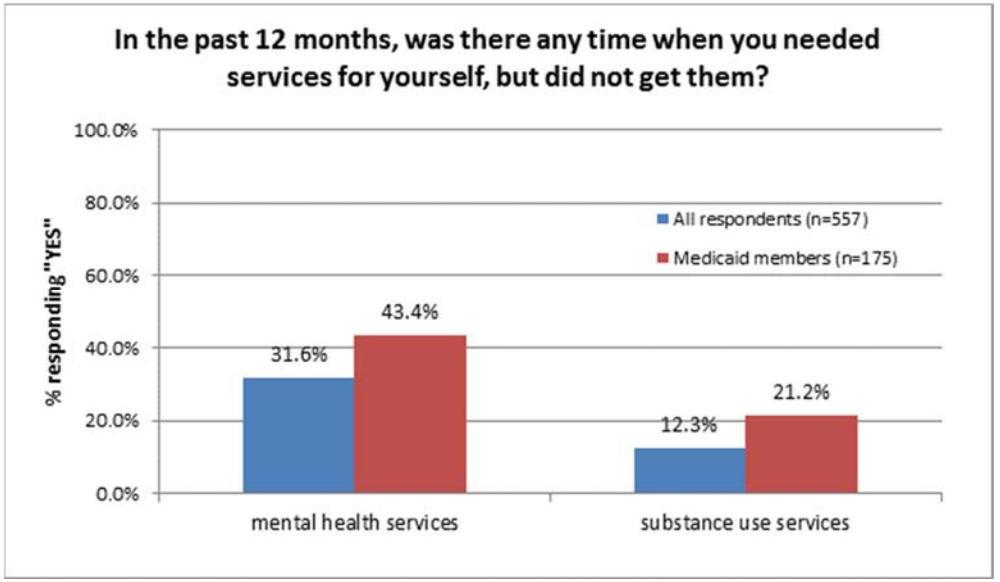


6. Behavioral Health Needs Survey Findings

Recognizing the continued importance of mental health and substance misuse as community identified priorities for improvement, the organizational partners involved in this Community Health Needs Assessment partnered with other health and human service providers in the fall of 2016 to conduct an assessment specifically focused on behavioral health needs. The results of that assessment were used to inform the development of an Integrated Delivery Network for behavioral health care services in the Southwestern and Upper Valley region of New Hampshire including the VRH service area. One aspect of this assessment was a consumer survey of area residents targeted to high need locations and populations with a particular emphasis on reaching populations covered by Medicaid. Some of key findings of this behavioral health needs assessment relevant to the 2018 VRH Community Health Needs Assessment are included here.

The behavioral health-focused assessment included a survey of consumers of behavioral health services. About 32% of consumer survey respondents indicated having difficulty getting the mental health services they needed in the past 12 months, including about 43% of Medicaid members; while 12% indicated they had difficulty getting substance use services they needed including about 21% of Medicaid eligible respondents.

Chart 12



Further analysis of these results showed that of those respondents who did receive some type of mental health services in the past 12 months, about 44% also indicated having difficulty getting the mental health services they needed. Among respondents who received no mental health services in the past 12 months, nearly 1 in 5 (about 19%) indicated a need for mental health services that they did not get. These findings may reflect different challenges to receiving services such as waiting lists (e.g. respondents may have had difficulty getting services initially, but eventually did so), gaps in the appropriateness or acceptability of services, financial obstacles to care and respondent readiness to seek services.

Similar findings were observed for respondents indicating difficulty accessing substance use services where nearly half of respondents (46%) who did receive substance use services in the prior 12 months also indicated difficulty in getting services they needed. Among those respondents who did not access substance use services in the prior 12 months, about 5% reported a need for services that they did not get.

Chart 13

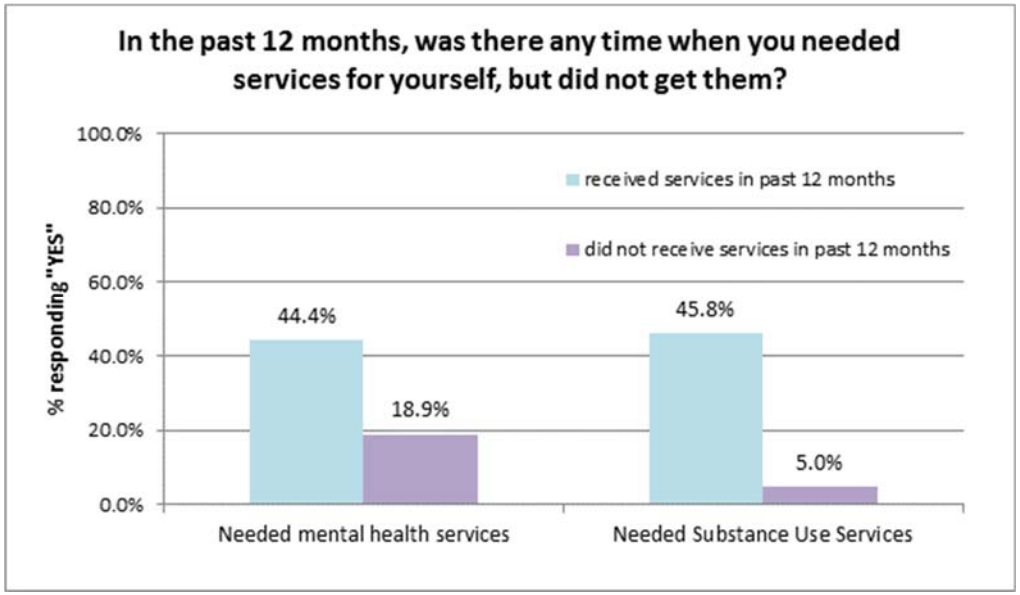


Chart 14 displays the finding that the top reasons reported for not getting needed mental health services are “I thought I could handle the problem without treatment” and “There were no openings or I could not get an appointment”. The top mental health services that people reported having difficulty accessing (Chart 15) are individual therapy or counseling and assistance with medication management.

Chart 14

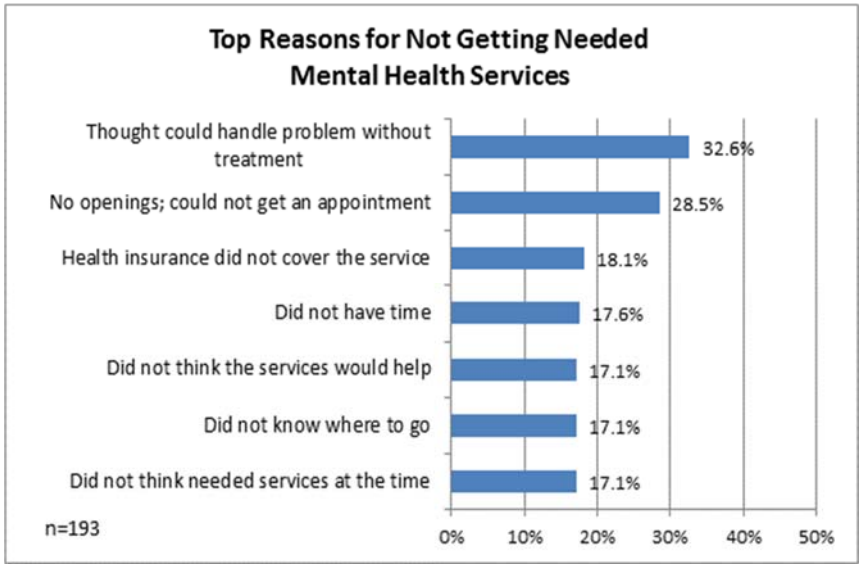
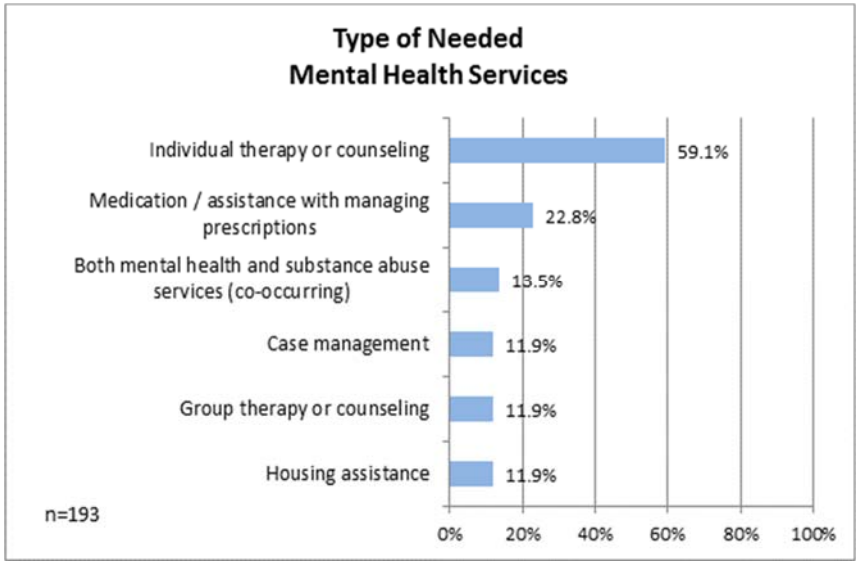


Chart 15



Reported reasons for substance use service access difficulties are similar with the top reasons being “I was not ready to stop using alcohol or drugs”, “I thought I could handle the problem without treatment”, and “There were no openings or I could not get an appointment”. However, some differences are observed for the type of services respondents had difficulty getting (Chart 17). While ‘individual therapy or counseling’ was again the top service mentioned, it was mentioned by a smaller proportion of respondents and a more diverse array of services were mentioned with higher frequency including co-occurring mental health and substance use services, peer and recovery support services, intensive outpatient treatment and opioid treatment.

