Lake Sunapee Region VNA & Hospice

Community Health Needs Assessment 2022









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

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Partner organizations for the 2022 Community Health Needs Assessment include New London Hospital, Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, Valley Regional Healthcare, Mt. Ascutney Hospital and Health Center, Visiting Nurse and Hospice for VT and NH, and Lake Sunapee Region VNA & Hospice with technical support from the NH Community Health Institute/JSI.

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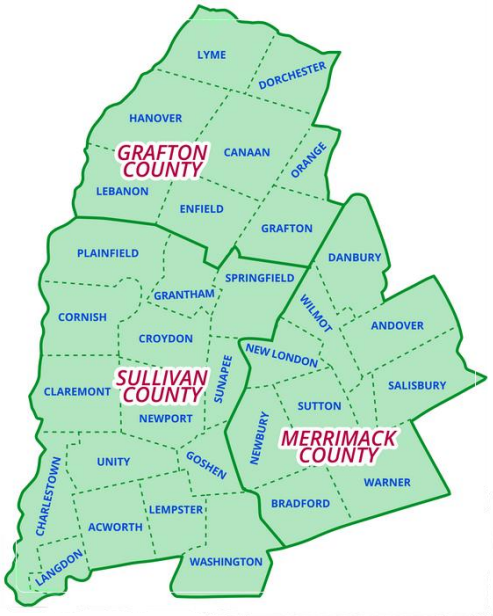
Lake Sunapee Region VNA & Hospice
2022 Community Health Needs Assessment

Executive Summary

During the period January through September 2021 an assessment of Community Health Needs in the Lake Sunapee Region VNA & Hospice service area was undertaken in partnership with New London Hospital, Dartmouth-Hitchcock, Alice Peck Day Memorial Hospital, Valley Regional Healthcare, 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:

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

For the purpose of the assessment, the geographic area of interest was 32 municipalities comprising the Lake Sunapee Region VNA & Hospice service area with a total resident population of 100,000 people. Methods employed in the assessment included: surveys of community residents made available through direct mailing, distribution at COVID-19 vaccination clinics, social media, email distribution and website links through multiple channels throughout the region; a direct email survey of community leaders representing multiple community sectors; a set of ten community discussion groups convened virtually across the region; and a review of available population demographics and health status indicators.



All information collection activities and analyses sought to focus assessment activities on vulnerable and disproportionately served populations in the region including populations that could experience limited access to health-related services or resources due to income, age, disability, and social or physical isolation. The community health needs assessment also acknowledged the significant impact of the COVID-19 pandemic, which was an over-arching concern affecting both the community health needs assessment process and the content of community input. Nearly half of survey respondents indicated that they were *currently* experiencing increased stress or anxiety as a result of the COVID-19 pandemic.

(Most responses to the community resident survey were received between March and July 2021). About 1 in every 4 respondents were currently experiencing loneliness or loss of connection to faith or social groups. The table below and on the next page provides a summary of the priority community health needs and issues identified through this assessment.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of mental health services	Ability to get mental health care was the highest priority identified by community respondents, including respondents ages 65 to 74, and was also the top priority identified by community leader survey respondents.	The ratio of population to mental health providers in Sullivan County (560 to 1) is nearly double the NH statewide ratio (310 to 1). The rate of Self Harm-related Emergency Department visits among area residents (218 per 100K population in Greater Sullivan County) was similar to the rate in NH overall (196 per 100K population) in 2018.	Identified as a high and continuing priority for community health improvement by all community discussion groups including concerns for insufficient local capacity, particularly for higher levels of care, and increased need resulting from anxiety, stress and isolation impacts of COVID-19.
Cost of health care services, affordability of health insurance	Health care cost issues including cost of health insurance and prescription drug costs were the next highest priorities identified by survey respondents. Cost of prescription drugs was the top issue overall selected by respondents age 75 and older.	The estimated proportion of people with no health insurance in the service area (5.9%) is similar to the overall percentage in NH (6.0%). About 9% of Greater Sullivan County area residents reported delaying or avoiding health care because of cost.	Community discussion participants identified health care costs and financial barriers to care as significant and ongoing concerns. It was also the second most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health'
Alcohol and drug use prevention, treatment and recovery	Prevention of substance misuse, addiction and access to substance misuse treatment and recovery services were top issues identified by both community respondents and community leaders as priorities for community health improvement.	In 2018, the rate of Drug and Alcohol Related Emergency Department Visits per 100,000 population in the region was significantly lower than in NH overall. The rate of overdose mortality is also lower than in NH overall.	Participants identified improvements in resources for substance misuse prevention, treatment and recovery, but also noted that the need is still high, there are still issues with stigma in certain settings and gaps in services for detox and recovery housing. Concerns were identified for substantial disruption of recovery support by the COVID-19 pandemic.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Disparities in socio-economic conditions affecting health and well-being such as housing affordability and access to transportation, healthy foods and affordable, dependable child care	Affordable housing, livable wages, public transportation and affordable, high quality child care were identified as top resources supporting a healthy community that are in need of improvement.	Nearly a third of households (31%) in the LSRVNA service area have housing costs >30% of household income. The service area is also characterized by a substantial range in community wealth where median household income in lower wealth communities is about half the median household income in higher wealth communities.	Affordability and availability of housing and transportation was a common denominator across discussion groups addressing concerns of aging, mental health and substance use recovery, jobs and economy. Disparities in access to these and other resources such as child care were described as significant problems pre-pandemic made much worse by the pandemic.
Availability of primary care and specialty medical services	About 14% of community survey respondents reported difficulty accessing Primary Health Care and about 8% reported difficulty accessing Specialty Care. Common reasons cited were 'Wait time too long', 'Not accepting new patients' and 'Service not available'.	Primary care physician FTEs per 100k population (19) in the Greater Sullivan County region are less than half the FTE capacity in NH overall (42 per 100K population). About 15% of adults in the service area report not having a personal doctor or health care provider.	Issues related to health care provider availability including turnover, choice, wait time and responsiveness was the topic area with the most comments in an open-ended question about 'one thing you would change to improve health'
Services and supports for older adults including transportation, opportunities for social interaction and in-home supports for aging in place	About 6% of community survey respondents indicated difficulty accessing In-Home Support Services. Common reasons indicated for access difficulties were "Cost too much", "Service not available", and "Did not know where to go".	The service area population has proportionally more seniors (about 22% are 65+) compared to NH overall (18%). About 27% of the 65+ population in the Lake Sunapee Region VNA service area report having serious activity limitations resulting from one or more disability.	Discussion groups confirmed that resources for transportation, social interaction, home health care and other in-home services supporting aging in place should be a top priority for community health improvement. Concerns were expressed that there is a general workforce shortage in the area for senior services and that there is a significant disparity in ability to afford available services and accommodations.

Lake Sunapee Region VNA & Hospice

2022 Community Health Needs Assessment

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A. COMMUNITY OVERVIEW WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total population of the Lake Sunapee Region VNA & Hospice primary service area in 2020 was 100,481 according to the United States Census Bureau (American Community Survey). Since the last Community Health Needs Assessment in 2017, the Lake Sunapee VNA & Hospice service area expanded to three additional towns - Lyme, Orange and Dorchester – with a combined resident population of 2,500 people. The population of the existing 29 towns in the service area has also increased by approximately 1.6% or about 1,500 people over the last 5 years since the last Community Health Needs Assessment.

Table 1 on the next page displays the service area population distribution by municipality, as well as the percentage of residents who are 65 years of age and older and the percentage who are 75 and older.

Compared to New Hampshire overall, the service area population has proportionally more seniors (about 22% are 65+ compared to about 18% in NH overall). As displayed by the map (Figure 1), a substantial range is observed for this statistic across the region.

The percent of residents age 65 years or more ranges from about 15% in Newport to 36% in Dorchester.

Communities with the largest number of residents age 75 years or more are Lebanon (1,508), Hanover (1,071) and New London (879).

Figure 1 - Percent of Population 65 years of age and older, Lake Sunapee Region VNA&H Service Area Towns

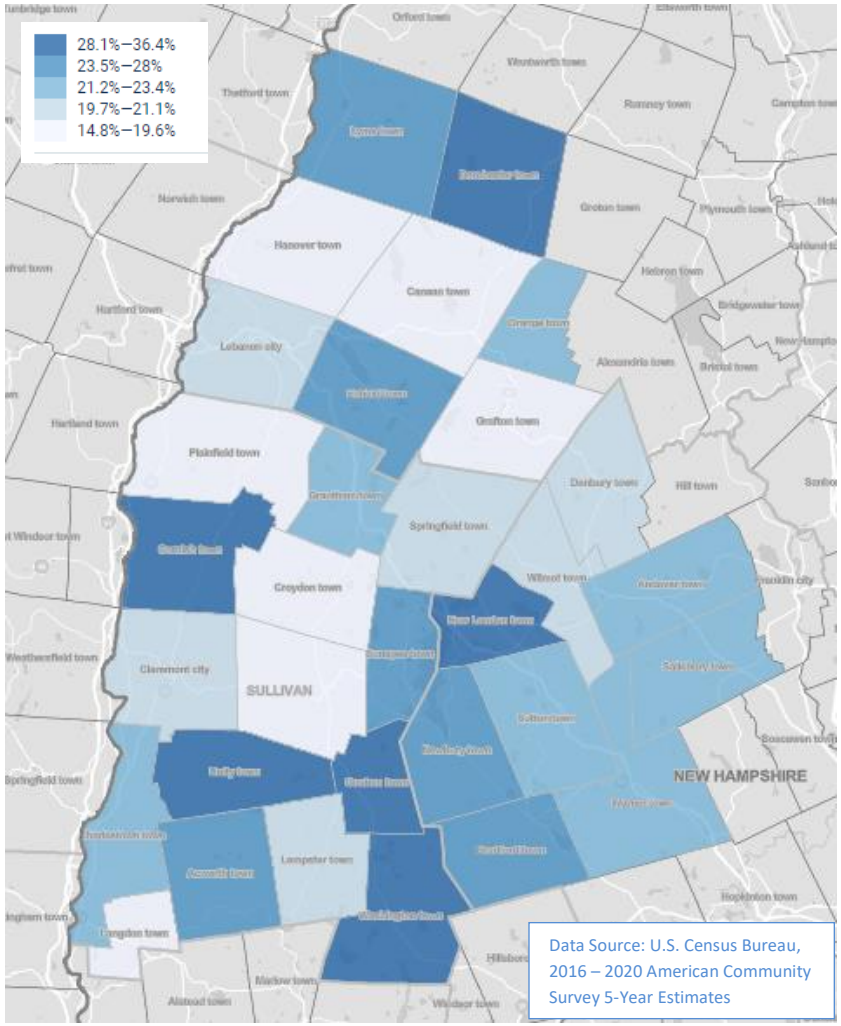


TABLE 1: Service Area Population by Municipality

		2020 Population	% of Total Service Area Population	% of Residents 65+ years of age	% of Residents 75+ years of age
Canaan	Grafton County	3,929	4%	16%	3%
Dorchester		472	<1%	36%	8%
Enfield		4,566	5%	28%	8%
Grafton		1,293	1%	20%	8%
Hanover		11,525	11%	16%	9%
Lebanon		13,718	14%	21%	11%
Lyme		1,713	2%	26%	7%
Orange		299	<1%	22%	12%
Andover	Merrimack County	2,720	3%	21%	13%
Bradford		1,419	1%	24%	6%
Danbury		1,360	1%	20%	8%
Newbury		1,795	2%	27%	11%
New London		4,326	4%	32%	20%
Salisbury		1,568	2%	23%	6%
Sutton		2,151	2%	23%	11%
Warner		2,925	3%	22%	9%
Wilmot		1,529	2%	21%	10%
Acworth	Sullivan County	1,009	1%	25%	7%
Charlestown		5,034	5%	21%	10%
Claremont		12,969	13%	20%	8%
Cornish		1,649	2%	32%	12%
Croydon		723	1%	17%	7%
Goshen		964	1%	29%	18%
Grantham		2,948	3%	23%	11%
Langdon		629	1%	16%	5%
Lempster		803	1%	20%	5%
Newport		6,376	6%	15%	5%
Plainfield		2,765	3%	19%	5%
Springfield		1,191	1%	20%	8%
Sunapee		3,476	3%	28%	11%
Unity		1,580	2%	32%	15%
Washington		1,057	1%	28%	7%
Lake Sunapee Region VNA&H Service Area		**100,481**		**21.5%**	**9.4%**
State of New Hampshire		**1,355,244**		**18.1%**	**7.2%**

Table 2 on the next page displays additional demographic information for the towns and cities of the Lake Sunapee Region VNA & Hospice service area. Towns and cities are ordered on the table by median household income, lowest to highest. The median household income across the region ($76,823) is similar to New Hampshire overall ($77,923). However, as displayed by the map on the right (Figure 2), there is a substantial range within the region on this measure with the highest median household income community (Lyme) having nearly three times the median household income in the lowest income community (Claremont). The percent of people living below the federal poverty level also varies across the region from 0% in Grantham to about 16% in Claremont and Andover. About one in four service area residents who are age 65 years or more live alone, a proportion similar to New Hampshire overall.

Median household income ranges from $46,848 in Claremont to $128,000 in Lyme.

About one in four service area residents who are age 65 years or more live alone ranging from 4% in Dorchester to 37% in Salisbury.

