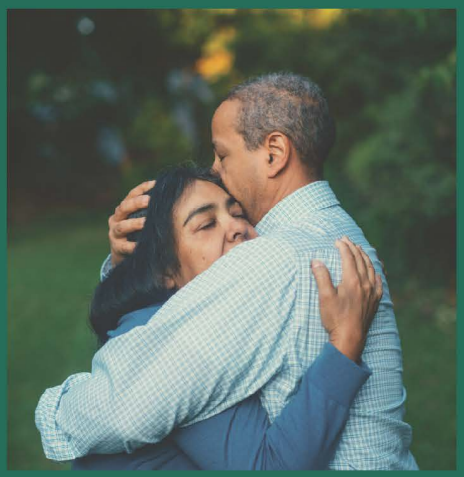
Community Health Needs Assessment

2024



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

Dartmouth Health

New London Hospital

New London Hospital

Community Health Needs Assessment

2024

Community Input on Health Issues and Priorities,

Selected Service Area Demographics and Health Status Indicators

Your input is valuable!

Please share your comments and questions about our Community Health Needs Assessment and our Community Benefits Action Plan by contacting:

Community Relations and Development
New London Hospital
273 County Road
New London, New Hampshire 03257

The 2024 Community Health Needs Assessment Partnership includes New London Hospital, Dartmouth Health, Alice Peck Day Memorial Hospital, Valley Regional Healthcare, Mt. Ascutney Hospital and Health Center, Cheshire Medical Center, Visiting Nurse and Hospice for Vermont and New Hampshire with technical support from the New Hampshire Community Health Institute/JSI.

Dartmouth Health
New London Hospital

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Alice Peck Day Memorial Hospital

Dartmouth Health
Mt. Ascutney Hospital and Health Center

Dartmouth Health
Cheshire Medical Center

Visiting Nurse and Hospice for Vermont and New Hampshire

Valley Regional Healthcare

New London Hospital

2024 Community Health Needs Assessment

Executive Summary

During the period September 2023 through May 2024, an assessment of Community Health Needs was completed by New London Hospital in partnership with Dartmouth Health, Alice Peck Day Memorial Hospital, Valley Regional Healthcare, Mt. Ascutney Hospital and Health Center, Cheshire Medical Center, Visiting Nurse and Hospice for Vermont with technical support from the New Hampshire Community Health Institute/JSI. The aims of the assessment are 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
- Guide community benefit activities of New London Hospital and partner organizations.

For the purpose of the assessment, the geographic area of interest is 15 municipalities comprising the New London Hospital primary service area with a total resident population of 33,192 people. Methods employed in the assessment included: surveys of community residents made available through social media, email distribution, website links and through paper surveys and collection boxes widely distributed in multiple locations and channels across the region; a direct email survey of community leaders and service providers representing multiple community sectors; a set of 12 community discussion groups convened across the region; and assembly of available population demographics and health status indicators.

Community engagement and information gathering 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 quantitative and qualitative information gathered through the different sources and methods was then synthesized to understand different perspectives, identify common themes and inform priorities for improvement.

The table on the next page provides a summary of the priority community health needs and issues identified through this assessment.