Chart 16

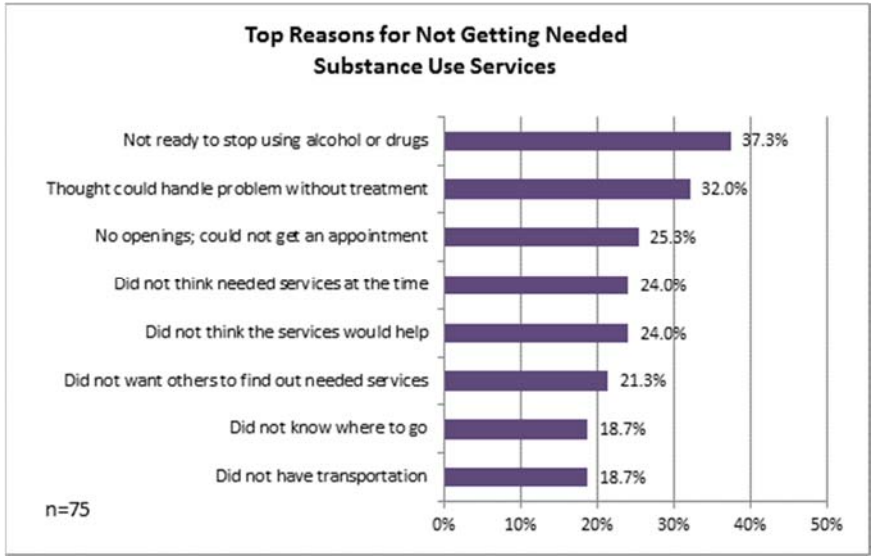
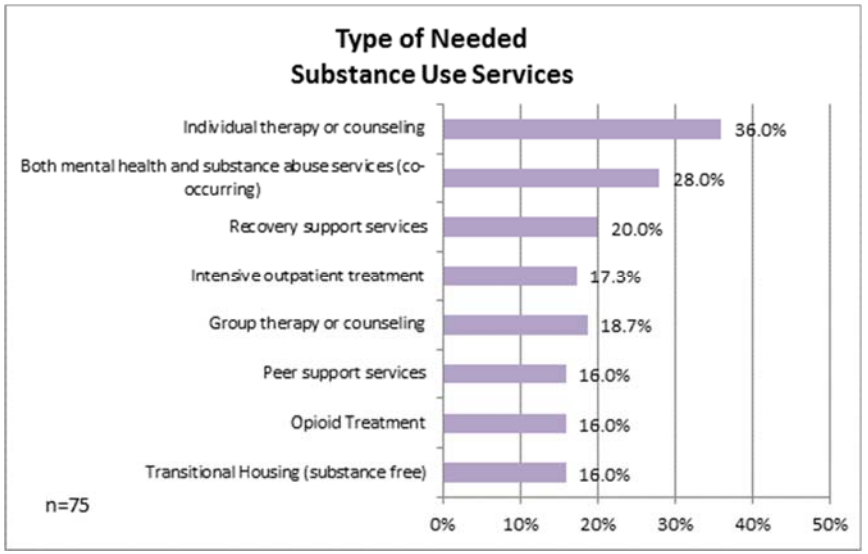
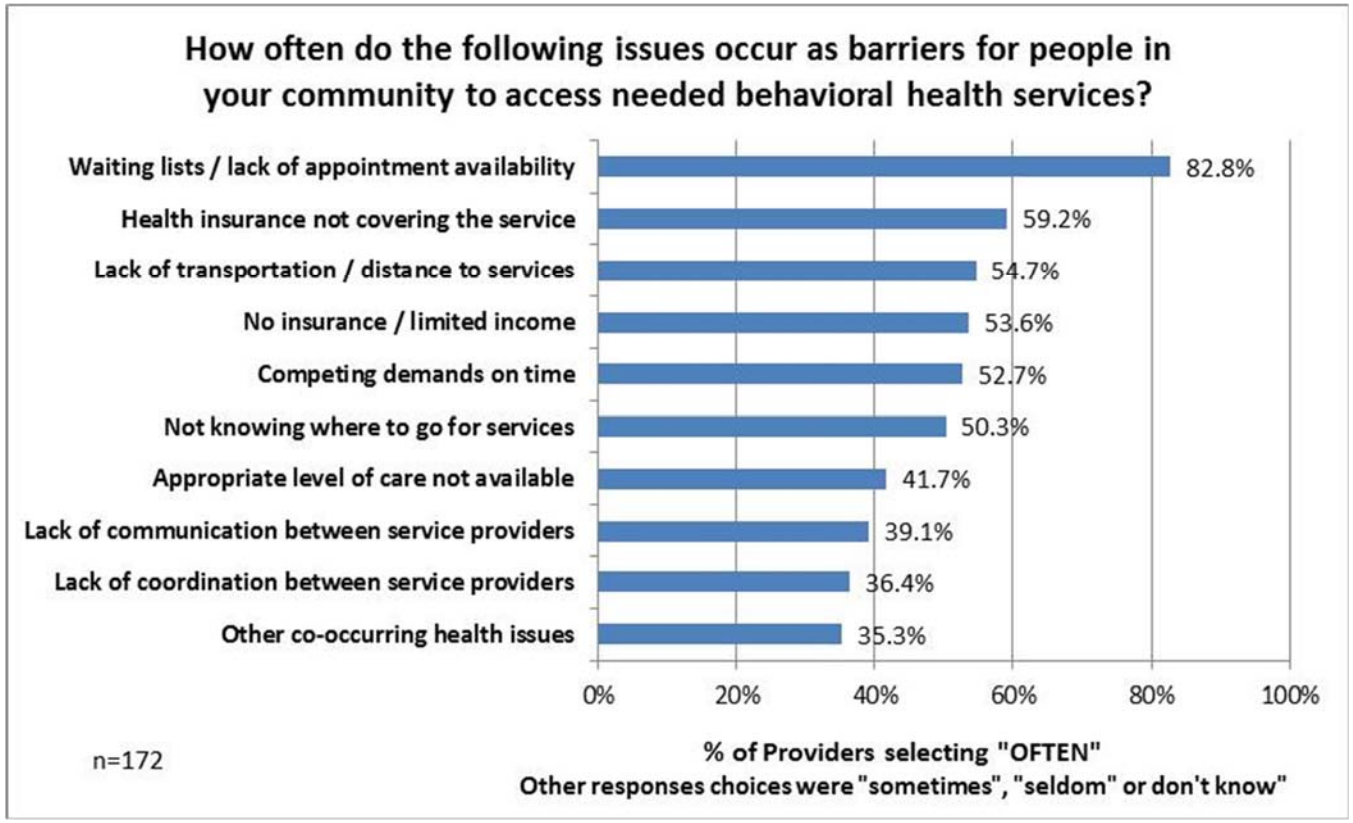


Chart 17



The focused assessment of behavioral health needs also included a survey of area health and human service providers (n=172). As displayed by Chart 18, respondents to the provider survey also reflect the observation that workforce capacity is an important concern with 'waiting lists / lack of appointment availability' cited as a top barrier to accessing behavioral health services in the region. Health insurance coverage limitations and lack of transportation / distance to services also noted as substantial barriers to accessing needed behavioral health services.