Figure 2 - Median Household Income by Town, Lake Sunapee Region VNA&H Service Area Towns

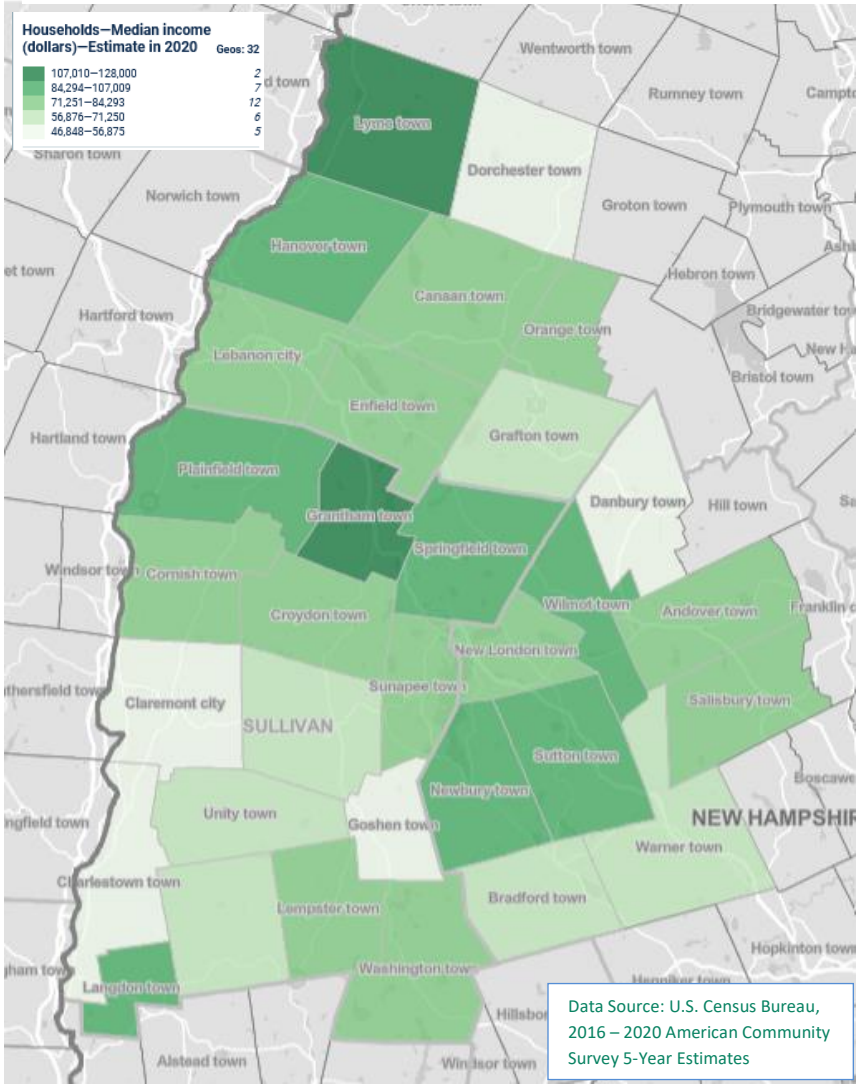


TABLE 2: Selected Demographic and Economic Indicators

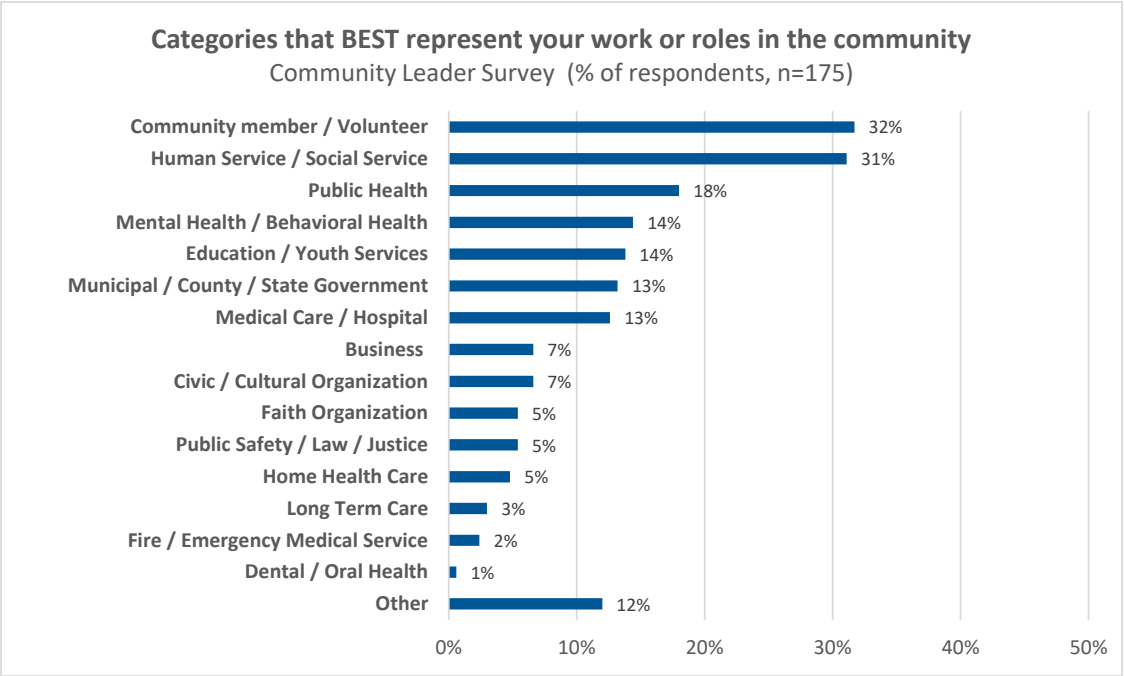
	Median Household Income	Residents with income under 100% of the poverty level (%)	Residents with a disability (%)	Residents age 65+ who live alone (%)
Claremont	$46,848	16%	18%	28%
Dorchester	$52,188	15%	23%	4%
Charlestown	$52,311	13%	13%	29%
Goshen	$54,688	9%	23%	19%
Danbury	$56,875	9%	13%	10%
Warner	$65,500	7%	16%	30%
Grafton	$66,176	7%	19%	21%
Newport	$66,441	13%	11%	29%
Acworth	$69,583	4%	9%	10%
Unity	$69,712	9%	12%	9%
Bradford	$71,250	1%	10%	36%
Sunapee	$72,539	15%	14%	9%
Lempster	$73,125	8%	10%	20%
Lebanon	$73,704	10%	13%	30%
Washington	$73,929	4%	10%	12%
Canaan	$74,940	8%	12%	23%
Cornish	$75,691	6%	8%	33%
Orange	$76,136	6%	14%	19%
Enfield	$76,688	14%	12%	15%
Lake Sunapee Region VNA&H Service Area	**$76,823**	**9.8%**	**12.2%**	**24.4%**
Andover	$77,059	16%	12%	16%
New London	$77,669	4%	10%	35%
New Hampshire	**$77,923**	**7.4%**	**12.8%**	**25.4%**
Croydon	$78,393	11%	11%	22%
Salisbury	$84,293	8%	14%	37%
Langdon	$91,875	12%	13%	17%
Plainfield	$92,344	4%	8%	14%
Wilmot	$93,864	3%	10%	17%
Springfield	$95,724	4%	7%	9%
Newbury	$98,616	1%	11%	20%
Hanover	$105,446	11%	8%	36%
Sutton	$107,009	1%	8%	14%
Grantham	$126,302	0%	9%	18%
Lyme	$128,000	2%	9%	17%

B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

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

The community leader survey was distributed via unique email link to 352 individuals with positions of leadership in agencies, municipalities, business, civic and volunteer organizations serving the combined service areas of the partner organizations ranging from the Greater New London / Newport area to the Upper Valley communities of New Hampshire and Vermont. The survey distribution list was developed by the assessment planning committee. Understanding that some organizational leaders may be more familiar with some areas of the wider region than others, the survey instrument asked respondents to identify '*the areas you primarily serve or are most familiar with*'. Of the 352 partners invited to participate in the Community Leader Survey, 207 completed surveys (59% response). Of the 207 respondents to the Community Leader survey, 32 indicated being familiar only with communities in Vermont included in the broader assessment region. The results reported here include responses from the remaining 175 community leaders who indicated familiarity with some or all of the New Hampshire sub-regions (the Greater New London / Newport area, Greater Claremont area or Greater Lebanon / Hartford area). Figure 3 displays the range of community sectors represented by these individuals. (Note: Respondents could identify as representatives of more than one sector).

| Figure 3 |



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

A total of 2,335 people who completed the Community Resident Survey indicated their residence as one of the 32 towns included in the Lake Sunapee Region VNA & Hospice service area. Table 3 below displays the grouping of respondents by community. At least one response was received from all 32 towns with the highest number of respondents from New London, Claremont, Lebanon, Grantham and Newport. Communities with the fewest numbers of responses were Dorchester (5 responses), Langdon (3), Salisbury (2) and Acworth (1).

Compared to the regional demographics overall, community survey respondents were proportionally older and more likely to be female. Approximately 22% of respondents have household income of less than $50,000, 32% have income of $50,000 up to $100,000, and 32% reported household income of $100,000 or more. About 15% of respondents did not provide household income information. Table 4 below displays selected characteristics of respondents to the community survey.

| Table 4 |

Age < 65 years	Female	Black, Indigenous and People of Color	Current military service or veteran
64%	68%	6%	9%
Household Income < $50K	**Currently Uninsured**	**Currently has Medicaid coverage**	**Hard to do some Daily Tasks without help**
22%	3%	7%	7%

| Table 3 |

Town	# of respondents	% of total*
New London	424	18%
Claremont	345	15%
Lebanon	236	10%
Grantham	162	7%
Newport / Croydon	160	7%
Hanover	107	5%
Sunapee	103	4%
Newbury	99	4%
Enfield	93	4%
Charlestown	76	3%
Canaan	72	3%
Wilmot	62	3%
Andover	52	2%
Sutton	49	2%
Springfield	47	2%
Bradford	42	2%
15 Other Service Area Towns	206	9%

*This analysis includes 2,335 total responses from individuals who reported their residence (zip code) as being within the LSRVNA&H service area.

1. Priority Community Health Issues

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

As displayed by Figure 4, '*Able to get mental health services*' was the top issue; selected by half of all respondents (50%). Related issues of cost of health care services (44%) cost of health insurance (43%), and cost of prescription drug costs (33%) were the next 3 of the top 5 issues identified by respondents to the community resident survey. Other top concerns identified by community survey respondents were prevention and treatment of alcohol and other drug misuse and ability to buy and eat healthy foods.

| Figure 4 |

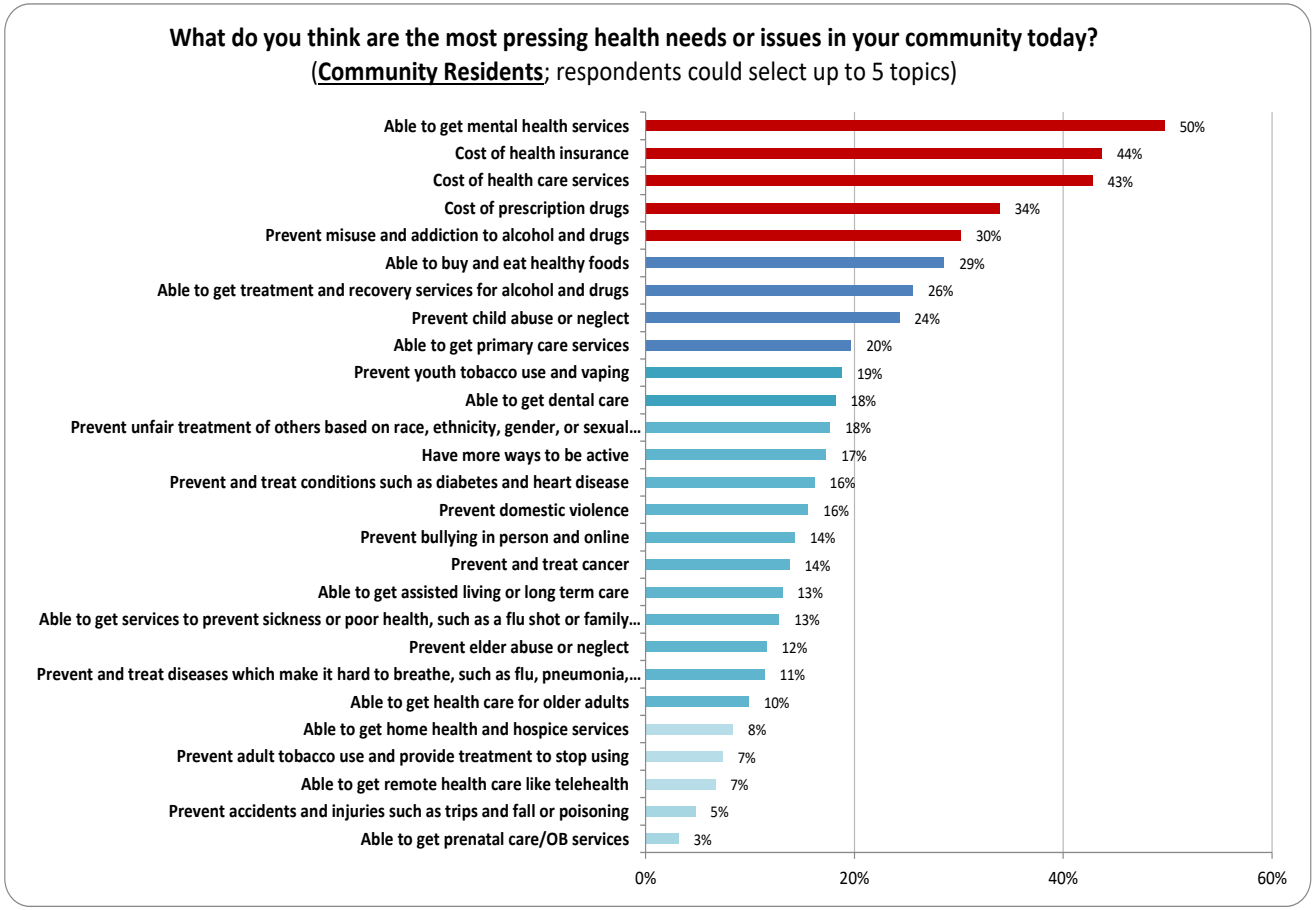


Table 5 displays the top priorities by age group. The most frequently selected needs or issues were similar across age groups with the exception of "able to buy and eat healthy foods", which was in the top five among respondents under the age of 45. Cost of prescription drugs was the most frequently cited issue for respondent 75 years of age or older. Respondents 75 and older were somewhat more likely than other respondents to select issues related to care for older adults including:

- *Able to get assisted living or long term care* (17% of respondents ages 75+ selected this issue compared to 12% of respondents of all other ages)
- *Able to get health care for older adults* (17% of age 75+; 9% of all other ages)
- *Able to get home health and hospice services* (12% of age 75+; 8% of all other ages)

| Table 5: Top Priorities by Age Group |

Age 18-44 (n=615)		Age 45-64 (n=865)		Age 65-74 (n=493)		Age 75+ (n=344)	
Able to get mental health services	65%	**Able to get mental health services**	53%	**Able to get mental health services**	43%	**Cost of prescription drugs**	37%
Cost of health care services	46%	**Cost of health insurance**	51%	**Cost of health care services**	41%	**Cost of health insurance**	34%
Cost of health insurance	43%	**Cost of health care services**	46%	**Cost of health insurance**	38%	**Cost of health care services**	33%
Able to buy and eat healthy foods	35%	**Cost of prescription drugs**	35%	**Cost of prescription drugs**	37%	**Prevent misuse and addiction to alcohol and drugs**	28%
Prevent misuse and addiction to alcohol and drugs	32%	**Prevent misuse and addiction to alcohol and drugs**	32%	**Prevent misuse and addiction to alcohol and drugs**	27%	**Able to get mental health services**	27%

The chart below displays the results from the Community Leader survey on the same question with the same response options. Community Leaders identified the same set of top priority community health needs and issues (mental health and substance misuse, health care costs, and healthy food availability). Community leaders were even more likely to prioritize 'ability to get mental health services' with more than two-thirds of respondents selecting this issue as one of the most pressing health needs.

| Figure 5 |

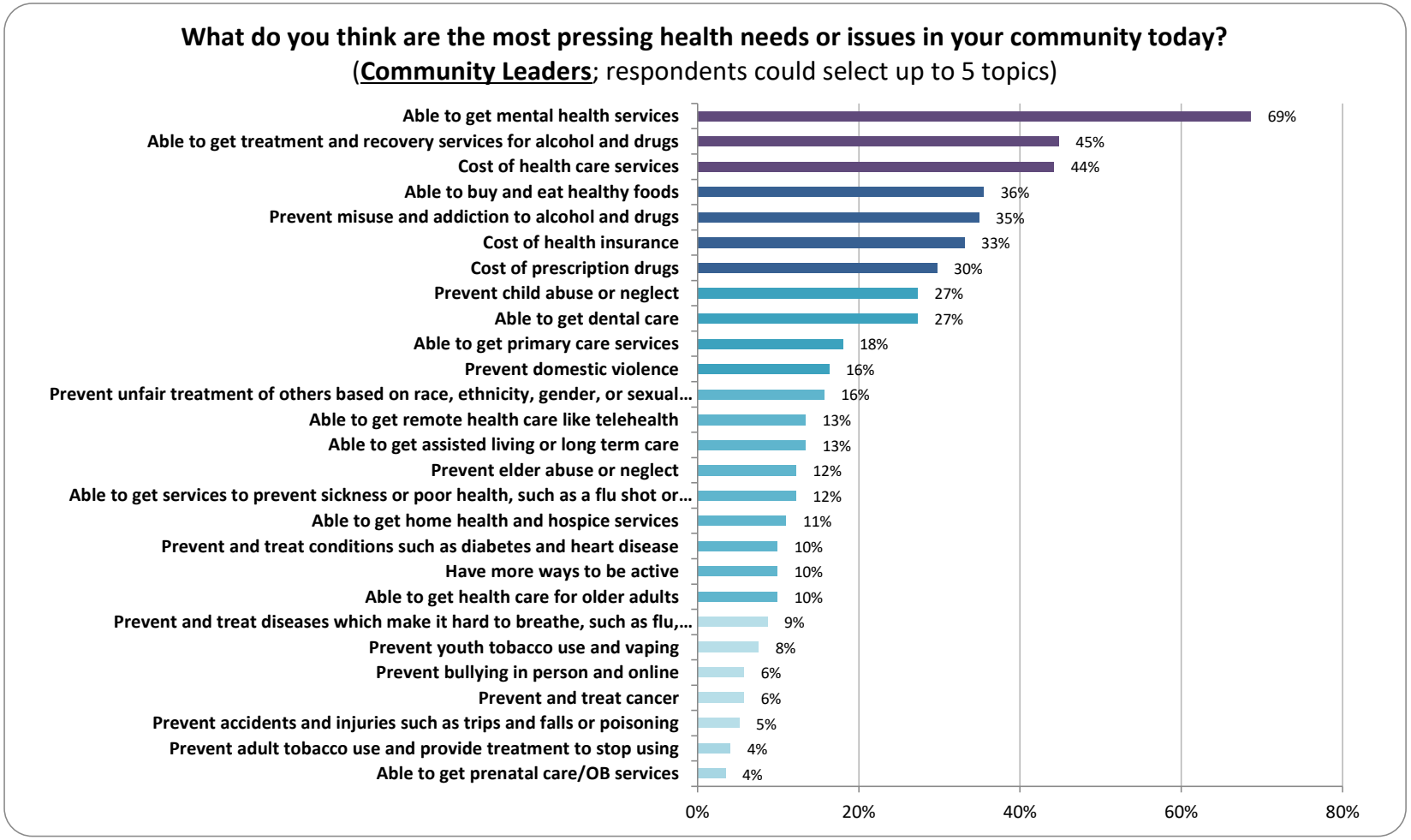
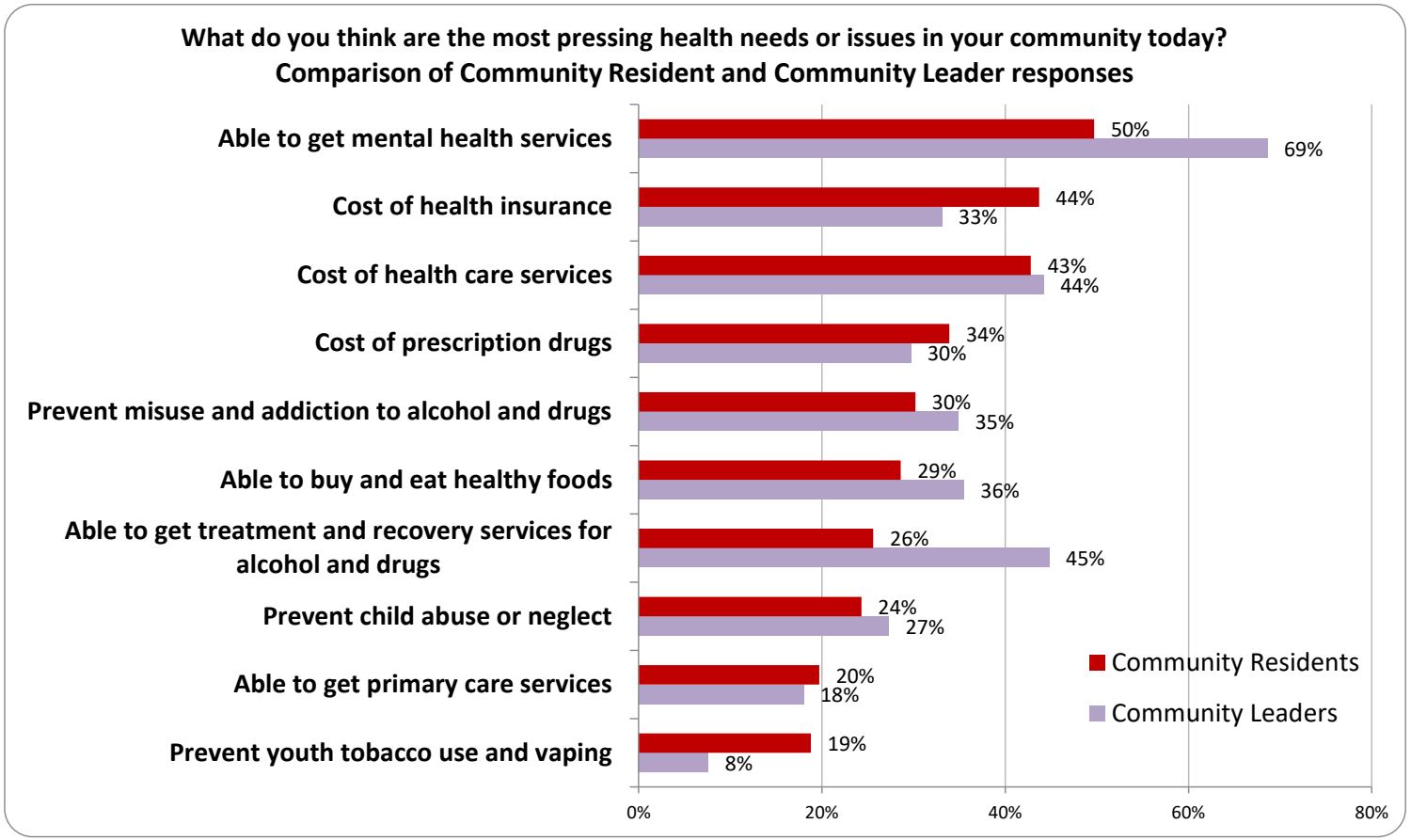


Figure 6 displays a comparison of the top 10 most pressing health issues selected by Community Resident survey respondents compared to the responses from Community Leaders on the same topics. Nine of the top 10 issues identified were the same between the two groups of respondents. Community residents were notably more likely to prioritize 'preventing youth tobacco use and vaping' than Community Leader survey respondents. The issue in the top 10 for Community Leaders, but not Community Resident survey respondents was 'Able to get dental care'; 27% of Community Leaders selected this issue as a top priority compared to 18% of Community Residents.