Summary of Community Health Needs and Issues by Information Source			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of primary care and medical sub-specialty services	Primary Health Care was the second most frequently mentioned service type people had difficulty accessing (32%). About 16% of community survey respondents also reported difficulty accessing medical sub-specialty care. 'Wait time too long' and 'Not accepting new patients' were the top reasons cited for access difficulty for both primary care and sub-specialties.	The Greater Sullivan Public Health Region has the lowest ratio of Primary Care Physician FTEs in the state – estimated at about 19 FTEs per 100k population. The Greater Sullivan region also has the third highest percentage of primary medical care visits with travel times greater than 30 minutes, one way (31%).	Issues related to health care provider availability including turnover, choice, wait time and responsiveness was the topic area with the most comments – about one quarter of more than 600 different comments on an open-ended question asking 'one thing you would change to improve health in your community'.
Cost of health care services including medications, affordability of health insurance	About 57% of community resident and 55% of community leader survey respondents indicated that the cost of health care and health insurance has 'gotten worse' over the last few years. Less than 3% thought this issue has 'gotten better'. 'Can't afford out of pocket expenses' was the top barrier identified by community leaders and service providers preventing people from accessing the health care services they need.	The estimated proportion of people with no health insurance (7%) is similar to the overall percentage in NH (6%). About 15% of area residents reported delaying or avoiding health care because of cost.	Community discussion participants identified health care costs and financial barriers to care as a significant issue. It was also the second most frequently mentioned topic area in the open-ended question about 'one thing you would change to improve health' Obstacles include high cost of private pay insurance, limitations of Medicare coverage, misalignment of coverage and the types of insurance providers accept, and unreasonably high deductibles.
Social drivers of health and well-being such as housing affordability, access to healthy foods and affordable, dependable child care	About 83% of community resident survey respondents said housing affordability has 'gotten worse' over the last few years; 1% thought this issue has 'gotten better'. Child care was the top social / human service that respondents had difficulty getting (20%). 'Cost too much' was the top reason cited for access difficulty (73%). Affordable Housing was by far the top issue selected by community leader respondents (85%) as a priority focus area for improvement to support a healthy community.	Nearly 1 in 10 area residents experience food insecurity in the past year and about 29% of households in the service area have housing costs >30% of household income. A wide range in community wealth also characterizes the service area where median household income in the wealthiest communities are twice as high as communities with the lowest median household incomes.	The high and rising costs of 'basic needs' was a common theme in discussion groups including accessing and maintaining stable, healthy housing; limited availability of quality low-income housing options; affording healthy foods; being able to pay for prescription medication, and costs of child care.

Summary of Community Health Needs and Issues by Information Source (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of mental health services	Mental Health Care was the second most frequently mentioned service type people had difficulty accessing (27%). Among people who had difficulty accessing mental health care, top reasons cited were "Wait time too long" (74%), 'Not accepting new patients' (51%) and 'Service not available' (49%).	The rate of Self Harm-related Emergency Department visits is significantly higher for residents of the Greater Sullivan Public Health Region (215 visits per 100,000 population) compared to the state overall (183 visits per 100k). Rates are highest among female residents (269 visits per 100k)	Mental health care was identified as a continuing and top priority for community health improvement in community discussion groups including concerns for insufficient local capacity, need for increased awareness and culturally competent providers. Needs were especially distinct among four populations: youth, veterans, Indigenous peoples, and individuals living with a substance use disorder.
Services for older adults including transportation, opportunities for social interaction, and supports for aging in place	About 14% of community survey respondents indicated difficulty accessing in-home support services. 'Services and resources for aging in a safe and supportive environment' was one of the top 5 most frequently identified areas by community leaders for focusing resources in support of a healthy community.	The service area population has a relatively high proportion of seniors. Overall about 24% are 65+ and more than one third of New London residents are 65 years of age or older. About 16% of the 65+ population in the NLH service area report having serious activity limitations resulting from one or more disability.	Ability to age in place was a topic raised in discussion groups and written comments with concerns expressed about shortages of workers to provide home care, issues of cost, lack of options for transportation to medical appointments and related concerns around social isolation and over-reliance on technology for information and communication.
Health and human service workforce shortages and challenges navigating the health care system	After out of pocket expenses, the top barriers identified by community leaders and service providers preventing people from accessing the health care services they need are 'Service not available; not enough local capacity' (65%) and 'Difficulty navigating the health care system' (59%).	Difficulty navigating the health care system and the related issue of workforce shortages manifests in measures of population health such as delayed care and inpatient stays for diagnoses potentially treatable in outpatient settings such as diabetes, hypertension or asthma.	This theme emerged in both discussion groups and survey comments. Health and human service providers are described as understaffed and stretched too thin for the level of need in the region. Frustration was expressed about connecting with provider staff, deterioration in customer service, difficulties navigating the process of finding and connecting with local specialists, and other complexities of the health care system.