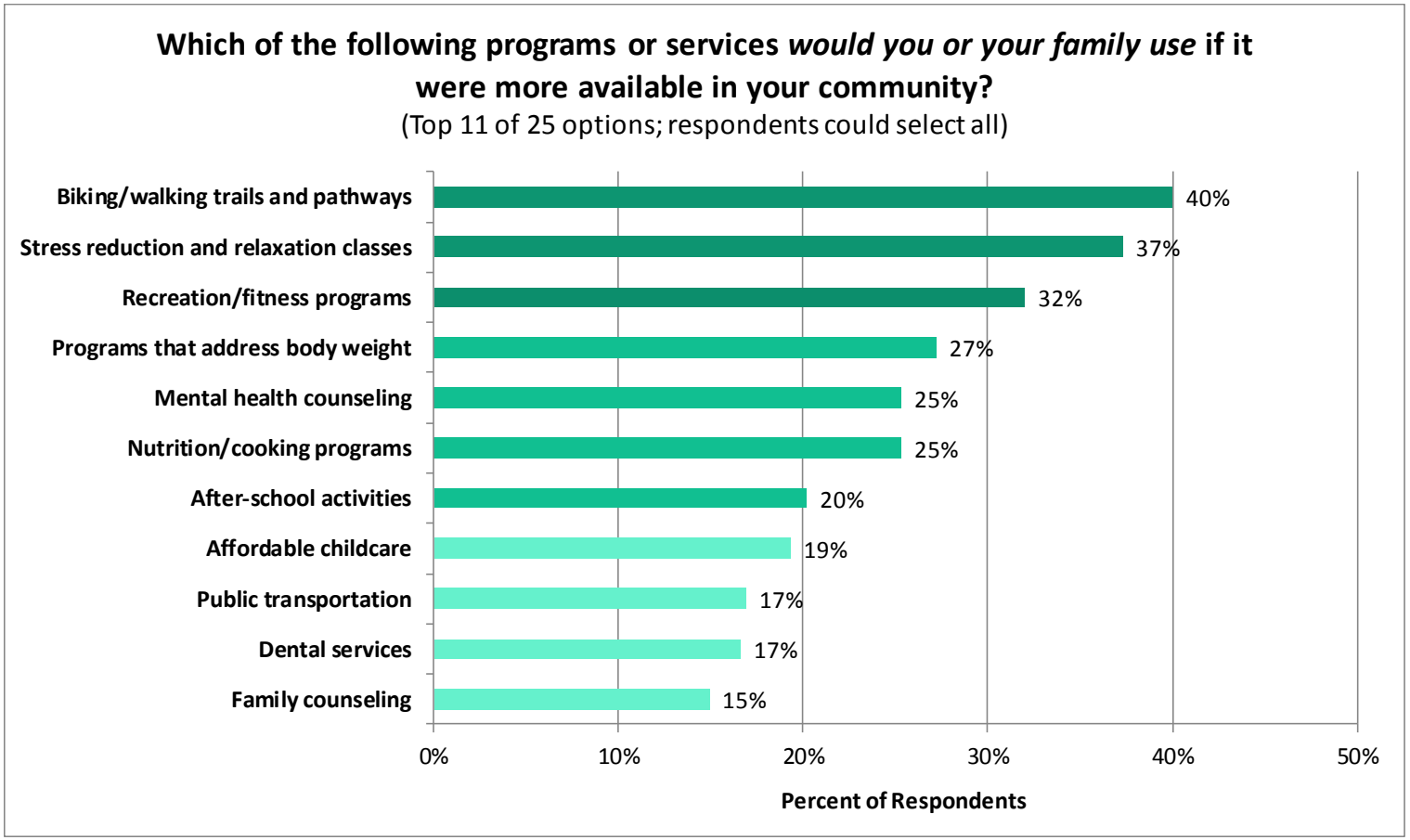
Chart 18



7. Community Health Resources and Suggestions for Improvement

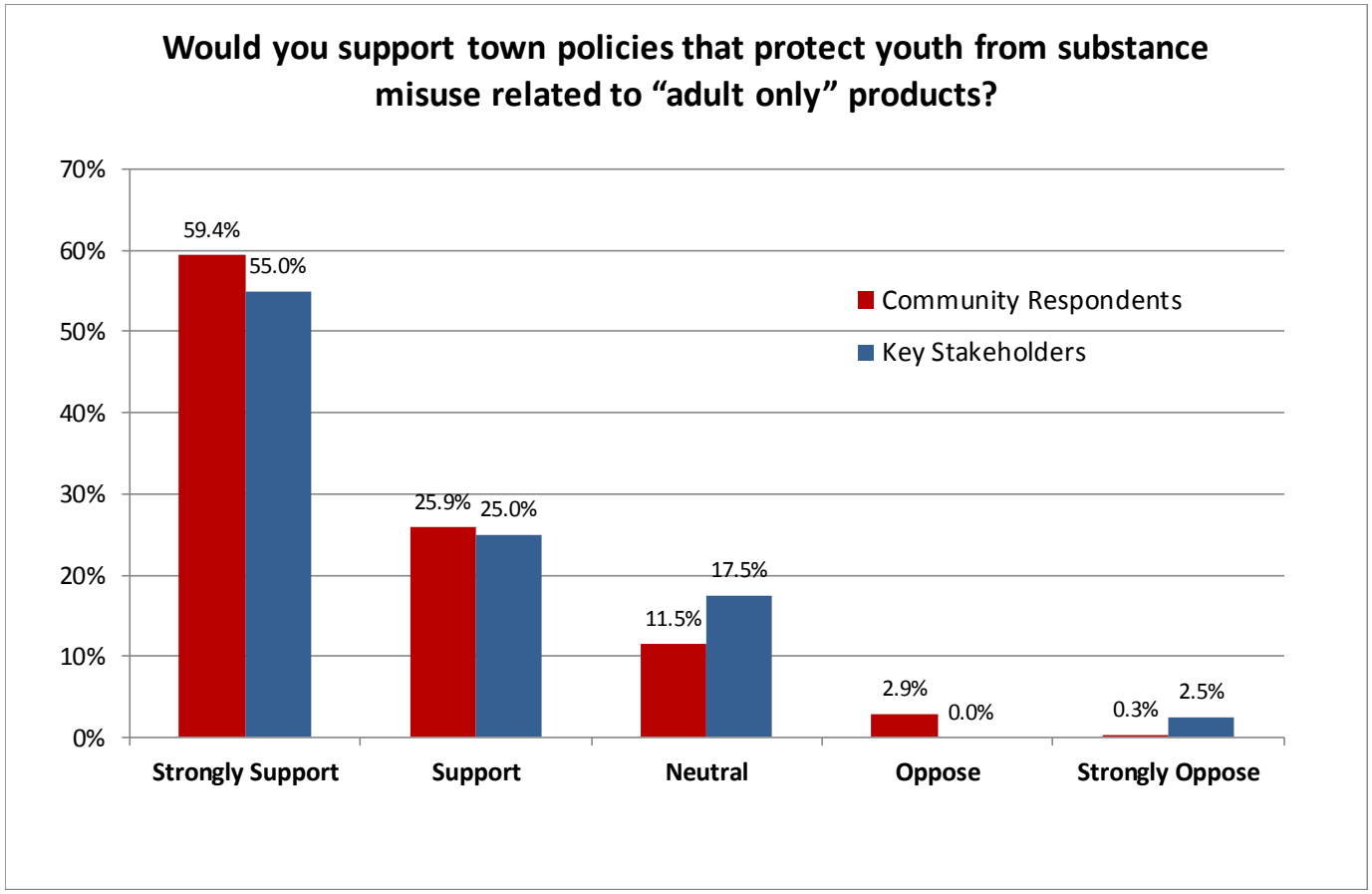
The 2018 VRH Community Needs Assessment Survey asked people to indicate from community health-related programs or services they would use if more available in the community. Biking/walking trails and paths was the most commonly selected resource of interest to survey respondents (40%), followed by 'Stress reduction and relaxation classes' and 'Recreation/fitness programs'.

Chart 19



Respondents to the community survey and the key stakeholder survey were asked the question, “Would you support town policies that protect youth from substance misuse related to “adult only” products?” Examples of such policies could include policies that limit advertising, limit retail locations, or restrict use at community events of alcohol, tobacco, ‘vaping’, marijuana and related paraphernalia. Support for these types of town policies was similar on the two surveys with about 85% of community respondents and 80% of key stakeholder respondents indicating support or strong support.

Chart 20



The 2018 Community Health Needs Assessment Survey asked people to respond to the question, ***"If you could change one thing that you believe would contribute to better health in your community, what would you change?"*** A total of 232 survey respondents (56%) 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 contribute to better health in your community, what would you change?"	
Affordability of health care/low cost or subsidized services; health insurance; health care payment reform	**14.2% of all comments**
Accessibility / availability of substance use treatment services; substance misuse prevention including tobacco	**13.8%**
Health care provider availability including certain specialties; hours and wait time; health care delivery system improvements, quality and options	**11.6%**
Accessibility/availability of mental health services; awareness, outreach and stigma	**9.5%**
Programs/services for youth and families; healthy lifestyle education	**8.2%**
Improved resources, programs or environment for healthy eating / nutrition / food affordability	**7.3%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**6.9%**
Improved job opportunities; affordable housing; child care; economy	**6.9%**
Caring community / culture; community connections and supports	**5.2%**
Overall wellness; health and wellness education; alternative health information and services	**4.3%**

"If you could change one thing that you believe would contribute to better health in your community, what would you change?"	
Reduce reliance on public assistance / welfare; enabling unhealthy behaviors	2.2%
Senior services / assisted living / concerns of aging; physical disability concerns	1.7%
Improved transportation services / public transportation; medical transportation	1.7%
Affordability / availability of dental services	1.3%
Public safety, violence, crime; gun control	0.9%
Environmental health concerns	0.4%
Satisfied with services / community	1.3%

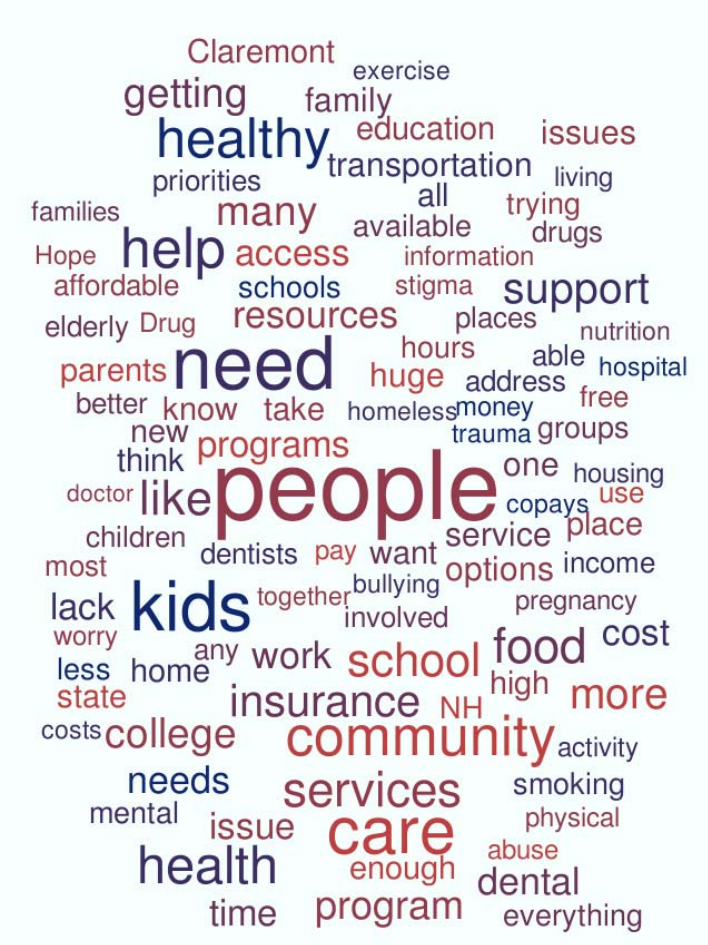
B. COMMUNITY HEALTH DISCUSSION GROUPS

A set of four discussion groups were convened in the spring of 2018 as part of the effort by Valley Regional Healthcare to understand the health-related needs of the community and to plan programs and services that address those needs. The purpose of the discussion groups was to get input on health issues that matter to the community and thoughts and perceptions about the health of the community. Discussion groups were convened representing a variety of important community sectors and perspectives, specifically the following:

- TLC Family Resource Center (8 participants)
- Claremont Soup Kitchen (3 participants)
- Ladies Union Aid Society (7 participants)
- Newport area parents and school personnel (6 participants)

1. Community Discussion Group Themes

The following paragraphs and table summarize the findings from the community discussion groups.