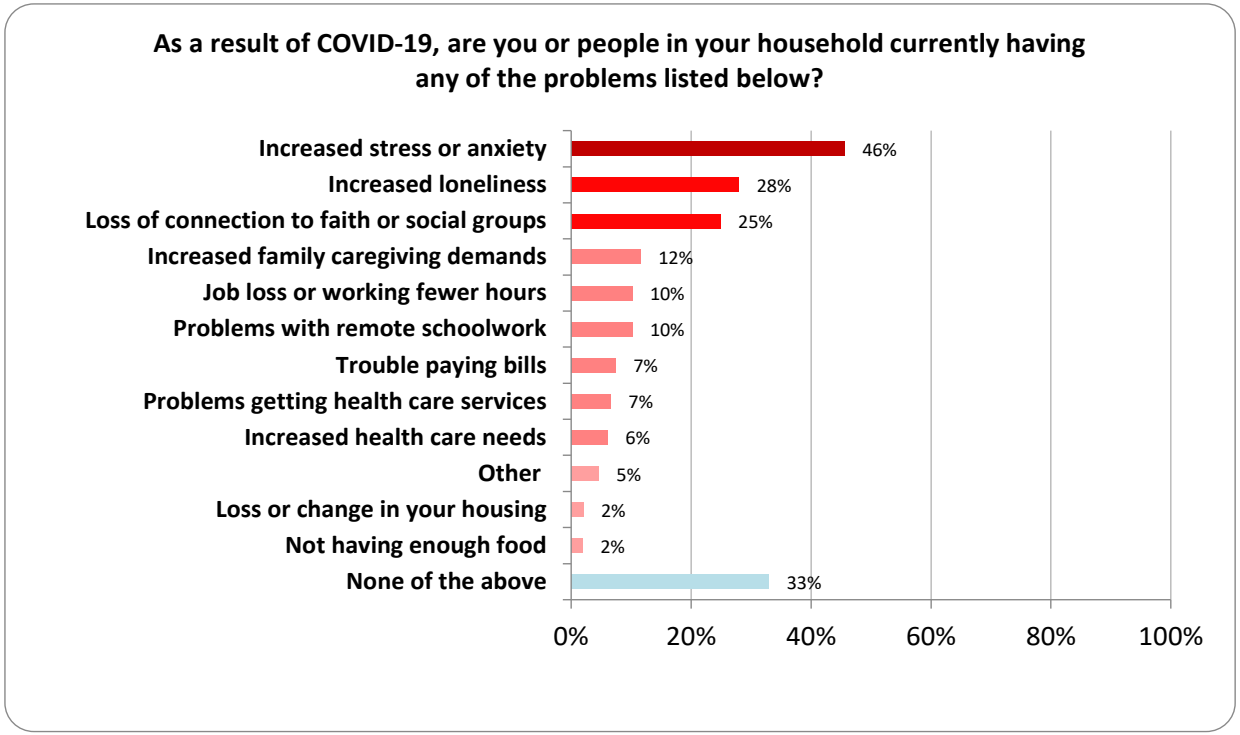
| Figure 6 |



2. COVID-19 Pandemic Impact

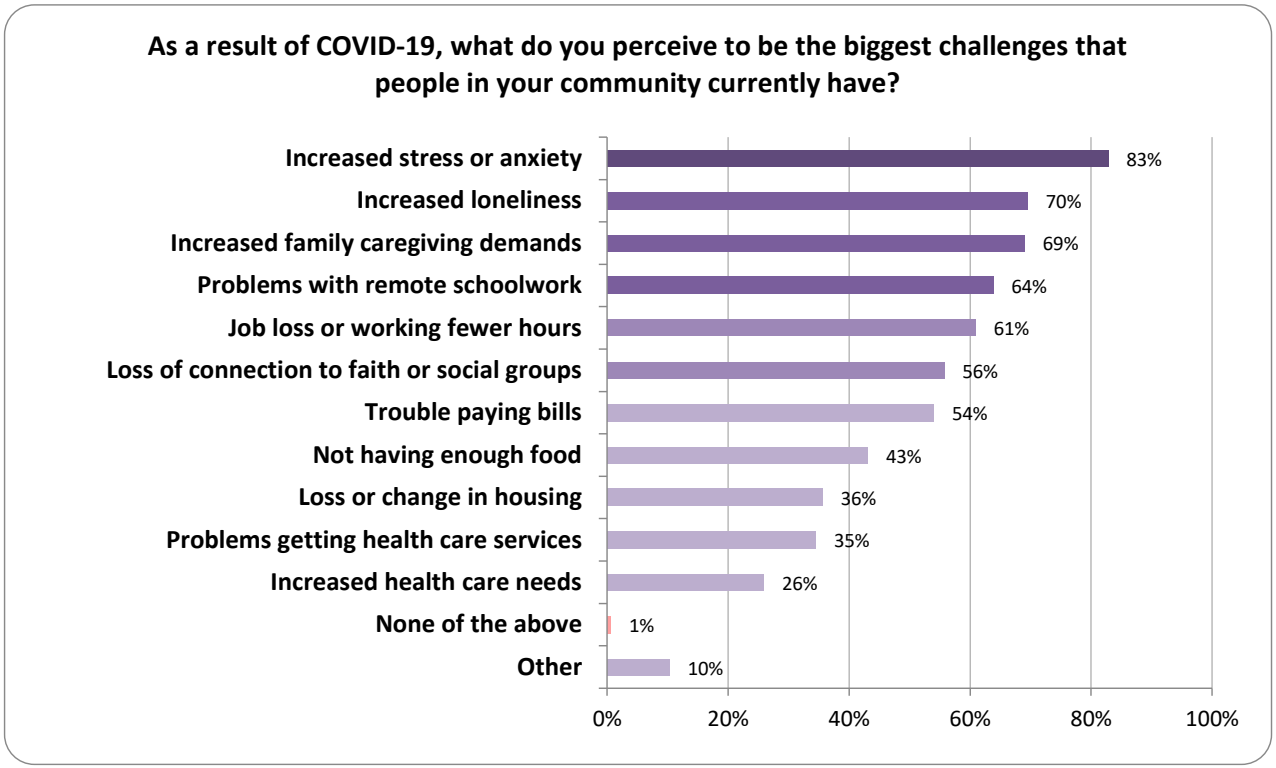
The COVID-19 pandemic has clearly had a significant impact on many community members and was an over-arching concern affecting the community health needs assessment process, as well as the context of community input. The planning committee felt it important to specifically ask community members for input on how COVID-19 was *currently* affecting them or people in their household and the question displayed on the chart below was the first question on the survey instrument. Nearly half of survey respondents indicated that they were *currently* experiencing increased stress or anxiety as a result of the COVID-19 pandemic. (Most responses to the community resident survey were received between March and July 2021). About 1 in every 4 respondents were currently experiencing loneliness or loss of connection to faith or social groups. The next most common problems reported were increased family caregiving demands (12%), job loss or reduced work hours (10%) and problems with remote schoolwork (10%). About one-third of respondents (33%) indicated not *currently* experiencing any of the impacts of COVID-19 listed as options on the question.

| Figure 7 |



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

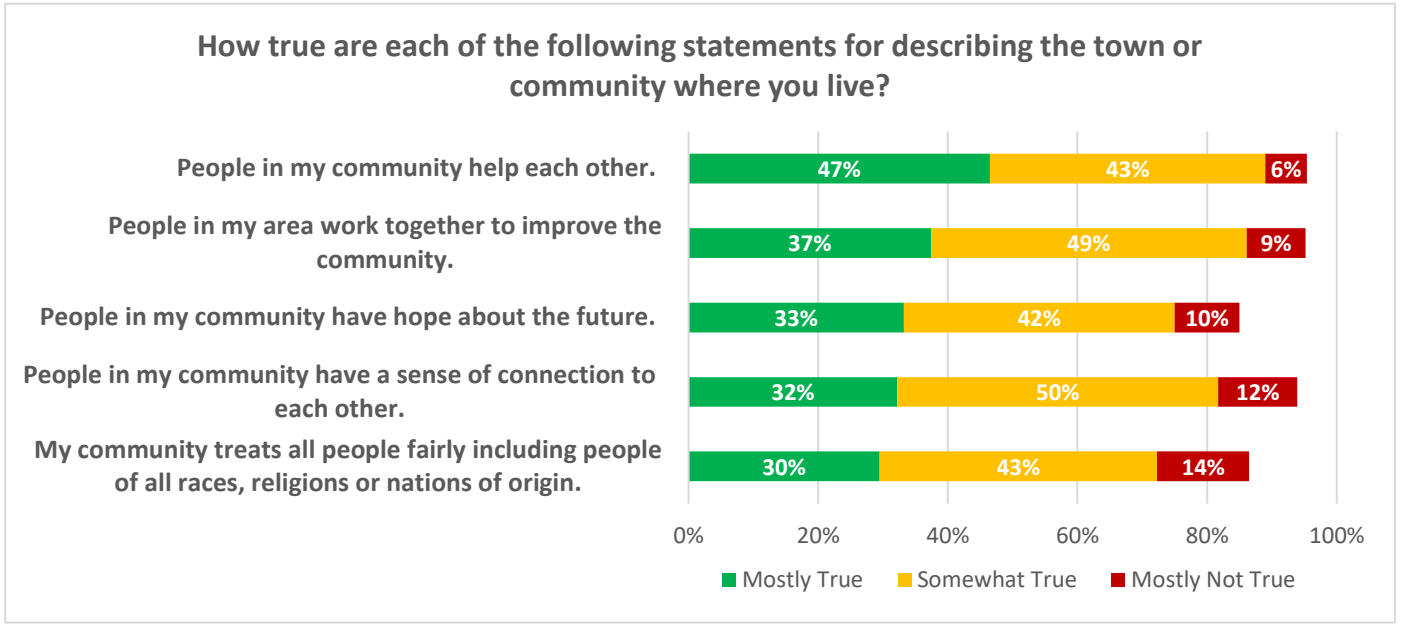
| Figure 8 |



3. Characteristics of a Resilient Community

The Community Resident survey asked people to indicate how true certain characteristics of a resilient community were for the community in which they live. As displayed by Figure 9, respondents overall thought the statement, "People in my community help each other" was 'mostly true' (47% of respondents). However, only 30% of respondents indicated that it was 'mostly true' and 14% indicated that it was 'mostly not true' that "My community treats all people fairly including people of all races, religions or nations of origin." (An additional 14% of respondents selected "Don't Know" for this statement.)

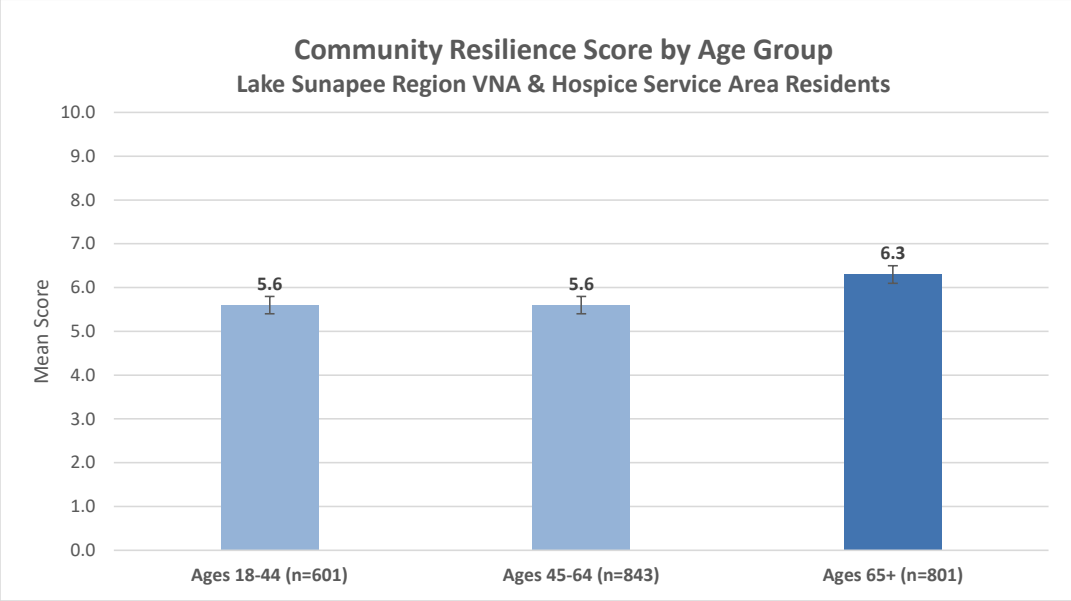
| Figure 9 |



Totals do not equal 100%. Response choice of "Don't Know" is not displayed.

Further analysis of this set of questions was conducted by calculating a composite 'Community Resilience Score' for each respondent with possible scores ranging from zero to 10 (5 questions, each question with possible values of 2, 1 or 0) where a score of 10 results when a respondent indicates that each of the 5 statements describing a resilient community are 'Mostly True'. Scores were then aggregated for 3 age categories of respondents: Ages 18-44, 45-64 and 65 years of age and older. The chart displays the mean Community Resilience Score calculated from the responses from service area residents for each of these age groups. The mean score for the 65 and older group is significantly different and higher than the mean scores for the other two age groups (One-Way ANOVA, $p<0.001$); indicating a greater sense of community resilience among the older residents of the service area.

| Figure 10 |



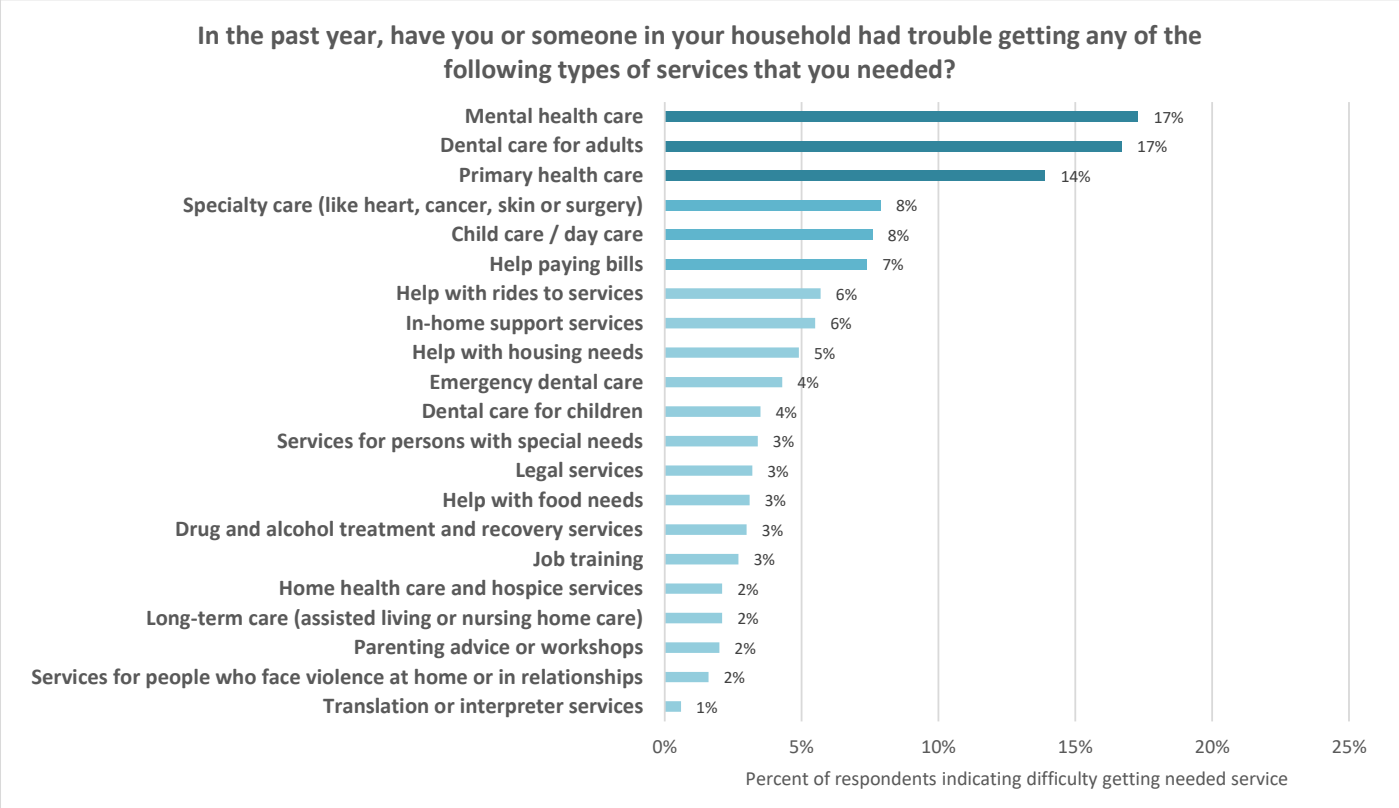
"Focus on making sure your neighbors are doing ok & welcoming new members of our community; taking care of each other."