Summary of Community Health Needs and Issues by Information Source (continued)			
Community Surveys	**Community Surveys**	**Community Surveys**	**Community Surveys**
Availability and affordability of dental care services	'Dental Care for Adults' was the most frequently selected service people had difficulty accessing (33% of community resident survey respondents). Top reasons cited for access difficulty were 'Wait time too long' (54%), 'Not accepting new patients' (42%) and 'Cost too much' (42%). Dental Services was one of the top resources residents of the Newport area indicated they would use if more available.	More than 1 in 3 area residents report not having visited a dentist or dental clinic in the past year. The Greater Sullivan Public Health Region experiences significantly more hospital emergency department visits for non-traumatic dental conditions (992 visits per 100,000 population) than in the state overall (636 per 100k).	Affordability and availability of dental care was raised as an issue in discussion groups and open-ended survey comments including the need to travel long distances outside the local service area to access dental services.

New London Hospital

2024 Community Health Needs Assessment

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A. Community Overview with Selected Service Area Demographics

The total population of the New London Hospital primary service area in 2022 was 33,192 according to the United States Census Bureau (American Community Survey) equivalent to about 2.4% of the total population of New Hampshire.

The estimated service area population has increased by approximately 0.4% or about 120 people over the last 3 years. New Hampshire's population grew by about 2% over the same time frame. Table 1 displays the service area population distribution by municipality, as well as the median age, the proportion of residents who are under 18 years of age and the proportion who are 65 and older.

Compared to New Hampshire (NH) overall, the service area population has proportionally more seniors - about 24% are 65+ compared to about 19% in NH overall – and the median age of service area residents is 6 years older than the state overall. A substantial range is observed for this statistic within the region from 18% of residents in both Newport and Springfield aged 65+ to 36% of New London residents. A similar range is observed for the percentage of residents who are under 18 years of age from 11% in Washington to 24% in Lempster.

| TABLE 1. Service Area Population by Municipality |

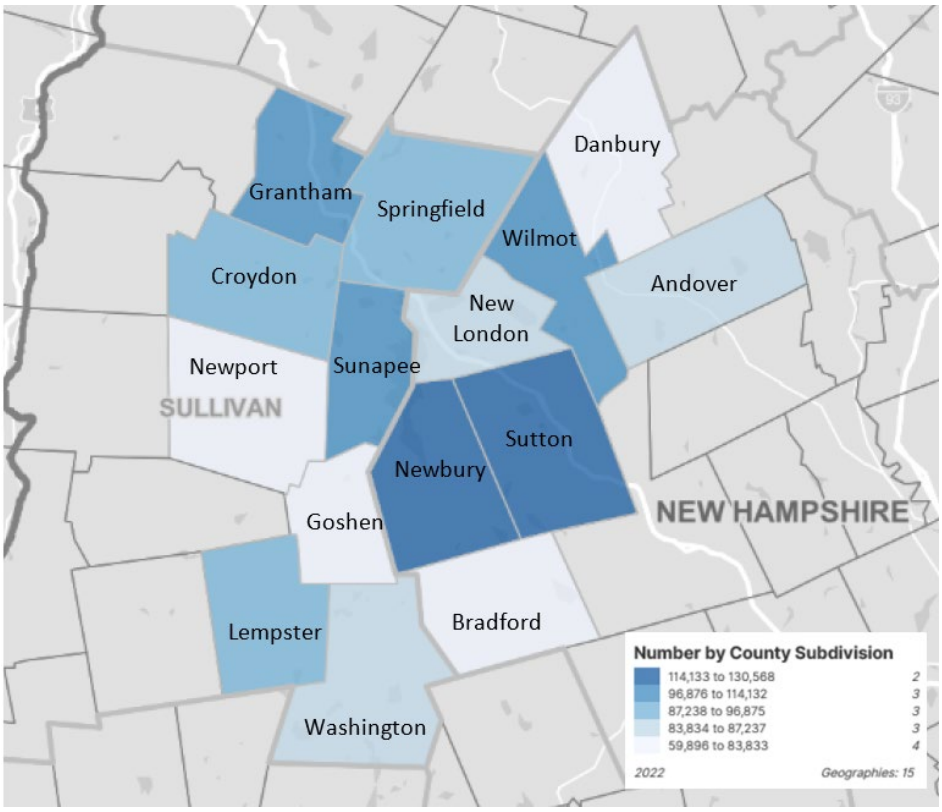
Municipality (in alphabetical order)	2022 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Andover	2,151	6%	46	16%	28%
Bradford	1,565	5%	47	22%	23%
Croydon	796	2%	51	18%	26%
Danbury	1,491	4%	49	19%	21%
Goshen	1,077	3%	51	12%	28%
Grantham	3,394	10%	52	22%	26%
Lempster	957	3%	43	24%	20%
New London	4,389	13%	52	12%	36%
Newbury	1,911	6%	49	20%	21%
Newport	6,347	19%	45	12%	18%
Springfield	939	3%	52	13%	18%
Sunapee	3,377	10%	53	12%	26%
Sutton	2,254	7%	47	19%	20%
Washington	1,042	3%	56	11%	30%
Wilmot	1,502	5%	47	18%	20%
Total NLH Service Area	**33,192**	**100%**	**49**	**16%**	**24%**
New Hampshire	**1,379,610**	**---**	**43**	**19%**	**19%**