- Discussion group participants had mixed perspectives about the overall health of the community. Positive factors cited included organized community activities involving physical activity, healthy food options and family fun activities, decreases in smoking, increased focus by some residents on personal fitness and exercise, and school and community resources such as food and nutrition programs that promote health and wellness. However, a number of comments also specifically cited substance misuse, obesity, and poor diet as problems contributing to poor health in the community, as well concerns about families under stress and associated lifestyles that contribute to poor health outcomes. Discussion participants described a divide in the community of health

outcomes influence by both income and generational attitudes. Discussion included concerns about the cost of buying healthy foods and "lack of generational knowledge, some don't care to know that this community is unhealthy".

> *"There is a divide of people who are aware and unaware – it comes down the poverty line and they would benefit the most. Need to figure out a way to shatter the barrier."* Parent Group Participant

- Participants identified a wide variety of community strengths and resources that promote health including the Claremont Community Center, the Newport Recreation Center, outdoor recreational areas including Monadnock and Moody parks, Arrowhead Recreational area, area schools, churches, Claremont Soup Kitchen ("the soup kitchen is one of the best places"), TLC Family Resource Center, West Central Behavioral Health, Hope for NH Recovery, farmers' markets, Amplified Arts, 'social groups for emotional well being', a "vibrant" Sullivan County Young Professionals group, 5K race events, the Fall Festival and Chili Cook-off, and Valley Regional Healthcare.

- Participants identified a range of barriers to promoting good health in the community such as affordability of health care, health insurance and the cost of medications; the cost of healthy foods and fitness centers; related issues of limited incomes and the effects of property taxes on family finances; eligibility barriers such as not qualifying for nurse home care, although it would be beneficial; the need for more awareness of available services; access to reliable transportation; and addressing intergenerational poverty, substance misuse and mental health.

> *"Communication between patients and therapists or court is lacking so the life style spirals." Soup Kitchen* Group Participant

- With respect to what organizations could be doing better to support or improve community health, participants identified needs for more collaboration and connection with community resources, broader partnerships with schools and businesses, increasing awareness of available services ("Advertising needs to be improved. People are unaware), offering services at more flexible times that accommodate work schedules, increasing integration of behavioral health services and supports, and more understanding of cycles of poverty ("Getting started with an apartment after being homeless is hard.") with increased customer service orientation, trauma informed care, and support for health and human service professionals who may experience 'compassion fatigue'.

> *"People need to stop judging and not feel judged. People get the bravery to apply or ask for help then they are greeted with judgement . . . need trauma informed services.* TLC Group Participant

2. High Priority Issues from Community Discussion Groups

In each of the community discussion groups convened in 2018, 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 care
- Alcohol and drug use prevention, treatment and recovery
- Affordability of health insurance and the cost of prescription drugs
- Lack of physical activity and the need for more recreational opportunities
- Health care services for seniors
- Support for families with low income; addressing poverty

Participants were then asked if they were: a) aware of any programs or activities that have focused on any of these areas; b) if they had noticed any improvements in these areas; and c) if they thought these are still the most important issues for the community to address for improving health or if there are new, different priorities. With some additions (see table on the next page), 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.

"West Central has added more programs but there aren't enough providers to handle the community. I don't have insurance to help and can't get into the West Central program. We need more support groups and job training programs." Soup Kitchen Group Participant

"*Nutrition is a huge problem. Parents will tell kids to pick out snacks and soda for dinner. It's easy and convenient. Stressful living causes lack of nutritious food*." Parent Group Participant

"Affordability and accessibility of care are still big issues. Insurance is dictating what professionals can provide." LUAS Group Participant

"There's lots to do at the CCC (Community Center), but it's expensive. We live in subsidized housing. There's cigarette butts all around and I don't want my kids to see that example; want them to know right and wrong healthy behavior. Other kids around are doing the opposite of what we're teaching them is healthy, so it makes it hard to go out. A lot of the things that are good cost a lot of money. TLC 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 2018 generally endorsed the same set of priorities as identified in 2015. Some additional themes emerged in these discussions and are noted in this table as well.

TABLE 9 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

	TLC Family Resource Center	Claremont Soup Kitchen	Ladies Union Aid Society	Parents and Teachers
High priority health issues from previous assessments*	Yes, these are still the main priorities Need to reduce stigma about asking for help Many older people who can't take care of themselves but look like they can, hidden need, handicapped elderly people Need more access to dental services for low income Access to healthy food that's affordable; cheaper to feed kids junk, starting off with bad food becomes a lifelong issue Transportation is a major issue, including the need to travel because of health insurance requirements / hoops Domestic violence issues, many people refuse to seek services, support	Yes, these are still the main priorities Medical insurance is not available to adults. No proper rehab. Suboxone clinics should be weaning these people off after a certain time Can't afford to eat properly Dental is a problem Schools help promote health such as dental and healthy foods, but bullying support is not available. Bullying is still an issue as an adult Transportation is still a huge issue Need affordable housing	Yes, these are still the main priorities Grandparents are raising children due to drug epidemic. Add child abuse and neglect Also need affordable childcare that is trust worthy Dental and transportation are also priorities	Same areas of focus as 2015, but have shifted in regards to priorities. Depression, mental health and addiction; "Worry about long term effects (of mental health and addiction) and what it does to families. "Dental health is huge"; Many people in low and middle classes are affected by dental costs and access to dental health. Homelessness and domestic violence
***Access to mental health care; Alcohol / drug use prevention, treatment and recovery; Affordability of health insurance and cost of prescription drugs; Lack of physical activity / more recreational opportunities; Health care services for seniors; Support for families with low income; addressing poverty**				

	TLC Family Resource Center	Claremont Soup Kitchen	Ladies Union Aid Society	Parents and Teachers
What people are concerned about	Copays, deductibles, healthcare bills Elderly handicapped trying to stay in home, if can't where do you go even if you have money, not many options Had doctors call DCYF on us because couldn't make it to the doctor repeatedly due to transportation problems Up against insurance companies to age in place and get extra help for home health care Insurance is too complicated with paperwork to understand it, need strong advocate	Communication breakdowns leading to loss of benefits Mental health; "Claremont has so much drama, drugs are so visible. I hate walking around Claremont it depresses me." Not a lot of places will support having animals in apartments including service animals	Affordability and accessibility of health care People may have insurance but copays may be too high to get care Kids are more worried about being safe at school Homeless kids	Affordability of food; "Half of pay check goes to food bill. " Cost of medicine limiting access to medication Cost of living (including taxes) and healthy living are in conflict; "Can't have both – have to pick one." "Not just low income, but includes middle income. Middle income is the new low income. "
Areas where there has been improvement	VRH adding substance misuse treatment facility is huge for the community Collaboration with Head Rest and West Central Behavioral Health to address substance misuse and mental health needs Teen pregnancy rate going down, but concerned about increasing STIs There is a resource directory online, but it's confusing even to service workers	"As I get older, the worse things get"	There has been improvement in keeping seniors in homes as long as they can, but there still needs to be more support for elderly who live at home, not just three hours a day or week Access to healthcare has become worse, drugs have become worse	"New London has mental health professional for Newport" "Less stigma in mental health needs."

C. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2018 Community Health Needs Assessment report provides information on key indicators and measures of community health status. Some measures associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 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.

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.