- *Community Survey Response to 'one thing you would change to improve health of your community'*

4. Barriers to Services

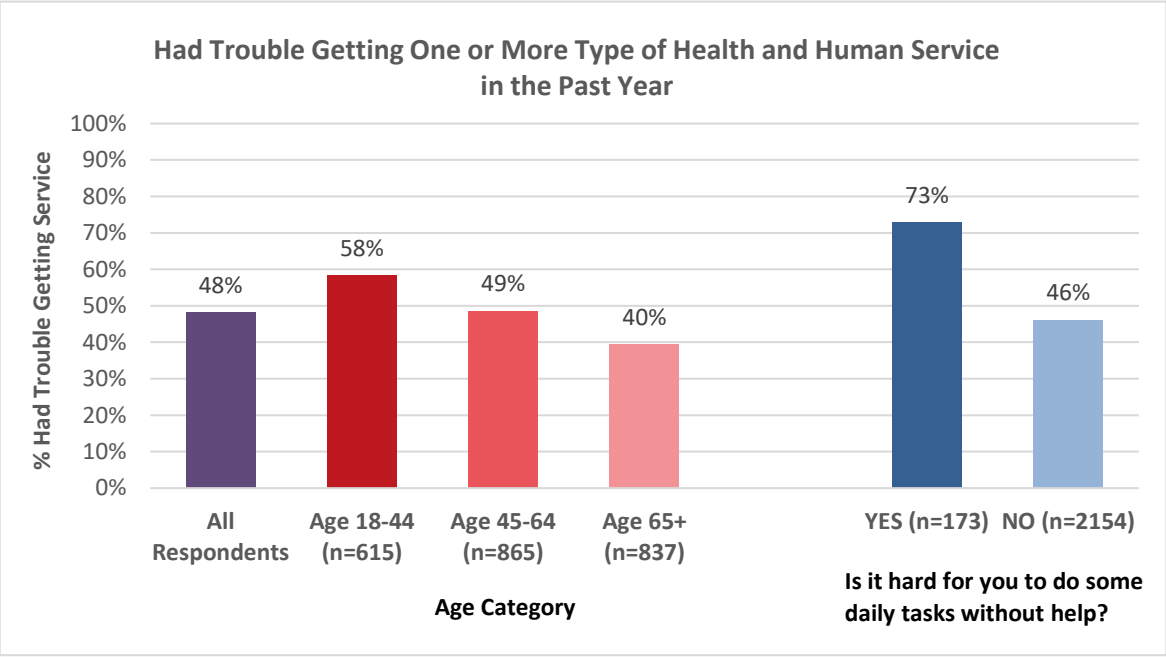
Respondents to the Community Resident survey were presented with a list of potential health and human services and asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of services that you needed?"* As displayed by the chart below, about 17% of respondents indicating have difficulty getting "Mental Health Care' and 'Dental care for adults' over the past year. About 14% of respondents indicated difficulty accessing 'Primary health care services' and 6% indicated difficulty getting 'In-home support services'. Overall, about half of all indicated having difficulty getting at least one type of service for themselves or someone in their household over the past year respondents (48% of all respondents). This relatively high statistic may be reflective in part of the impact of COVID-19 on need, availability, and accessibility of some health and human services.

| Figure 11 |



As displayed by the chart below, a significant relationship was observed between the likelihood that respondents reported having difficulty accessing services and age category. While a relatively high proportion of respondents in all age categories reported difficulty accessing at least one type of service in the past year, younger respondents were more likely to report such difficulties (p<.001). Respondents who reported that it was hard for them '*to do some daily tasks without help such as bathing, getting dressed, or doing errands like shopping or going to the doctor's office*' were also much more likely to report having trouble getting one or more type of health and human service in the past year (p<.001).

| Figure 12 |



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked - for each type of service selected - a follow-up question about the reasons why they had difficulty. Table 6 displays reasons reported by people who had difficulty getting services for the top three most frequently selected service types, as well as for In-Home Support Services. Among respondents indicating difficulty accessing Mental Health Care, the top reason cited was 'service not available'. Among respondents indicating difficulty accessing Primary Health Care, the top reason cited for access difficulties was 'Wait time too long'. For Dental Care for Adults and also for In-Home Support Services, the top reason for access difficulty was 'Cost too much'.

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

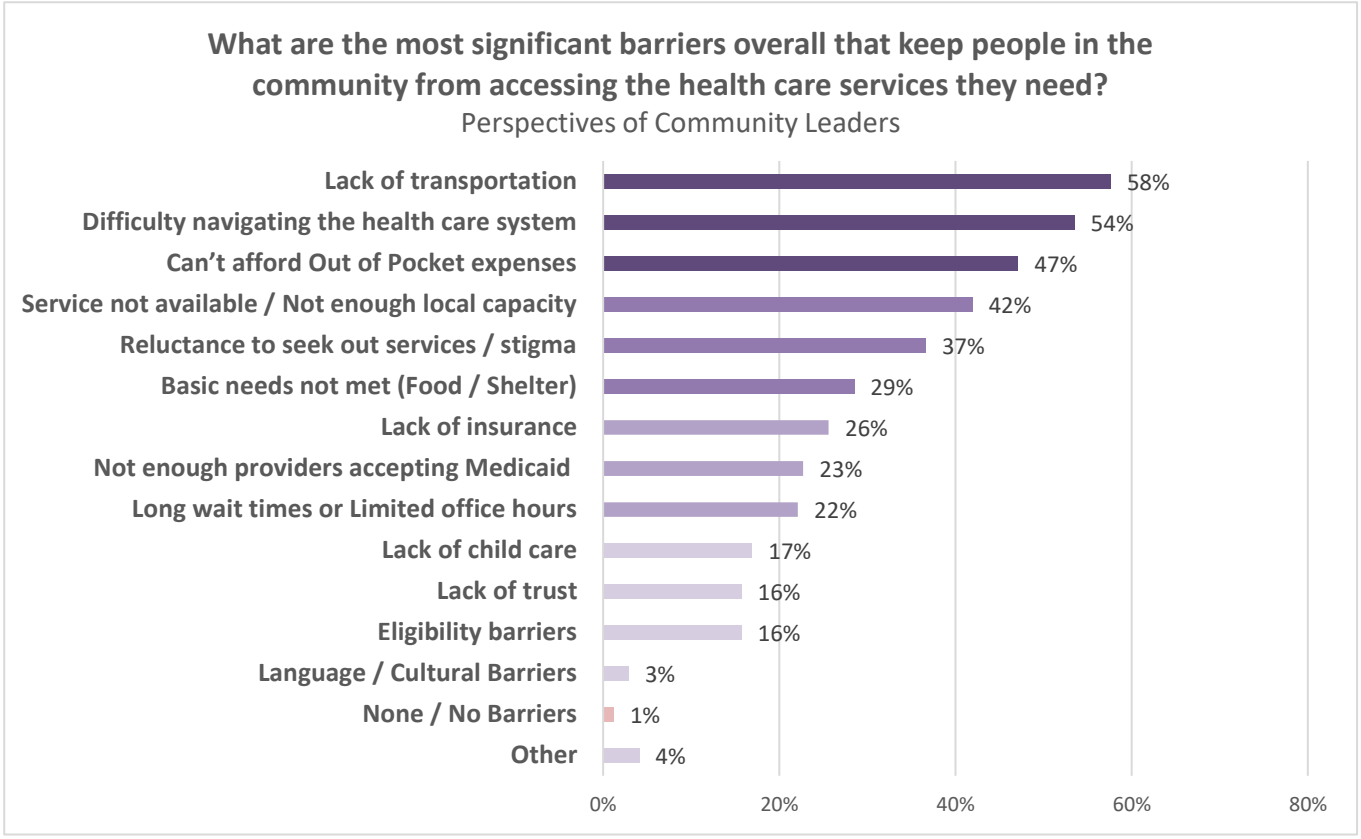
(Percentage of respondents who reported difficulty accessing a particular type of service)

MENTAL HEALTH CARE (n=403, 17.3% of respondents)	DENTAL CARE FOR ADULTS (n=391, 16.7% of respondents)	PRIMARY HEALTH CARE (n=325, 13.9% of respondents)	In-Home Support Services (n=128, 5.5% of respondents)
39% of respondents who indicated difficulty accessing Mental Health Care also selected **"Service not available"** as a reason	**39%** of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Cost too much"** as a reason	**35%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Wait time too long"** as a reason	**26%** of respondents who indicated difficulty accessing In-Home Support Services also selected **"Cost too much"** as a reason
Wait time too long (38%)	**No dental insurance or not enough dental insurance (36%)**	**Not accepting new patients (29%)**	**Service not available (24%)**
Not accepting new patients (28%)	**Wait time too long (22%)**	**Service not available (21%)**	**Did not know where to go (12%)**
Cost too much (24%)	**Service not available (18%)**	**Cost too much (14%)**	**Not accepting new patients (11%)**

In a separate question, Community Survey respondents were asked: ***"In the past year, how often has anyone in your household missed getting health care or social services because of unfair treatment?"*** 'Unfair treatment' was further specified as "discrimination or stigma based on your race, ethnic group, gender, sexual orientation, age, disability, language, or education". Overall, 1% of respondents indicated that they or someone in their household had **"Often"** missed getting health care or social services because of unfair treatment, 5% indicated **"Sometimes",** and 94% indicated **"Never"** missing health care or social services because of unfair treatment.

Respondents to the Community Leader survey were asked to identify the most significant barriers overall that prevent people in the community from accessing needed health care services. The top issue identified by this group was lack of transportation, followed by 'difficulty navigating the health care system', out of pocket expenses, insufficient availability of services.

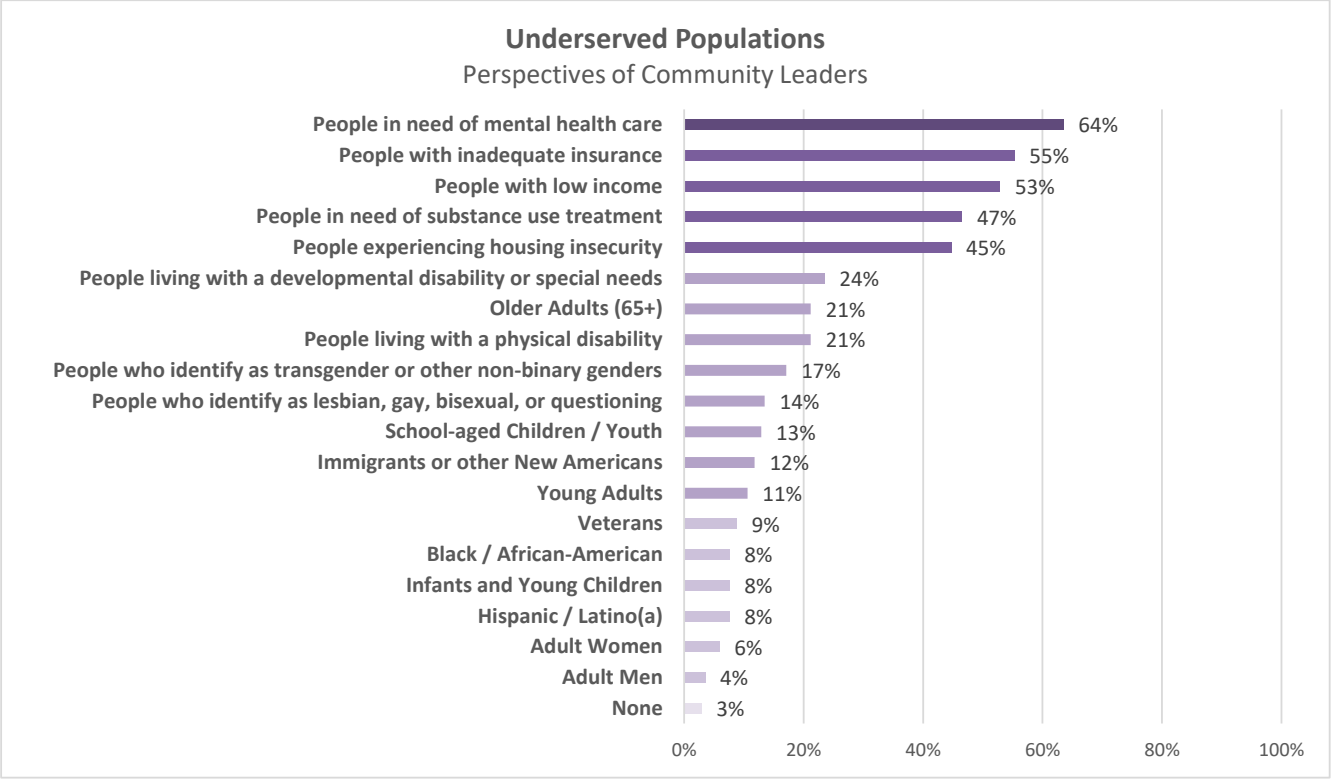
| Figure 13 |



Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. As displayed by Figure 14, populations most frequently identified by Community Leader respondents as underserved were people in need of mental health care, with inadequate health insurance, in need of substance abuse treatment, with low income, and people experiencing housing insecurity.

In a related question, Community Leaders were asked, "Are there particular types of health providers, specialties or services that are needed in the community due to insufficient capacity or availability?" More than two-thirds of respondents (68%) answered affirmatively. Mental health services were by far the most common type of service cited in an open-ended follow-up question asking respondents to describe the types of providers or services with insufficient capacity or availability (cited by 58% of those indicating any specific type of provider or service).