Table 2 displays additional demographic information for the towns of the New London Hospital primary service area. The region overall has similar demographics compared to New Hampshire with regard to median household income, the percent of people living in poverty, the percent of household with children headed by a single parent, and the percent of people living with a disability. However, there is a substantial range within the region on these measures. For example, the town with the highest median household income community (Sutton, $130,568) has median household income over twice as high as the lowest income community (Goshen, $59,896). Similarly, a substantial range is observed for the percent of people living below the federal poverty level (FPL) with an estimate of 0% in Grantham compared to about 13% of residents in Danbury and 14% of residents in Newport and Sunapee. Overall, the percent of residents within the service area living below the federal poverty level mirrors the statewide percentage at about 7% of households. The map on the next page displays the distribution of median household income across towns in the service area.

| TABLE 2. Selected Demographic and Economic Indicators |

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Sutton	$130,568	3%	7%	9%
Newbury	$116,250	3%	4%	9%
Grantham	$114,132	0%	22%	9%
Wilmot	$110,917	2%	29%	7%
Sunapee	$102,361	14%	25%	14%
Croydon	$96,875	10%	41%	13%
Springfield	$95,833	4%	48%	6%
NLH Service Area	**$92,548**	**7%**	**24%**	**12%**
New Hampshire	**$90,845**	**7%**	**27%**	**13%**
Lempster	$89,000	7%	45%	9%
New London	$87,237	3%	3%	12%
Andover	$86,591	10%	26%	11%
Washington	$84,886	3%	35%	12%
Bradford	$83,833	7%	38%	8%
Newport	$74,263	14%	34%	16%
Danbury	$62,500	13%	35%	15%
Goshen	$59,896	7%	6%	23%

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



Median Household income ranges from $59,896 in Goshen to $130,568 in Sutton

As displayed by Table 3, 96% of the population of the New London Hospital service area identifies as 'White' and about 2% identify as Hispanic ethnicity. In general, the service area is somewhat less diverse with regard to race and ethnicity compared to New Hampshire overall.

| TABLE 3. Race and Ethnicity Characteristics |

Area	Race							Ethnicity
	White	Black / African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Other Race	2 or more races	Hispanic or Latino
NLH service area	96.0%	0.5%	0.3%	0.5%	<0.1%	0.2%	2.4%	1.9%
New Hampshire	90.0%	1.5%	0.2%	2.6%	<0.1%	1.1%	4.6%	4.3%

Social Drivers of Health: Household wealth and poverty are examples of Social Drivers of Health (SDOH; also referred to as Social Determinants of Health). Social Drivers of Health are conditions in the places where people live, learn, work, and play that can directly or indirectly affect risks and outcomes related to health and wellness. Examples of SDOH include: availability of quality healthcare; access to affordable, healthy food; educational performance and attainment; transportation; safe, quality housing; employment status and opportunities; public infrastructure; and other social, economic, and environmental factors. The World Health Organization (WHO) Commission on Social Determinants of Health has stated that progress on SDOH can be the most successful means of enhancing all people's well-being and addressing disparities in health outcomes. Further, numerous studies suggest that SDOH can account for between 30-55% of health outcomes.[1] Social drivers of health can be influenced by social and economic policies, as well as community health improvement initiatives. As displayed by Table 4, SDOH can be categorized in five categories.