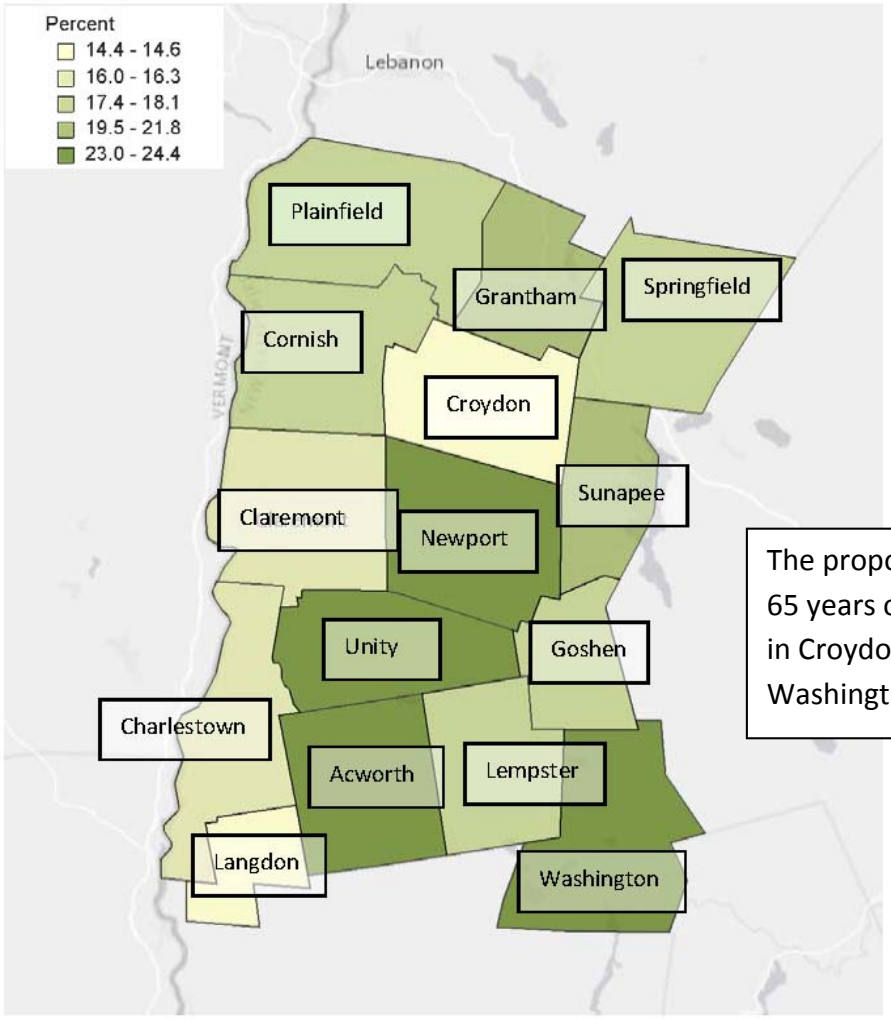
a. General Population Characteristics

According to the 2016 American Community Survey (US Census Bureau), the population of the Valley Regional Healthcare service area is older on average than in New Hampshire overall. The service area map on the next page displays the percent of the population 65 years of age and older by town. Between 2010 and 2016, the population of the VRH Service Area decreased by 1.6%.

Population Overview	Valley Regional Healthcare Service Area	New Hampshire
Total Population	**43,051**	1,327,503
Age 65 and older	**18.7%**	15.8%
Under age 18	**19.7%**	20.1%
Change in total population compared to 2010 census	**-1.6%**	+0.8%

Data Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates and 2010 US Census.

Figure 2 - Percent of Population 65 years of age and older
VRH Service Area Towns



The proportion of the population age 65 years or more ranges from 14.4% in Croydon to 24.4% in Acworth and Washington.

b. Poverty

The correlation between economic prosperity and good health status is well established. Inversely, the lack of economic prosperity, or poverty, can be associated with barriers to accessing health services, healthy food, and healthy physical environments that contribute to good health. Information describing household income and poverty status was included in the first section of this report. The table below presents the proportion of children under age 18 living below 100% and 200% of the Federal Poverty Level in the VRH Service Area compared with percentages for New Hampshire. The proportion of children in the service area who are living in poverty is similar to the proportion in NH overall. However, the proportion of children living near the poverty level is about 6% higher than across the state overall.

Area	Percent of Children in Poverty Income < 100% FPL	Percent of Children in or near Poverty Income < 200% FPL
VRH Service Area	**11.2%**	**33.0%**
New Hampshire	11.0%	26.8%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

c. Education

Educational attainment is also considered a key driver of health status with lower levels of education linked to both poverty and poor health. The table below presents data on the percentage of the population aged 25 and older without a high school diploma (or equivalent). The estimated proportion of the population of the VRH Service Area without a high school diploma or equivalent is about 2% higher than overall New Hampshire percentage.

Area	Percent of Population Aged 25+ with No High School Diploma
VRHH Service Area	**9.6%**
New Hampshire	7.4%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

d. Language

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". It is estimated that less than 1% of the VRH service area population aged 5 and older 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	**0.4%**
New Hampshire	1.5%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

e. Housing

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

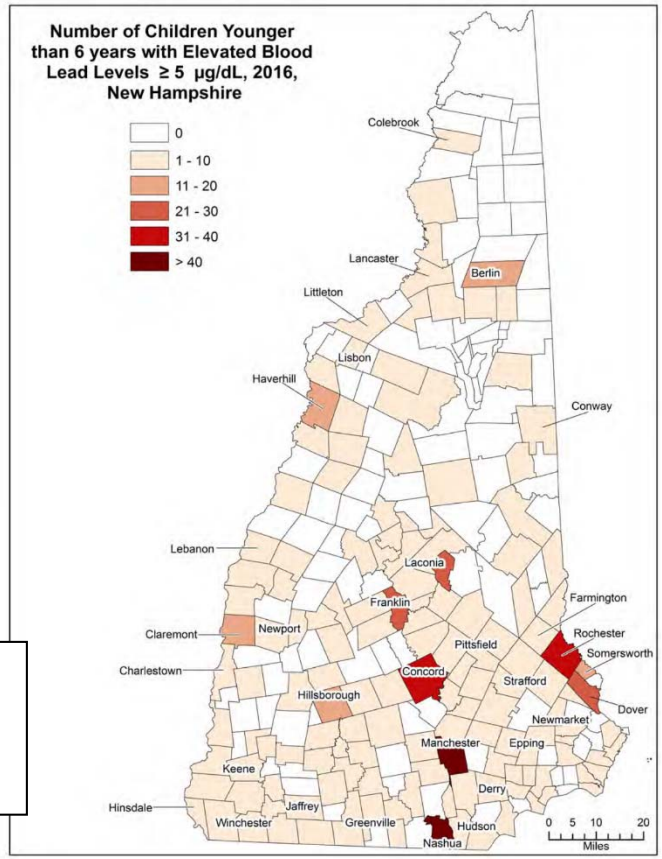
"Substandard" housing units are housing units that have at least one of the following characteristics 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) an average of more than one occupant per room, 4) selected monthly owner costs as a percentage of household income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

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

Area	Percent of Housing Units Categorized As "Substandard"	Percent of Households with Housing Costs >30% of Household Income
VRH Service Area	**32.7%**	**33.6%**
New Hampshire	32.8%	33.3%

Data Source: 2012 – 2016 American Community Survey 5-Year Estimates; Sub-standard Housing and Housing Cost Burden data accessed from Community Commons.

Children living in houses and apartments built prior to 1978 are at increased risk for lead exposure due to the presence of lead-based paint. Many NH communities are considered high risk due to having a high proportion of old housing stock. Claremont in particular has been identified as one of 21 high risk communities in NH. The city has also been a recognized leader in enacting policies for proactive screening and prevention. The map displays the number of children aged 6 years or younger who tested who tested positive in 2016 for blood lead levels at or above the Centers for Disease Control's recommended intervention level of 5 micrograms per deciliter.



Geographic Distribution of Blood Lead Levels ≥5 µg/dL Among Children Aged 6 Years or Younger in NH, 2016
Data Source: NH Healthy Homes & Lead Poisoning Prevention Program, 2016

f. Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. About 6% of households in the VRH service have no vehicle available.

Area	Percent of Households with No Vehicle Available
VRH Service Area	**6.1%**
New Hampshire	5.3%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

g. Disability Status

Disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. The US Census Bureau (American Community Survey) identifies people reporting serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation. According to the 2016 American Community Survey, 14.4% of VRH Service Area residents report having at least one disability, a rate that is slightly higher than the overall New Hampshire rate and possibly a reflection of the proportionally older population.

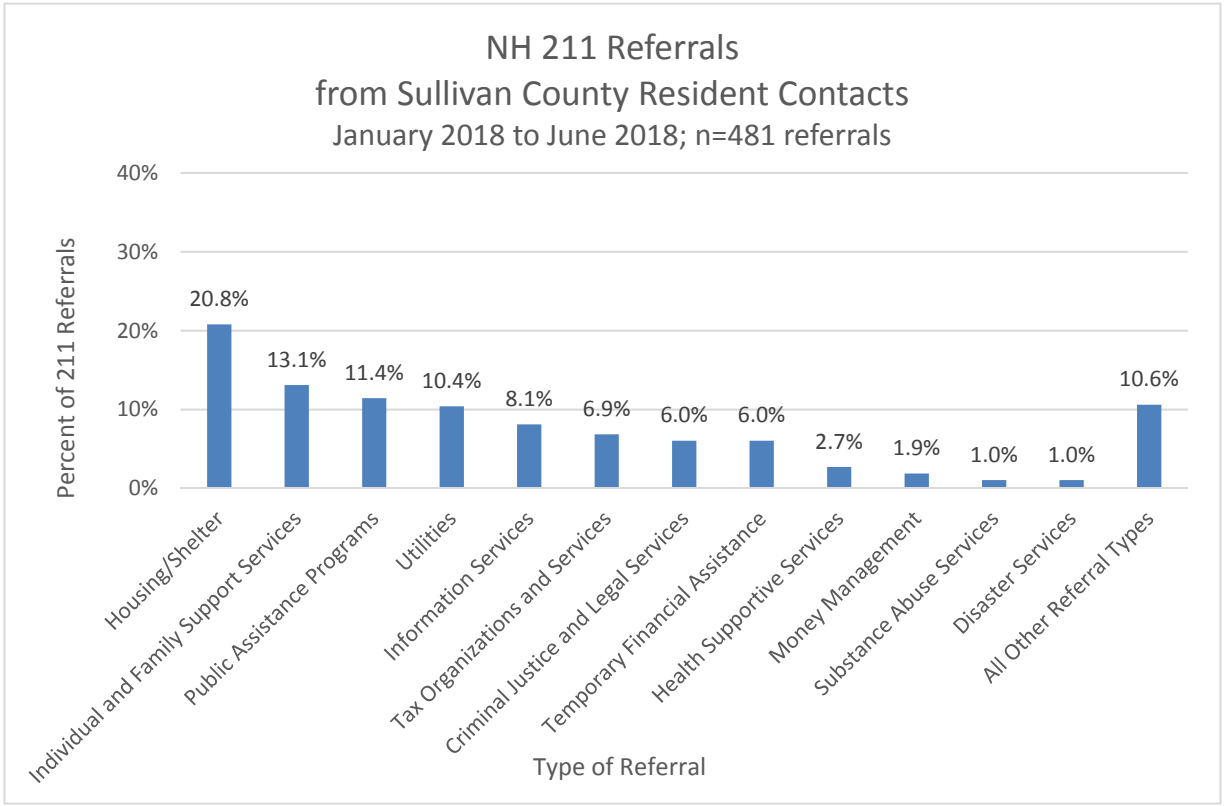
Area	Percent of Population Reporting Serious Difficulty With Hearing, Vision, Cognition and/or Ambulation
VRH Service Area	**14.4%**
New Hampshire	12.3%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates.