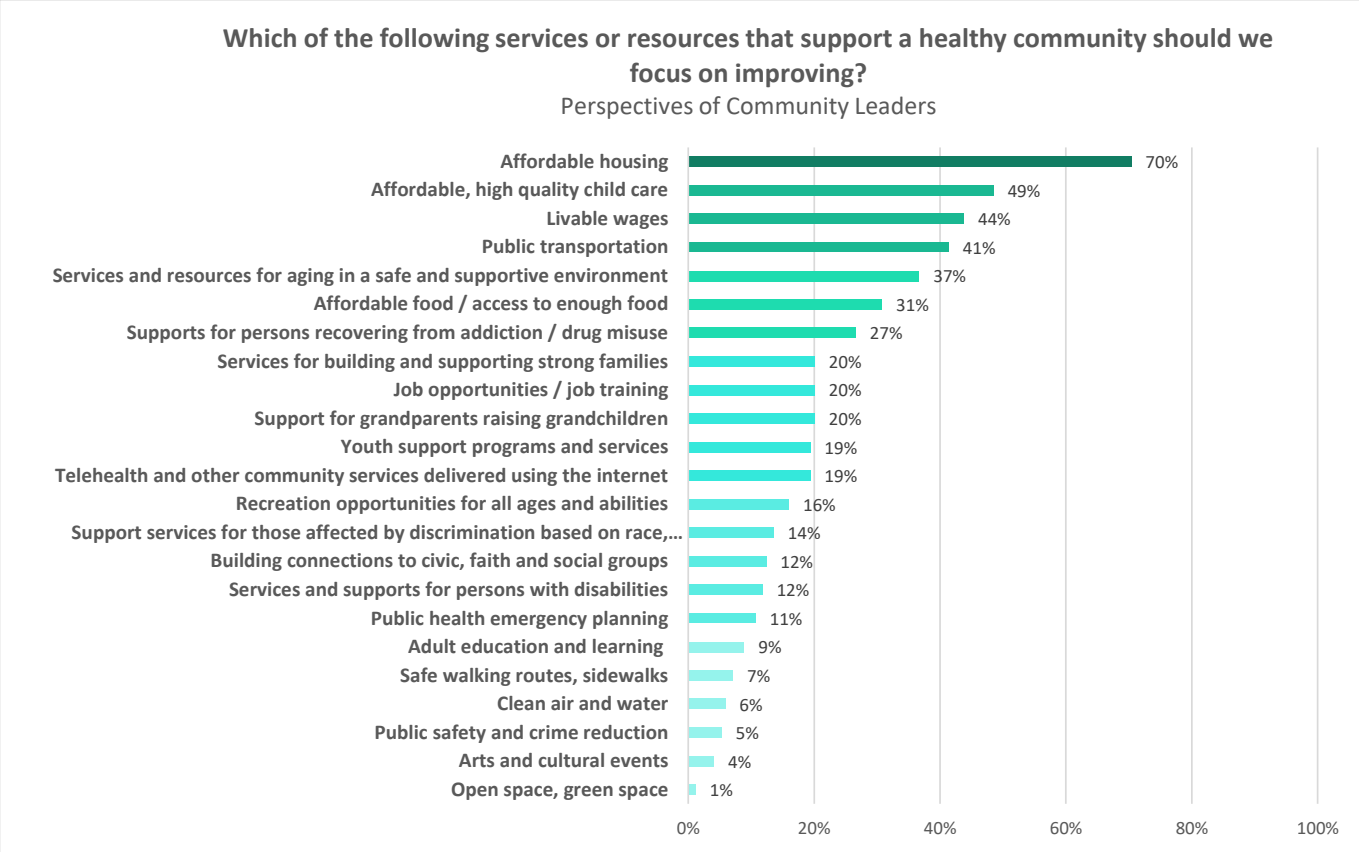
| Figure 14 |



5. Services and Resources to Support a Healthy Community

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

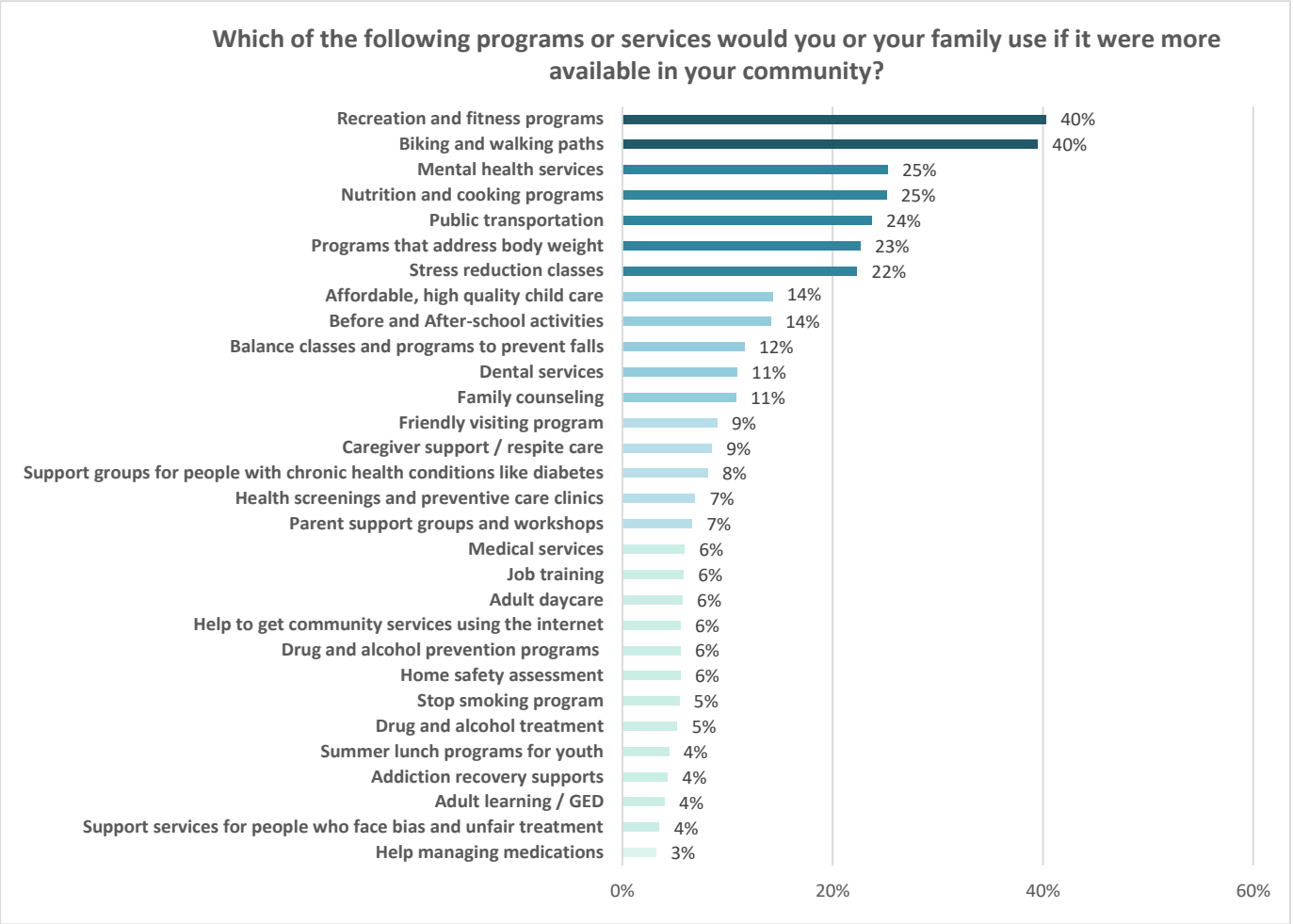
| Figure 15 |



6. Interest in Specific Community Health Programs or Services

Community members were asked a variation on the question of community services or resources to support health. Community residents were asked what **programs or services they would use if more available** in the community. The survey instrument included a list of 30 topics organized into 6 overall conceptual groups as follows: Services for Children and Parents; Services for Older Adults; Healthy Lifestyle Programs; Counseling and Mental Health Services; Health Care Services; Community Services and Supports.

| Figure 16 |



Survey respondents could select any number of individual topics from across the different topic groups. As displayed by the chart, the highest amount of interest was reported for as *Recreation and fitness programs*, as well as *Biking and walking paths*. Other services frequently mentioned were mental health services, nutrition programs, public transportation, programs that address body weight, and stress reduction classes.

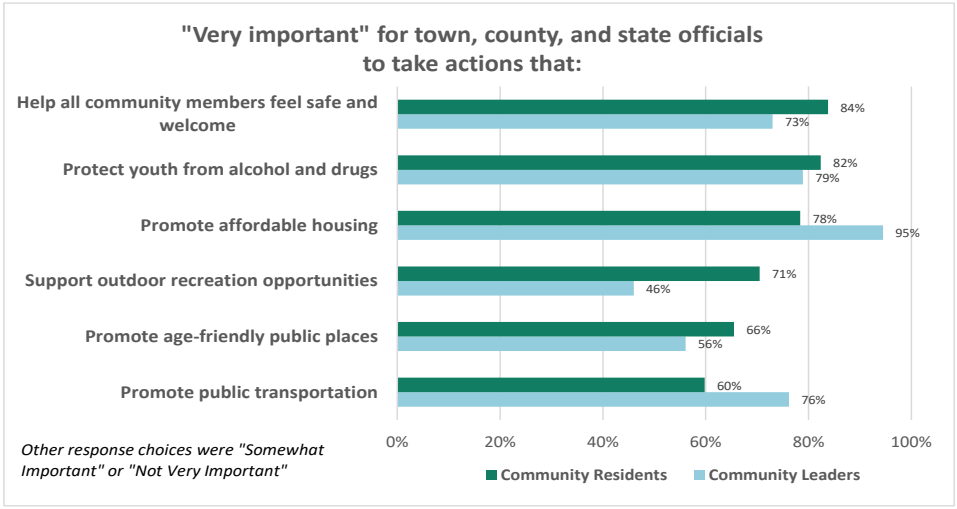
Respondents of all ages were most likely to select the same two resources they would use if more available (Recreation and Fitness Programs; Biking and Walking Paths). After that, some differences were observed across age groups with people Ages 18-44 more likely to select Mental Health Services and Affordable, high quality child care; people Ages 45-64 more likely to select stress reduction classes; and people Ages 65+ more likely to select Public Transportation and Balance Classes as services they would use.

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

Age 18-44 (n=615)		Age 45-64 (n=865)		Age 65+ (n=837)	
Recreation and fitness programs	51%	**Biking and walking paths**	43%	**Recreation and fitness programs**	32%
Biking and walking paths	47%	**Recreation and fitness programs**	41%	**Biking and walking paths**	30%
Mental health services	43%	**Nutrition and cooking programs**	29%	**Public transportation**	23%
Nutrition and cooking programs	35%	**Programs that address body weight**	27%	**Balance classes and programs to prevent falls**	21%
Affordable, high quality child care	31%	**Stress reduction classes**	26%	**Programs that address body weight**	18%

Respondents to the community resident and community leader surveys were asked how important is it for town, county, and state officials to take certain actions associated with community health. As displayed by the Figure 17, nearly all community leader respondents (95%) indicated it was “very important” for officials to take actions that ‘promote affordable housing’. The actions most frequently indicated to be “very important” by community residents were ‘protect youth from alcohol and drugs’ and ‘help all community members feel safe and welcome’.

| Figure 17 |



The 2022 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you believe would improve health in your community, what would you change?"* A total of 1,357 survey respondents (58%) provided written responses to this question. Table 8 provides a summary of the most common responses by topic theme.

TABLE 8

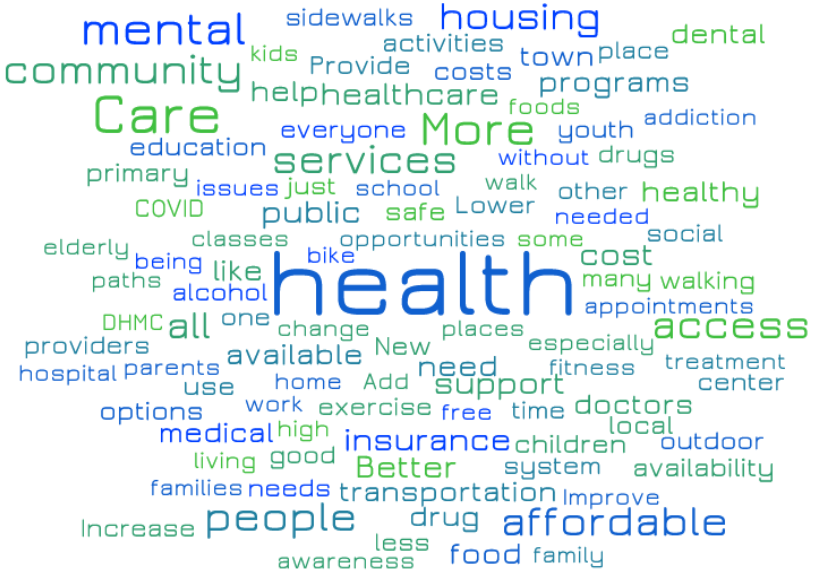
"If you could change one thing that you believe would improve health in your community, what would you change?"