Because of the potential importance of SDOH in affecting community health outcomes and opportunities for improvement, the 2024 Community Health Needs Assessment included aspects of SDOH in the community survey content and community discussion group topics. Results of those assessment activities are shared beginning on the next page.

| TABLE 4. Social Drivers of Health |

Economic Stability	Physical Location & Environment	Development & Education	Community, Safety & Social Context	Food	Health Care System
• Employment • Income and Wealth • Expenses and Debt • Health insurance • Financial safety net	• Housing affordability, quality • Transportation • Walkability • Safety of built environment • Parks, green space • Recreation, leisure opportunities • Clean air and water	• Literacy • Language • Early childhood development • Strong families • Vocational training • Higher education	• Community engagement • Community support systems, social capital • Stress • Exposure to violence, trauma • Community safety, crime, justice • Discrimination, stigma	• Food security • Access to affordable, healthy food options	• Health professional and Pharmacy availability • Access to culturally appropriate and respectful care • Quality of care

Adapted from the Kaiser Family Foundation[2]

[1] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

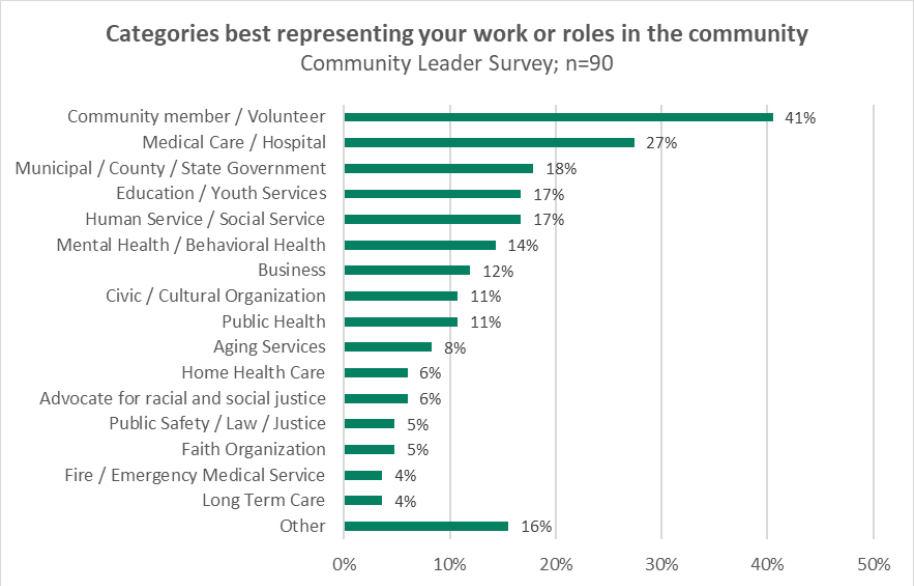
[2] Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, Kaiser Family Foundation Issue Brief, 2018.

B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and April 2024, the Community Health Needs Assessment committee fielded two surveys; one with targeted distribution to community leaders and one broadly disseminated to residents across the region. The survey instruments were designed to have some questions in common to facilitate comparisons and contrasts in the analysis.

The community leader survey was distributed via unique email link to 350 individuals in positions of leadership in agencies, municipalities, business, civic and volunteer organizations serving the combined service areas of the partner organizations ranging from the Greater New London / Newport area to the Upper Valley communities of New Hampshire and Vermont. The survey distribution list was developed by the planning committee. With the understanding that some organizational leaders may be more familiar with some areas of the wider region than others, the survey instrument asked respondents to identify 'the areas you primarily serve or are most familiar with'. Of the 350 partners invited to participate in the Community Leader Survey, 206 completed surveys (59% response). Of the 206 respondents to the Community Leader survey, 90 (44%) indicated being familiar with the Greater New London / Newport area. The results included in this assessment report from the community leader survey are specific to that group of 90 respondents. Figure 2 displays the range of community sectors represented by these individuals. (Note: Respondents could identify as representatives of more than one sector).

| Figure 2 |



The community resident survey was distributed electronically through email and social media communication channels, on the New London Hospital website, promoted through posters and fliers with links and QR codes posted around the region, and by paper copies made available at a variety of distribution points throughout the region including libraries, clinics, community meetings and Meals on Wheels programs.