h. Community Referral Needs

An additional barometer of community needs is referral activity through NH 2-1-1. During the period January 2017 through June 2018, New Hampshire 2-1-1 made 481 referrals as a result of calls from Sullivan County residents. The chart below displays the distribution of these referrals by referral type. The most common type of referral was for Housing/Shelter (21% of referrals) followed by referrals to individual and family support programs (13%) and referrals to public assistance programs (11%).

Chart 21



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 covered by Medicare or Medicaid. It is important to note that the data source for these municipal level estimates is a 5 year span of the American Community Survey. A combination of five years of data is required to produce reasonably stable estimates on these and other measures from the survey samples. This particular time period spans a period of significant change in the health insurance market with the implementation of the federal Affordable Care Act and the beginning of Medicaid expansion in New Hampshire. The overall proportion of the population without health insurance is estimated to be 9.5%. In the 2015 Community Health Needs Assessment, the estimated percentage of the service area population without health insurance was 13.0%. The proportion of the population with Medicaid is higher than the state average with nearly 1 in 4 Claremont residents and nearly 1 in 5 Newport residents enrolled in Medicaid.

TABLE 10

Area	Percent of the Total Population with No Health Insurance Coverage	Percent with Medicare Coverage Alone or in Combination	Percent with Medicaid Coverage Alone or in Combination
Unity NH	15.3%	20.1%	5.5%
Croydon NH	14.8%	17.5%	12.3%
Acworth NH	14.2%	26.3%	9.5%
Goshen NH	13.1%	19.9%	13.2%
Charlestown NH	12.9%	20.3%	11.0%
Springfield NH	11.1%	18.5%	5.6%
Washington NH	10.6%	23.8%	4.4%
Lempster NH	10.4%	22.5%	10.8%
Newport NH	10.3%	24.8%	18.8%
Claremont NH	9.9%	20.3%	24.1%
VRH Service Area	**9.5%**	**21.1%**	**14.6%**
New Hampshire	8.4%	20.0%	12.9%
Langdon NH	8.2%	17.5%	13.2%
Sunapee NH	6.2%	24.3%	5.3%
Cornish NH	5.6%	17.7%	9.7%
Grantham NH	5.2%	19.8%	4.6%
Plainfield NH	3.0%	18.0%	8.9%

Data Source: U.S. Census Bureau, 2012 – 2016 American Community Survey 5-Year Estimates; Kaiser Foundation State Health Facts

b. Adults with a Personal Health Care Provider

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

Area	Percent of adults who report having a personal doctor or health care provider
VRH Service Area	**86.2%**
New Hampshire	86.8%

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

c. Preventable Hospital Stays

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

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
VRH Service Area	**40.6**
New Hampshire	44.8

Data Source: Dartmouth Atlas of Health Care, 2014; accessed through Community Commons

d. Behavioral Health

Overall health depends on both physical and mental well-being. The table below shows proportion of adults who self-report that their mental health was not good for 14 or more days in the past 30 days, a measure that is correlated with depression and other chronic mental health concerns as well as overall health-related quality of life. About 10% of adults in the service area report 14 or more days in the past 30 days when their mental health was not good, a proportion similar to the overall proportion in NH.

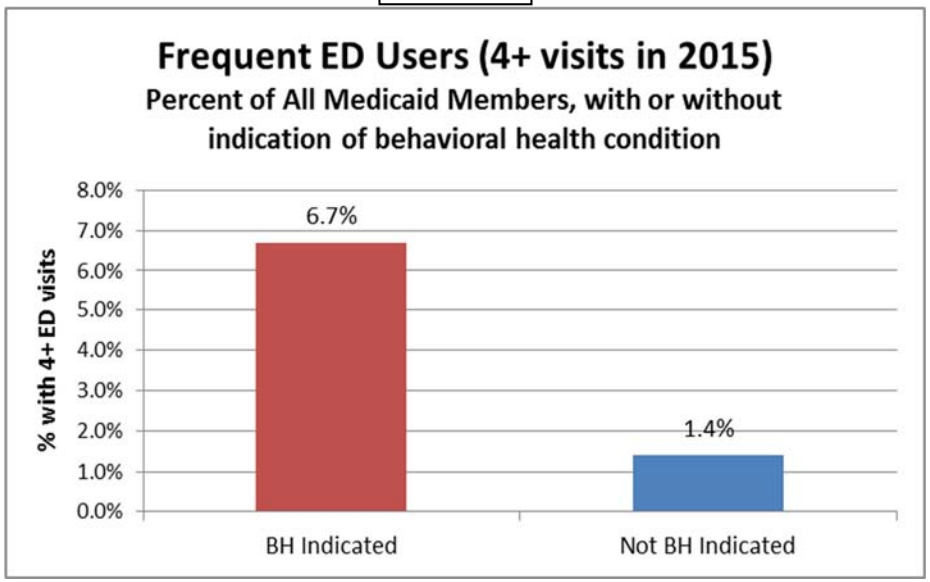
Area	Percent of adults reporting 14 or more days in the past 30 during which their mental health was not good
VRH Service Area	**10.0%**
New Hampshire	11.0%

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

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

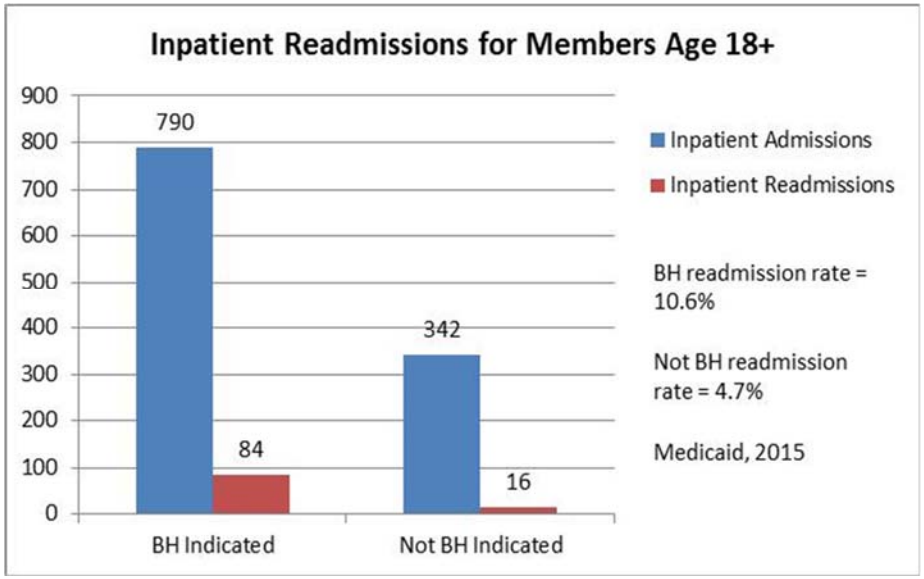
As part of regional planning work to develop an Integrated Delivery Network (IDN) for behavioral health, analyses were conducted with Medicaid claims data to compare emergency department utilization and hospital re-admissions for Medicaid members with evidence of a behavioral health condition based on claims history. Chart 22 displays the finding that Medicaid members residing in IDN Region 1, which includes the VRH service area, with a behavioral health (BH) condition were more likely to have had four or more visits to an emergency department in 2015 (6.7% of members with evidence of a behavioral health condition compared to 1.4% of members without). Similarly, the 30 day hospital inpatient readmission rate for behavioral health indicated Medicaid members (10.6%) was more than double the rate for non-behavioral health indicated members (4.7%).

Chart 22



Data Source: NH Medicaid, 2015 claims data

Chart 23



e. Dental Care Utilization (Adult)

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

Area	Percent of adults who have not visited a dentist or dental clinic in the past 5 years
VRH Service Area	**13.1%**
New Hampshire	11.4%

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

f. Poor Dental Health

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

Area	Percent of adults who report having six or more of their permanent teeth removed
VRH Service Area	**19.9%**
New Hampshire	15.5%

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

3. Health Promotion and Disease Prevention Practices

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

a. Access to Healthy Food Options

The Food Environment Index is a measure of the availability of economical, close, and nutritious food options in a community. The Index was developed by the County Health Rankings program at the University of Wisconsin Population Health Institute and is comprised of two variables: *Limited access to healthy foods* from the USDA's Food Environment Atlas estimates the percentage of the population who are low income and do not live close to a grocery store, and; *Food insecurity* from Feeding America estimates of the percentage of the population who did not have access to a reliable source of food during the past year. The Food Environment Index measures the quality of the food environment in a county on a scale from 0 to 10 where 10 is the best.