Health care provider availability including certain specialties; hours and wait time; health care delivery system improvements, quality and options	**14% of all comments**
Affordability of health care services and insurance; health care payment reform; subsidized health care services	**13%**
Availability / affordability of mental health services; mental health awareness / stigma	**10%**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**9%**
Caring community / culture; community diversity and acceptance; opportunities and facilities for social interaction	**8%**
Affordable housing; wages and cost of living; taxation, welfare and public spending priorities	**7%**
Improved resources, programs or environment for healthy eating / nutrition / food affordability	**6%**
Accessibility/availability of substance use treatment services; substance misuse prevention including tobacco	**5%**
Senior services / concerns of aging / home health care / assisted living	**4%**
Improved transportation services and resources / public transportation; medical transportation	**4%**
COVID-19 Prevention, Policies	**3%**
Healthy lifestyle awareness and education, prevention and personal accountability	**3%**
Services or resources for youth and families; affordable child care	**3%**
Natural Environment / Environmental Protection / Noise and Pollution	**2%**
Community Safety; physical infrastructure and accessibility	**2%**
Affordability / availability of dental services	**1%**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

Convening community discussion groups was challenging for the 2022 Community Health Needs Assessment. Due to the ongoing Covid-19 pandemic, discussion groups had to be held virtually to protect the health and safety of participants. The Community Health Needs Assessment Committee worked with community partners to identify and recruit a variety of groups and participants intended to represent a broad cross-section of the region and different community interests. In spite of the challenging context of the ongoing pandemic, the committee and our community partners successfully convened 10 different community discussion groups representing the following sectors, attributes or topics:

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



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

1. Impact of COVID-19

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

- Significant impacts on family finances, unemployment, food insecurity, juggling work, child care, remote schooling; "COVID has impacted just being able to get things done in general."
- COVID has had a big impact on family mental health; "The impact of remote schooling on child mental health seems to have been largely dismissed."
- Reduced access to care and delayed care; "I have clients who are going without routine medical care or mental health because they have no one to watch their child and they're not allowed to bring them."
- Limits or stopped a lot transportation services; has impacted seniors in particular; and also a problem with Medicaid transportation providers canceling scheduled rides with no backup causing patients to miss important visits; especially an issue for rural residents in winter
- Difficulties navigating virtual visit technology
- For mental health and substance use recovery, not being able to meet in support groups; not being able to have social interaction has been very detrimental to recovery.
- "Everyone is being affected multiple ways all the time . . . . There has been incredible pressure to get information out as rapidly as possible. It's been a really long year. A lot of stress. A lot of pressure."

> ***"I miss my friends at COA and that social connection, and being able to give back to the community in the way that I did. I'm finding it very difficult to find ways to contribute that don't involve contact."***
> - *Senior Group Participant*

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

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

2. Resources to Support Aging in Place

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

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

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

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

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

3. Addressing Discrimination and Stigma

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

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

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

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

4. High Priority Issues from Community Discussion Groups

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

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

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

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

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

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

TABLE 9 – COMMUNITY DISCUSSION GROUPS; MAJOR THEMES & PRIORITIES

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

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

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

	Are the top health issues from previous assessments still a high priority?	What are other top priorities?	Noticed any improvements?
Rural Community Residents	• They are still very relevant and very much in need of further attention. • There are probably a whole other list of other things to add to but if it's too long It's not useful	• Suicide Prevention • Aging in place with dignity and with the right supports • Transportation • Access to ambulance services in rural towns • High speed internet access ("20 years behind other communities") • Perinatal care / birthing services • Homelessness	• Haven't seen any real improvements • Participated in a similar needs assessment last year, 'don't know what became of that' • Just think there has been a lot of talk, but we don't do anything.
Individuals with Complex Health Needs	• Yes, those are still priorities although would include transportation • There's a great need for mental health services; see a lot seniors who could use some help, but they would have no idea how to reach out and get it. • Health care is expensive.	• Transportation for a lot of people is a huge barrier	• Everybody is working harder together to solve a problem. Instead of working against each other, each doing their own thing.
Seniors	• Not specifically asked / discussed	• The COVID situation has highlighted concerns that people already had. "Something as simple as obtaining groceries. For people who can no longer drive or are disabled to the point that they have to use a walker or use a wheelchair, obtaining food and other necessary items such as prescriptions is a challenge." • Suggestion of setting up demonstration facilities, such as demonstration kitchens or bathrooms, with the VNA for teaching self-care, self-help skills. Example: "I didn't know how to keep cutting my toenails . . . . I just could no longer reach down and effectively deal with them. If there was a setup where somebody could show me how to do it better that would be great." Or a kitchen setup to 'show me how to effectively deal with opening cans, safety with knives and kitchen utensils; different ways to deal with food prep in a safe way.'	

D. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2022 Community Health Assessment report provides information on key data indicators and measures of community health status. Some measures that are associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 32 town region identified as the Lake Sunapee Region VNA & Hospice service area. In some instances, data are only available at the county level or the New Hampshire Public Health Network region level. Regarding the latter, two Public Health Networks together include 26 of the 32 towns the Lake Sunapee VNA service area including all 16 of the towns in the Greater Sullivan County Public Health Network region and 10 of the 12 towns in Upper Valley Regional Public Health Network.

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 2020 American Community Survey, the population of the Lake Sunapee Region VNA & Hospice service are is older on average than in New Hampshire overall (about 21.5% are 65 years of age or older compared to about 18% in NH overall. Between 2016 and 2020, the population of the service area grew 1.6%, a slightly slower pace than New Hampshire population growth overall.

Indicators	Lake Sunapee Region VNA & Hospice Service Area	New Hampshire
Population Overview		
Total Population	**100,481**	1,355,244
Age 65 and older	**21.5%**	18.1%
Under age of 18	**17.2%**	19.3%
Change in population (2016 to 2020)	**+1.6%**	+2.2%

Data Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates

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 percent of people in the Lake Sunapee Region VNA & Hospice Service Area living in households with income below the federal poverty level and the percent of children under age 18 in households with income below the Federal Poverty Level. Three towns have child poverty estimates over 25%: Claremont (25.7%), Andover (36.9%) and Langdon (37.3%).

Area	Percent of people with household income below the federal poverty level (Income < 100% FPL)	Percent of children (under 18) in households below the federal poverty level (Income < 100% FPL)
LSRVNA&H Service Area	**9.8%**	**10.6%**
New Hampshire	7.4%	9.0%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.

c. Education

Educational attainment is also considered a key driver of health status with lower levels of education linked to both poverty and poor health. A similar proportion of the population of the Lake Sunapee Region VNA & Hospice Service Area have earned at least a high school diploma or equivalent compared to New Hampshire overall. The table below presents data on the percentage of the population aged 25 and older with a high school diploma (or equivalent).

Area	Percent of Population Aged 25+ with High School Diploma or Equivalency
LSRVNA&H Service Area	**92.9%**
New Hampshire	93.3%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.

d. Language

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

Area	Percent of Population Aged 5+ Who Speak English Less Than "Very Well"
LSRVNA&H Service Area	**0.4%***
New Hampshire	1.2%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.
**Percentage estimate is significantly lower than the NH statewide estimate.*

e. Housing

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

Area	Percent of Households with Housing Costs >30% of Household Income	Percent of Occupied Housing Units Lacking Complete Plumbing Facilities	Percent of Occupied Housing Units Lacking Complete Kitchen Facilities
LSRVNA&H Service Area	**31.2%**	**0.7%**	**0.7%**
New Hampshire	30.5%	0.5%	0.7%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.

f. Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. The next table presents data on the percent of households that have no vehicle available. It is estimated that nearly 6% of households in the region have no vehicle available.

Area	Percent of Households with No Vehicle Available
Lake Sunapee VNA & Hospice Service Area	**5.5%**
New Hampshire	5.0%

Data Source: U.S. Census Bureau, 2015 – 2019 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 identifies people reporting serious difficulty with six basic areas of functioning – hearing, vision, cognition, ambulation, self-care or independent living. Compared to NH overall, a lower percentage of residents 18 years of age and older in the Lake Sunapee Region VNA & Hospice Service Area report having at least one disability.

Percent of Population Reporting Serious Activity Limitations Resulting from a Disability		
Age Group	**Lake Sunapee Region VNA & Hospice Service Area**	**New Hampshire**
Percent Disabled <18	**3.7%**	4.7%
Percent Disabled 18-64	**9.4%**	10.2%
Percent Disabled 65+	**27.4%**	30.7%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.

2. Access to Care

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

a. Insurance Coverage

Table 10 on the next page displays estimates of the proportion of residents who do not have any form of health insurance coverage by municipality, as well as the proportion of residents with Medicare, Medicaid or Veterans Administration coverage. In combination, the percentage of the population with Medicaid or no insurance coverage (18.7%) is similar to New Hampshire overall (19.1%).

It should be noted that the data source for these municipal level estimates is a 5 year span of the American Community Survey. A combination of five years of data is required to produce reasonably stable estimates on these and other measures from the survey samples. As such, the estimates may not fully reflect shorter term economic or policy conditions influencing fluctuations in insurance benefit coverage.

> ***"Cost of Medicare for retired people. When you make $1600 a month in social security and if you missed signing up at 65 you have to pay penalty. I now pay $220 a month for Medicare. The cost and penalty is a barrier to getting health care."***
>
> - *Community Survey Response to 'one thing you would change to improve health of your community'*

Table 10: Health Insurance Coverage Estimates

Area	Percent of total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Springfield	14.4%	19%	4%	5%
Acworth	13.4%	26%	5%	3%
Newport	12.5%	16%	15%	3%
Canaan	10.8%	19%	18%	1%
Danbury	10.4%	24%	13%	4%
Lempster	9.3%	25%	9%	3%
Dorchester	9.3%	40%	23%	3%
Unity	9.0%	28%	10%	6%
Charlestown	8.6%	25%	22%	4%
Washington	8.2%	27%	6%	7%
Grafton	8.1%	25%	12%	4%
Lebanon	7.3%	23%	16%	3%
Salisbury	7.0%	25%	9%	3%
Claremont	6.8%	25%	27%	5%
Croydon	6.6%	20%	17%	3%
Wilmot	6.4%	21%	3%	3%
Goshen	6.2%	32%	20%	3%
Andover	6.0%	23%	7%	2%
New Hampshire	**6.0%**	**19.7%**	**13.1%**	**2.6%**
LSRVNA Service Area	**5.9%**	**23.0%**	**12.8%**	**3.3%**
Sunapee	4.8%	31%	16%	3%
Lyme	4.6%	26%	4%	2%
Orange	4.0%	22%	2%	1%
Warner	3.5%	23%	16%	2%
Bradford	3.2%	25%	12%	2%
Enfield	2.8%	29%	5%	8%
New London	2.7%	31%	5%	3%
Cornish	2.1%	32%	8%	3%
Newbury	1.9%	28%	6%	2%
Hanover	1.9%	15%	3%	1%
Sutton	1.8%	21%	3%	2%
Langdon	1.3%	18%	15%	2%
Plainfield	0.9%	20%	9%	2%
Grantham	0.0%	22%	7%	5%

Data Source: U.S. Census Bureau, 2016 – 2020 American Community Survey 5-Year Estimates.
*Coverage alone or in combination

b. Delayed or avoided health care visit because of cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a health care visit in the past year because of cost. A higher rate on this measure is reflective of limitations of household income or health insurance benefits inhibiting access to care.

Area	Percent of adults who report having delayed or avoided health care because of cost in the past year
Greater Sullivan County Public Health Region	**8.9%**
Upper Valley Public Health Region	**4.5%**
New Hampshire	9.3%

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

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

c. Provider Capacity

> ***"Make healthcare more affordable. We have plenty of available services, but many can't afford to use them."***
> - *Community Survey Response to 'one thing you would change to improve health of your community'*

This indicator reports the number of Full Time Equivalent (FTE) physicians in active practice with specialties in primary care or in psychiatry. Access to high-quality, cost-effective healthcare is influenced by an adequate physician availability in balance with population needs. As displayed by the table below, the Upper Valley Public Health Region is reported to have substantially more provider FTE capacity while the inverse is the case for Greater Sullivan compared to New Hampshire overall; possibly a reflection of the regional referral and medical training center role served by the Dartmouth-Hitchcock Medical Center.

Area	Primary Care FTE per 100k Population	Psychiatrist FTE per 100k Population	Population to mental health provider ratio
Greater Sullivan County Public Health Region	**18.7**	**1.8**	
Upper Valley Public Health Region	**111.7**	**17.2**	
Sullivan County			**560:1**
New Hampshire	42.3	5.0	310:1

Data Sources: NHDHHS, Office of Rural Health and Primary Care, 2021; County Health Rankings for Mental Health Provider Ratio, 2020

d. Adults with a Personal Health Care Provider

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

Area	Percent of adults who report having a personal doctor or health care provider
Greater Sullivan County Public Health Region	**87%**
Upper Valley Public Health Region	**82%**
New Hampshire	88%

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

e. Preventable Hospital Stays

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

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

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

f. Dental Care Utilization (Adult)

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

Area	Percent of adults who visited a dentist or dental clinic in the past year
Greater Sullivan County Public Health Region	**64%**
Upper Valley Public Health Region	**82%**
New Hampshire	72%

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

Regional rate is not significantly different than the overall NH rate

> ***"Prices of medical care and prescription drugs and DENTAL, too many folks have lost too many teeth which affects overall general health."***
>
> - *Community Survey Response to 'one thing you would change to improve health of your community'*

3. Health Promotion and Disease Prevention

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

a. Food Insecurity

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food contributing to reduced quality, variety, or desirability of diet, disrupted eating patterns and reduced food intake.

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

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

> ***"Affordable access to healthy food, healthy food costs too much."***
> - *Community Survey Response to 'one thing you would change to improve health of your community'*

b. Physical Inactivity (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. About 1 in 4 adults in Sullivan County can be considered physically inactive on a regular basis.

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

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

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

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

These indicators include the percentage of adults who self-report that they received an influenza vaccine in the past year (at the time of the survey) or have ever received a pneumococcal vaccine (age 65+). In addition to measuring the population proportion receiving preventive vaccines, these measures can also highlight access to preventive care issues or opportunities for health education including addressing concerns for vaccine safety and efficacy. This latter consideration has received significant attention in recent months due to the efforts to achieve broad distribution and administration of COVID-19 vaccines. The table on the next page includes the most recently available statistic for the percentage of area residents fully vaccinated for COVID-19. The Upper Valley Public Health Region has the highest COVID-19 vaccination rate (72.9%) of all NH public health regions.