A total of 1,351 community members completed the Community Resident Survey, representing all 15 towns of the New London Hospital primary service area as well as a number of bordering communities. Table 5 below displays the grouping of respondents by community. Among respondents who provided information on their current local residence, about 17% are residents of New London and about 15% are residents of Newport or Croydon (shared 03773 zip code). Among survey respondents who indicated their primary residential location, about 7% are located beyond the primary hospital service area with the most common locations being Warner (about 2% of respondents), Claremont (1%), Franklin, Henniker and Concord (each <1%).

Compared to the regional demographics overall, community survey respondents were proportionally older and more likely to be female. Approximately 18% of respondents have household income of less than $50,000, while 38% reported household income of $100,000 or more. About 13% of respondents did not provide household income information. Table 6 below displays selected characteristics of respondents to the community survey.

| TABLE 5 |

Town	# of respondents	% of total*
New London	202	17%
Newport, Croydon	179	15%
Sutton	100	9%
Grantham	84	7%
Andover	67	6%
Springfield	62	5%
Washington	61	5%
Bradford	57	5%
Sunapee	56	5%
Newbury	49	4%
Lempster	48	4%
Goshen	43	4%
Danbury	42	4%
Wilmot	36	3%
Other locations	87	7%

***Percent of respondents who provided information on the location of their residence. About 13% of respondents did not provide this information.**

| TABLE 6 |

Age < 45 years	Age > 65 years	Woman	Black, Indigenous and People of Color
25%	37%	76%	3%
Household Income < $50K	**Household Income > $100K**	**Currently Uninsured**	**Currently has Medicaid coverage**
18%	38%	2%	5%

1. Progress on Community Health Priorities and Concerns

Assessments of community health needs are conducted every three years by New London Hospital and partner organizations. Over the course of these assessment cycles, a relatively consistent pattern has been observed with regard to the priority issues and concerns identified for health improvement by the community. Among these priorities have been:

- cost of health care services including health insurance and prescription drugs;
- access to behavioral health services including mental health care and substance use treatment;
- availability of health care services including primary care and medical sub-specialties;
- senior services and concerns of aging;
- availability and affordability of dental services; and
- affordability and availability of basic needs including housing, healthy food and child care.

In consideration of this observed consistency over time, the 2024 Community Health Needs Assessment asked respondents to the Community Resident and Community Leader surveys to reflect on a set of statements describing the main priorities and themes identified in the recent past by indicating if there has been improvement or not in those areas. Specifically, the surveys included the following statement and question:

> *"In past surveys like this one, people have said that the health needs listed below are the most important for us to work on. Do you think these needs have gotten worse, are about the same, or have gotten better in the last few years or so?"*