Area	Food Environment Index
Sullivan County	**8.7**
New Hampshire	9.1

Data source: 2015 USDA Food Security Survey data; index developed by County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute

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 the region can be considered physically inactive on a regular basis – a rate similar to the rest of New Hampshire.

Area	Physically inactive in the past 30 days, % of adults
VRH Service Area	25.3%
New Hampshire	20.8%

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

c. Pneumonia and Influenza Vaccinations (Adults)

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

Area	Adults who have received a flu shot in past 12 months and those who have ever received a pneumococcal vaccination	
	Influenza Vaccination 18 years of age or older	Pneumococcal Vaccination 65 year of age or older
VRH Service Area	**45.8%**	**75.8%**
New Hampshire	43.7%	77.2%

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

d. Substance Misuse

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

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

unintentional injuries. Males are more likely than females to report excessive drinking behavior, including a relatively high proportion of males in the VRH service area who report heavy alcohol use.

Area	Engaged in Binge Drinking in Past 30 days, Percent of Adults		
	Male	Female	Total
VRH Service Area	**17.1%**	**10.7%**	**13.9%**
New Hampshire	21.7%	12.3%	16.8%

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

Area	Heavy Alcohol Use, Percent of Adults		
	Male	Female	Total
VRH Service Area	13.4%	4.5%	8.9%
New Hampshire	6.4%	6.8%	6.5%

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

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 proportion of high school aged youth reporting binge drinking behavior is slightly higher than the overall state percentage, although the difference is not statistically significant.

Area	Engaged in Binge Drinking in Past 30 days, Percent of High School Youth
Greater Sullivan County Public Health Region	19.1%
New Hampshire	15.9%

Data Source: NH Youth Risk Behavior Survey, 2017
Regional proportion is not statistically different from NH overall

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 11% of high school youth in the Greater Sullivan County Public Health Region report having ever used a prescription drug that was not prescribed to them, a proportion similar to the state overall.

Area	Ever used prescription drugs 'not prescribed to you', Percent of High School Youth
Greater Sullivan County Public Health Region	10.8%
New Hampshire	11.5%

Note: The NH YRBS asked, "During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?"
Data Source: NH Youth Risk Behavior Survey, 2017
Regional proportion is not statistically different from NH overall

e. Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day. Nearly 1 in 5 adults (19.8%) in the communities of the VRH service area are estimated to be current smokers. The estimate of the percent of adults statewide who are current smokers is 17%.

Area	Percent of Adults who are Current Smokers
VRH Service Area	**19.8%**
New Hampshire	17.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015
Regional proportion is not statistically different from NH overall

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 VRH service area is significantly higher than the rate in New Hampshire overall over the period 2012 to 2016.

Area	Teen Birth Rate per 1,000 Women Age 15-19
VRH Service Area	**17.8***
New Hampshire	11.0

Data source: NH Division of Vital Records Administration birth certificate data; 2012-2016.
***Rate is statistically different and higher** than the overall NH rate*

g. Children in Out of Home Placement

One measure of child safety, abuse and neglect in a community is the number of children placed in temporary out-of-home care. The table below displays information on the number and rate of children/youth who were in out of home Child Protection Services or Juvenile Justice Services placement. The rate of such placements in Sullivan County in 2014 (most current data available) was 6.4 children per 1,000 children compared to 3.7 per 1,000 children in NH overall.

Area	Children under age 18 in Out of Home Placement	
	Number	Rate per 1,000 Children
Sullivan County	**55**	**6.4**
New Hampshire	1,001	3.7

Data source: Annie E. Casey Foundation, Kids Count Data Center, 2014 data.

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	Rate per 1,000 population
Sullivan County	**359**	**4.2**
New Hampshire	8,025	3.0

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

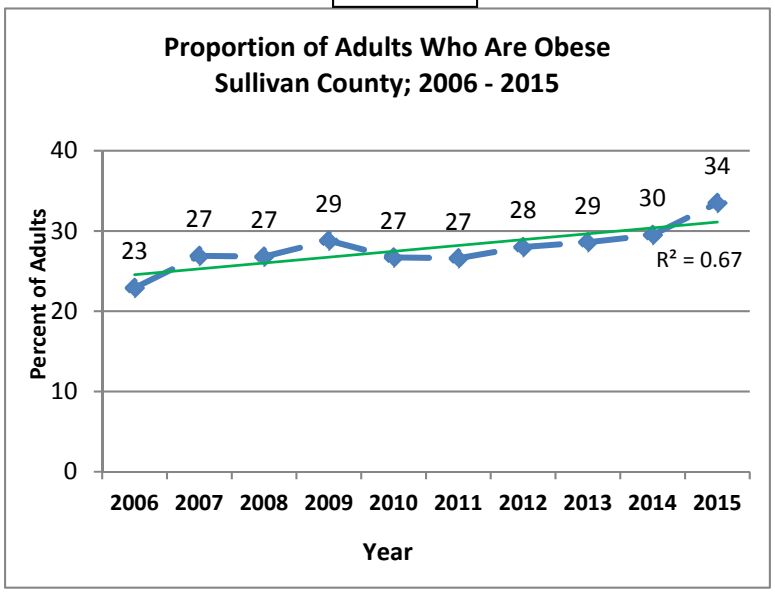
4. Selected Health Outcomes

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

a. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) or greater than 25.0 (overweight or obese). The chart displays a 10 year trend in Sullivan County toward increasing prevalence of obesity in the adult population, although a plateau in the proportion of adults who are obese appears to have been achieved in more recent years.

Chart 24



Area	Percent Obese	Percent Overweight or Obese
VRH Service Area	**31.7%**	**68.1%**
New Hampshire	27.0%	63.6%

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

Regional proportions are not statistically different from NH overall

Data Sources: CDC Division of Diabetes Translation, Diabetes Atlas, 2004 – 2003; NHDHHS, Behavioral Risk Factor Surveillance System 2014-2015

b. Heart Disease

Heart disease is the second leading cause of death in New Hampshire and 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 was the cause of 448 deaths in the VRH service area.

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

Area	Percent of Adults with Heart Disease (self-reported)
VRH Service Area	4.7%
New Hampshire	4.0%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2014-2015
Regional proportion is not statistically different from NH overall

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

Area	Percent of adults who have had their cholesterol levels checked within the past 5 years
VRH Service Area	86.5%
New Hampshire	83.0%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2015.
Regional proportion is not statistically different from NH overall

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 Sullivan County residents was statistically similar to the overall rate for New Hampshire in the 2012 to 2016 time frame. 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 VRH service area where 81 deaths were attributed to Cerebrovascular disease over the five year period from 2012 to 2016.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
VRH Service Area	**98.3**	**26.4**
New Hampshire	94.6	27.9

Data Source: NH Division of Vital Records death certificate data, 2012-2016
Regional rates are not statistically different from the overall NH rate

c. Diabetes

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

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. About 10% of adults in the VRH service area report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes, age adjusted
VRH Service Area	**10.3%**
New Hampshire	8.6%

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

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

Area	Percent of Medicare Beneficiaries with Diabetes with Annual Hemoglobin A1c Test
VRH Service Area	**90.0%**
New Hampshire	90.3%

Data Source: Dartmouth Atlas of Health Care, 2014; accessed through Community Commons
Regional proportion is not statistically different from NH overall

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

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
VRH Service Area	**19.4**
New Hampshire	18.2

Data Source: NH Division of Vital Records death certificate data, 2012-2016
Regional rate is not statistically 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.

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

Cancer Screening Type	VRH Service Area	New Hampshire
Percent of adults who are aged 50+ that met USPSTF colorectal cancer screening recommendations*	78.4%	74.9%
Percent of females aged 50+ who have had a mammogram in the past two years**	77.5%	80.8%
Percent of females aged 18-64 who have had a pap test in the past 3 years**	84.6%	80.0%

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

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

Regional proportions are not statistically different from NH overall

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 Prostate cancer was significantly lower in the VRH service area compared to the state overall between 2011 and 2015, while incidence of other most common cancers was similar.