Area	Influenza Vaccination in the past year; 18 years or older	Pneumococcal Vaccination Ever; 65 years or older	COVID-19, Fully Vaccinated; percent of total population
Greater Sullivan County Public Health Region	**49.3**	**79.8%**	56.2%
Upper Valley Public Health Region	**43.9%**	**84.5%**	72.9%
New Hampshire	44.0%	82.1%	62.8%

Data Sources: NHDHHS, Behavioral Risk Factor Surveillance System, 2017. NHDHHS COVID-19 Data Dashboard as of April 14, 2022.

d. Substance Misuse

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

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

Area	Excessive Drinking in Past 30 days, Percent of Adults
Sullivan County	**19%**
New Hampshire	20%

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

The misuse of prescription drugs, particularly prescription pain relievers, poses significant risk to individual health and can be a contributing factor leading to misuse of other drugs and a cause of unintentional overdose and mortality. About 10% of high school youth in the Greater Sullivan County Public Health Region reported having ever used a prescription drug that was not prescribed to them on the 2019 Youth Risk Behavior Survey.

Area	Ever used prescription drugs 'not prescribed to you', Percent of High School Youth		
	Male	Female	Total
Greater Sullivan County Public Health Region	9.5%	10.1%	9.9%
Upper Valley Public Health Region	5.0%	5.0%	5.1%
New Hampshire	10.9%	8.9%	10.0%

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

> ***"Do something about the opioid crisis. It's still here. Friends are still dying in 2021 from accidental heroin (fentanyl) overdoses."***
>
> - *Community Survey Response to 'one thing you would change to improve health of your community'*

e. Cigarette Smoking

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

Area	Percent of Adults who are Current Smokers+	Smoked during pregnancy, rate per 100 births^
Sullivan County	18.0%	
Greater Sullivan County Public Health Region		**21.4***
Upper Valley Public Health Region		**10.1**
New Hampshire	17.0%	11.0

+Data Source: County Health Rankings, 2018.

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

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

Data source: NH Division of Vital Records Administration birth certificate data; 2014-2016.

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

4. Health Outcomes

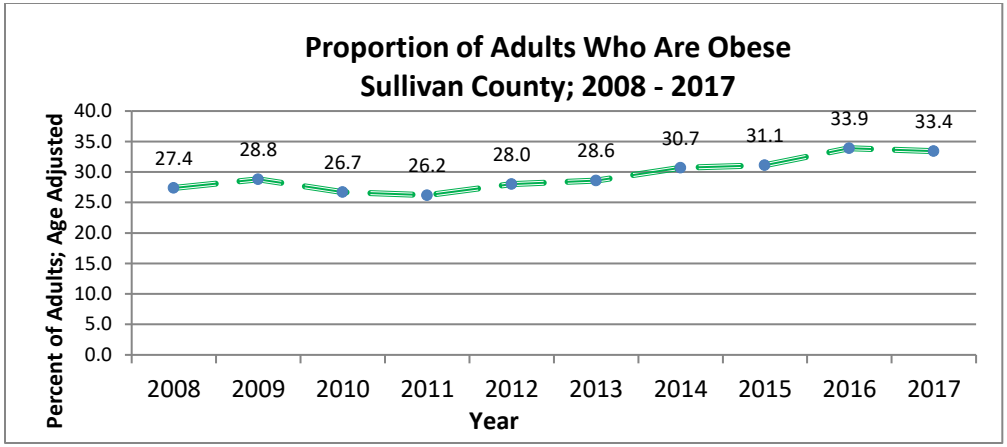
Traditional measures of population health status focus on rates of illness or disease (morbidity) and death (mortality) from specific causes. Advances in public health and medicine over the last century have reduced infectious disease and complications of child birth as major contributors to or causes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

a. Overweight and Obesity

Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of significant health issues including hypertension, heart disease and diabetes. The indicators below report the percentage of adults aged 18 and older (BRFSS), as well as high school students (YRBS) who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese). The chart on the next page displays the increasing trend in adult obesity in Sullivan County over a ten year period from 2008 to 2017.

Area	Adults Aged 20+ Years, Percent Obese	High School Students, Percent Obese
Greater Sullivan County Public Health Region		**16.5%***
Upper Valley Public Health Region		**7.9%**
Sullivan County	**33.4%***	
New Hampshire	26.4%	12.8%

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



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

b. Heart Disease

Heart disease was the second leading cause of death between 2012 and 2016 in the region after all forms of Cancer. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance abuse including tobacco use. Over the 5 year period from 2012 to 2016, 'Diseases of the Heart' were the cause of 910 deaths in the Greater Sullivan and Upper Valley Public Health Regions.

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

Area	Percent of adults who have high blood pressure	Adults told by a health professional that their blood cholesterol was high
Greater Sullivan County Public Health Region	**31%**	**31%**
Upper Valley Public Health Region	**26%**	**27%**
New Hampshire	30%	33%

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

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

Area	Hypertension – Inpatient, age adjusted rate per 100,000 population; 18+ years of age	Heart Failure – Inpatient, age adjusted rate per 100,000 population; 18+ years of age
Greater Sullivan County Public Health Region	**17.7**	**246.8***
Upper Valley Public Health Region	**19.3**	**260.8***
New Hampshire	30.8	320.5

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

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

Heart Disease and Stroke Mortality: Coronary Heart Disease, a narrowing of the small blood vessels that supply blood and oxygen to the heart, is the largest component of heart disease mortality. The rate of death due to coronary heart disease among Lake Sunapee Region VNA Service Area residents was significantly lower than the overall rate for New Hampshire in the 2012 to 2016 time period. Cerebrovascular disease (stroke), which happens when blood flow to a part of the brain stops, is the fifth leading cause of death in New Hampshire and the region.

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Greater Sullivan County Public Health Region	**95.3**	**27.1**
Upper Valley Public Health Region	**60.7***	**21.1**
New Hampshire	92.3	27.0

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

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

c. Diabetes

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

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. About one in twelve adults (8%) in Sullivan County and New Hampshire overall report having been told by a health professional that they have diabetes.

Area	Percent of Adults with Diabetes, age adjusted
Sullivan County	8%
New Hampshire	8%

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

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

Area	Uncontrolled Diabetes - Inpatient, age adjusted rate per 100,000 population, 18+ years of age	Diabetes Long -Term Complications - Inpatient, age adjusted rate per 100,000 population, 18+ years of age
Greater Sullivan County Public Health Region	**6.3***	**49.0**
Upper Valley Public Health Region	**12.0**	**37.7**
New Hampshire	24.6	55.5

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

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

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Greater Sullivan County Public Health Region	**20.9**
Upper Valley Public Health Region	**9.3***
New Hampshire	17.7

Data Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom, 2012- 2016

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

d. Cancer

Cancer is the leading cause of death in New Hampshire and in the Lake Sunapee Region VNA service area. Although not all cancers can be prevented, risk factors for some cancers can be reduced. It is estimated that nearly two-thirds of cancer diagnoses and deaths in the US can be linked to behaviors, including tobacco use, poor nutrition, obesity, and lack of exercise. Over the 5-year period from 2012 to 2016, 'Malignant Neoplasms' were the cause of 916 deaths in the Greater Sullivan and Upper Valley Public Health Regions.

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

Cancer Screening Type	Greater Sullivan County Public Health Region	Upper Valley Public Health Region	New Hampshire
Had colonoscopy in past 10 years (ages 50 to 75)	63.9%	72.5%	72.7%
Had mammogram past two years (women 40+)	75.1%	62.8%	76.9%
Women 21 to 65 receiving Pap test in past 3 years	**95.7%***	75.9%	85.1%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2016.

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

Cancer Incidence and Cancer Mortality: The table below shows cancer incidence rates by site group for the cancer types that account for the majority new cancer cases (incidence). The incidence rate for Melanoma of the Skin was significantly higher in the Upper Valley Public Health Region compared to the state overall between 2014 and 2018, while incidence of lung and prostate cancer was lower.

	Cancer Incidence per 100,000 people, age adjusted		
	Greater Sullivan County Public Health Region	Upper Valley Public Health Region	New Hampshire
Overall cancer incidence (All Invasive Cancers)	**470.8**	**441.8***	481.9
Cancer Incidence by Type			
Breast (female)	**136.3**	**140.2**	143.4
Prostate (male)	**93.0**	**85.2***	109.7
Lung and bronchus	**61.4**	**45.4***	62.6
Colorectal	**37.7**	**34.0**	36.3
Melanoma of Skin	**39.3**	**50.8****	32.2
Bladder	**28.0**	**22.6**	27.4

Data Source: NH State Cancer Registry, 2014 – 2018

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

****Rate is statistically different and higher** than the overall NH rate; other rates not statistically different*

Cancer Mortality: The table below shows the overall cancer mortality rate and for the cancer types that account for the majority of cancer deaths. The overall cancer mortality rate in the Upper Valley Public Health Region was lower than the overall state rate over the period 2012 – 2016 (the most recent data available).

	Cancer Mortality per 100,000 people, age adjusted		
	Greater Sullivan County Public Health Region	**Upper Valley Public Health Region**	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	**148.3**	**125.9***	158.9
Cancer Mortality by Type			
Lung and bronchus	**40.6**	**27.8***	43.2
Pancreas	**11.8**	**10.9**	10.4
Prostate (male)	**14.2**	**18.4**	19.0
Breast (female)	**15.3**	**18.2**	19.1
Colorectal	**6.9***	**11.0**	12.5

Data Source: NH State Cancer Registry, 2012 - 2016

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

Other regional rates are not significantly different than overall NH rate

e. Asthma

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

Asthma Prevalence: This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma.

Area	Percent of Adults (18+) with Current Asthma
Sullivan County	**14.8%**
New Hampshire	11.8%

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

Asthma-Related Hospitalization: The table below displays age adjusted rates of inpatient hospitalization of younger adults, age 18-39, for complications of asthma. The regional rate is higher than for the state overall, although the number of admissions is not large enough to conclude that the observed difference is statistically significant.

Area	Asthma in Younger Adults - Inpatient, age adjusted rate per 100,000 population
Greater Sullivan County Public Health Region	**59.6**
Upper Valley Public Health Region	**36.0**
New Hampshire	20.3

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

e. COVID-19

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

The first cases of COVID-19 infection in New Hampshire were reported in 2020. Since that time, there have been over 300,000 identified cases of COVID-19 infection in New Hampshire and 2,464 deaths. The rate of COVID-19 deaths in the Upper Valley Public Health Region is lower than for the state overall and is the lowest among NH's 13 Public Health.

. Area	Cumulative COVID-19 Cases, per 100K population	Cumulative Deaths with COVID-19 as a Contributing Factor, per 100K population
Greater Sullivan County Public Health Region	**21,424**	**163**
Upper Valley Public Health Region	**19,147**	**44**
New Hampshire	22,536	182

*Data Source: NH Department of Health and Human Services, COVID-19 Response Dashboard as of April 14, 2022

f. Intentional and Unintentional Injury

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

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

Area	Drug and Alcohol Related - ED Visits, age adjusted rate per 100,000 population	Drug and Alcohol Related - Inpatient, age adjusted rate per 100,000 population
Greater Sullivan County Public Health Region	**50.6***	**8.6***
Upper Valley Public Health Region	**42.0***	**7.3***
New Hampshire	140.1	24.2

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

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

Drug Overdose Mortality: The table below displays the rate of drug overdose mortality for Sullivan County and for New Hampshire in 2020 (as of September 2021). The number of drug overdose deaths in NH overall has been trending down since 2017 when the rate over overdose mortality per 100,000 population was 36.4.

Area	Overdose Deaths per 100,000 people
Sullivan County	**20.7**
New Hampshire	30.3

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

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

Area	Self-Inflicted Harm - ED Visit, age adjusted rate per 100,000 population	Self-Inflicted Harm - Inpatient, age adjusted rate per 100,000 population
Greater Sullivan County Public Health Region	**217.8**	**31.2**
Upper Valley Public Health Region	**177.5**	**51.1**
New Hampshire	195.9	47.3

Data Source: NH Uniform Healthcare Facility Discharge Dataset, NHDHHS Office of Health Statistics and Data Management, 2018
Regional rates are not significantly different from 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 ten year period from 2010 to 2019, the suicide rate in the service area was similar to the overall NH rate of suicide deaths.

Area	Suicide Deaths per 100,000 people; any cause or mechanism
Greater Sullivan County Public Health Region	18.5
Upper Valley Public Health Region	18.0
New Hampshire	17.3

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

g. Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. During the period 2017 to 2019, 597 deaths in Sullivan County occurred before the age of 75 and the average annual total of YPLL-75 was 6,080 years of potential life lost per 100,000 population. This total is not significantly different per 100,000 population than the total for New Hampshire overall.

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

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

"Support for aging-in-place in rural communities. Drivers, home health care aides, caregiver respite, daily safety checks by phone or in person, in-home service for blood draws for lab work, home safety/security assessments, help with housework, help with outdoor chores."

- *Community Survey Response to 'one thing you would change to improve health of your community'*

"Feasibility of planning for moving to a downsized home / apartment / facility for seniors anticipating care is needed, but affordable. We are in a rural town . . . and are isolated at times. There is simply no extended affordable solution for couples requiring assisted living help (medication, food assistance, transportation to doctor and hospital care. This is anxiety producing . . . ."

- *Community Survey Response to 'one thing you would change to improve health of your community'*