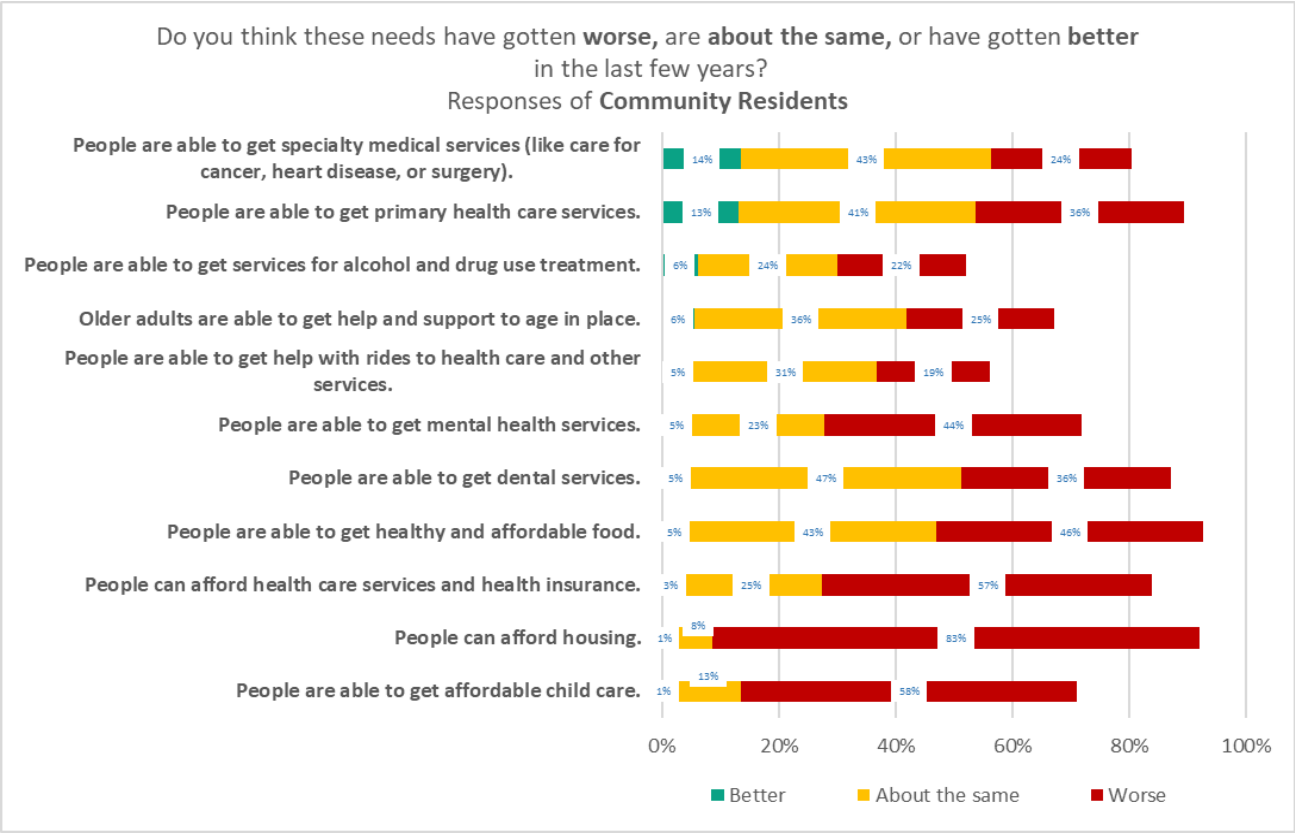
Figure 3 on the next page displays the results for this question set for respondents to the community resident survey. In general, more community residents reported needs getting worse compared to those reporting needs getting better in each of the topic areas over the last few years.

More than 50% of survey respondents indicated the ability to afford housing, child care and health care services has gotten worse. The only two areas where more than 10% of respondents indicated needs had gotten better are ability to get primary health care services (13% said it is 'Better') and specialty medical services (14% 'Better').

> *"Lack of child care makes it so at least one parent has to work a low paying job to be able to pick up and drop off children from school. Almost impossible to find jobs like that never mind being able to afford child care if you do find it."*
>
> *- Community Resident Survey Respondent*

> *"Make health care more affordable. Even with insurance, out of pocket costs are skyrocketing."*
>
> *- Community Resident Survey Respondent*

| Figure 3 |



Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the need is Better. Totals do not equal 100%, because the response choice of "Don't Know" is not displayed.