Cancer Incidence per 100,000 people, age adjusted		
	VRH Service Area	New Hampshire
Overall cancer incidence (All Invasive Cancers)	479.5	497.4
Cancer Incidence by Type		
Breast (female)	136.6	145.3
Prostate (male)	**71.9***	120.9
Lung and bronchus	70.4	67.3
Colorectal	40.1	38.8
Non-Hodgkin Lymphoma	27.1	21.1
Melanoma of Skin	26.4	29.7
Bladder	23.2	28.3

Data Source: NH State Cancer Registry, 2011 - 2015

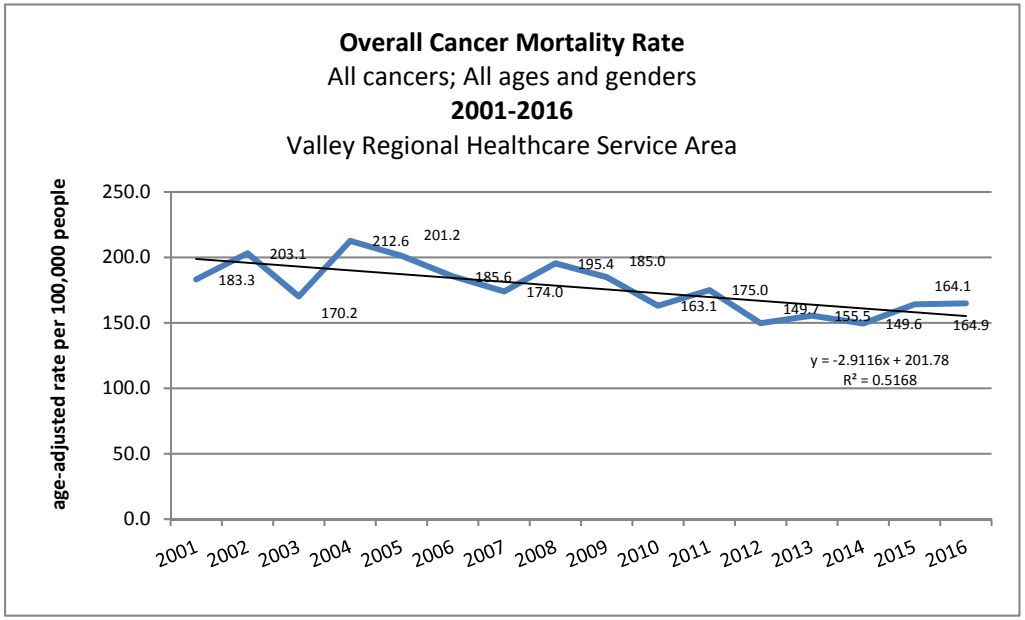
***Rate is statistically different and lower** than the overall NH rate; Other rates not statistically different*

Cancer Mortality: The table below shows the overall cancer mortality rate and the mortality rates 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 -1.4% per year since the year 2001.

Cancer Mortality per 100,000 people, age adjusted		
	VRH Service Area	New Hampshire
Overall cancer mortality (All Invasive Cancers)	156.4	162.3
Cancer Mortality by Type		
Lung and bronchus	45.4	44.4
Pancreas	10.0	10.7
Prostate (male)	17.5	20.1
Breast (female)	15.2	19.4
Colorectal	8.5	12.8

Data Source: NH State Cancer Registry, 2012 - 2016

Regional rates are not significantly different overall NH rates



Data Source: NH State Cancer Registry, 2001 - 2016

e. Asthma

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

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

Area	Percent of Children (ages 0 to 17) with Current Asthma*	Percent of Adults (18+) with Current Asthma**
VRH Service Area	**12.9%**	**10.9%**
New Hampshire	7.2%	10.1%

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

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

Regional proportions are not statistically different from the overall NH proportions

f. Intentional and Unintentional Injury:

Accidents and injury are the third leading cause of death in the region and in the state. Deaths due to falls in older adults have been increasing in New Hampshire as the population ages.

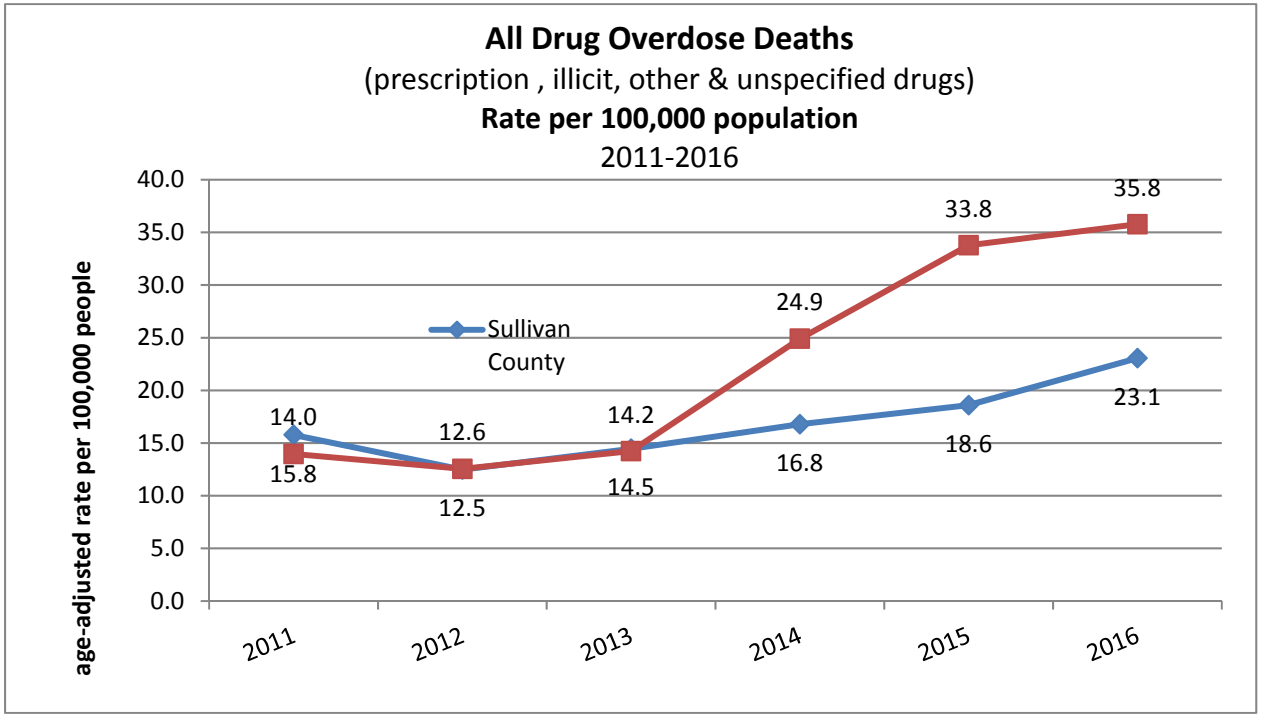
Area	Fall related deaths (age 65 and over) Age-adjusted rate per 100,000
VRH Service Area	**78.5**
New Hampshire	97.1

Data Source: NH Division of Vital Records death certificate data, 2012-2016
Rate is not significantly different than overall NH rate

Drug Overdose Mortality: Of particular note in recent years, New Hampshire has been among the hardest hit states by the epidemic of opioid misuse, ranking third behind West Virginia and Ohio in the number of opioid-related deaths per capita and highest for deaths per capita from synthetic opioids like fentanyl. During the period 2014 to 2016, the overall overdose mortality rate in the Valley Regional Healthcare service area was significantly lower than in the state overall. However, as shown by the chart on the next page, the rate of overdose mortality has been increasing in the service area, although at a rate of increase less than experienced across NH overall.

Area	All drug overdose deaths (prescription , illicit, other & unspecified drugs) Age-adjusted rate per 100,000 population
VRH Service Area	**19.4***
New Hampshire	31.4

Data Source: NH Division of Vital Records death certificate data, 2014-2016
***Rate is statistically different and lower** than the overall NH rate



Suicide: This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care. During the period 2012 to 2016, the suicide rate in the region was similar to the overall NH rate of suicide deaths.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
VRH Service Area	**19.3**
New Hampshire	15.3

Data Source: NH Division of Vital Records death certificate data, 2012-2016
Regional rate is not significantly different than the overall NH rate statistically.

g. Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. During the period 2014 to 2016, 568 deaths in Sullivan County occurred before the age of 75.

Area	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Sullivan County, NH	6,557
New Hampshire	5,921

Data source: National Center for Health Statistics, National Vital Statistics System accessed via County Health Rankings, 2014-2016.

5. Comparison of Selected Community Health Indicators between 2015 and 2018

The table below displays comparisons of estimated rates for key community health status indicators between the current community health assessment (2018) and the previous assessment conducted in 2015, as well as the most recent statewide statistic for each indicator. This comparison is provided for reference purposes. It is important to note the differences between the 2015 and 2018 estimates for the region and the state comparison estimate are not significantly different for most indicators. Statistics that suggest improvement from the prior assessment (although not statistically significant) are highlighted in green font and those that suggest declines from the previous assessment are highlighted in red.

Table 11: Comparison of Selected Community Health Indicators between 2015 and 2018 with NH State Comparison

Community Health Indicator	Geographic Area	2015 Community Health Assessment	2018 Community Health Assessment	NH State Comparison (most recent statistics available)
Access to care				
Percentage of adult population (age 18+) without health insurance coverage	VRH Service Area	13.0%	**9.5%**	8.4%
Do not having a personal doctor or health care provider, percent of adults	VRH Service Area	14.4%	**13.8%**	13.2%
Have not visited a dentist or dental clinic in the past 5 years, percent of adults	VRH Service Area	14.0%	**13.1%**	11.4%
Health Promotion and Disease Prevention				
Current smoking, percent of adults	VRH Service Area	21.1%	**19.8%**	17.0%
Physically inactive in the past 30 days, % of adults	VRH Service Area	21.6%	**25.3%**	20.8%
Binge drinking, percent of adults	VRH Service Area	15.1%	**13.9%**	16.8%
Teen Birth Rate, per 1,000 Women Age 15-19	VRH Service Area	27.0	**17.8*** *Statistically significant decrease	11.0

Community Health Indicator	Geographic Area	2015 Community Health Assessment	2018 Community Health Assessment	NH State Comparison
Health Outcomes				
Obese, percent of adults	VRH Service Area	28.0%	**31.7%**	27.0%
Ever told had diabetes, percent of adults	VRH Service Area	8.0%	**10.3%**	8.6%
Current asthma, percent of adults	VRH Service Area	9.0%	**10.9%**	10.1
Coronary Heart Disease Mortality, per 100,000 people, age-adjusted	VRH Service Area	109.9	**98.3**	94.6
Cancer Incidence, All sites, per 100,000 people, age-adjusted	VRH Service Area	508.7	**479.5**	497.4
Cancer Deaths, All Sites, per 100,000 people, age-adjusted	VRH Service Area	164.8	**156.4**	162.3