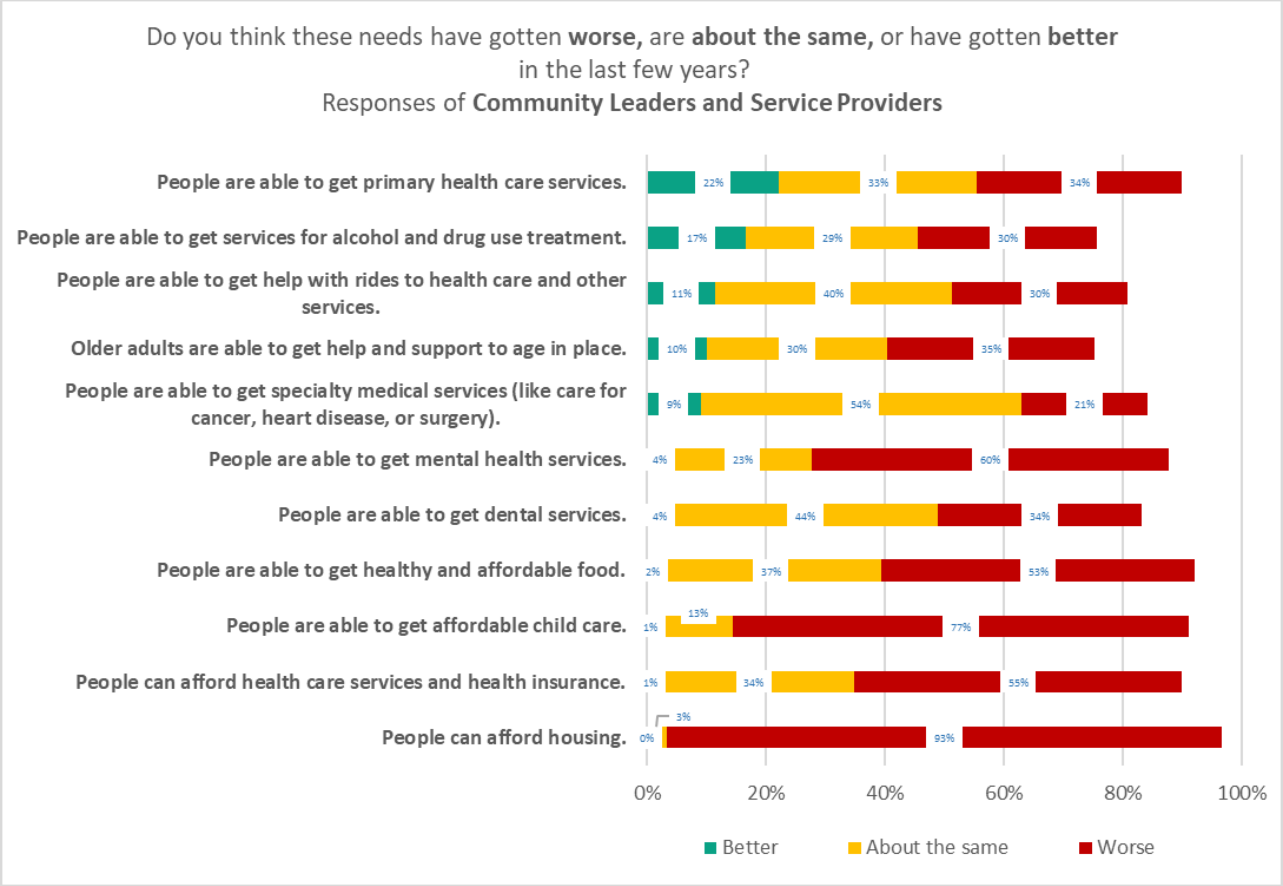
Figure 4 on the next page displays the results for the same question set for respondents to the survey of community leaders and service providers. A similar pattern is observed with community leaders also more likely to indicate needs have gotten worse than better.

As with respondents to the community resident survey, more than 50% of community leader survey respondents indicated the ability to afford housing, child care and health care services has gotten worse. In addition, more than 50% of community leaders report that ability to get mental health services and to afford healthy food has gotten worse. Areas where more than 10% of community leaders indicated needs have gotten better are ability to get primary health care services (22% said it is 'Better'), ability to get substance use treatment (17%, Better), ability to get

> *"(Need) Significant increase in affordable housing. It impacts everyone, including the ability of health care professionals to live and work here, and the ability of people in our community to be safe and comfortable, and to have resources available for other needs such as nourishing food and health care costs."*
>
> *- Community Leader, Civic sector*

rides to health care and other services (11%, Better) and ability of older adults to get help and support to age in place (10%, Better).

| Figure 4 |

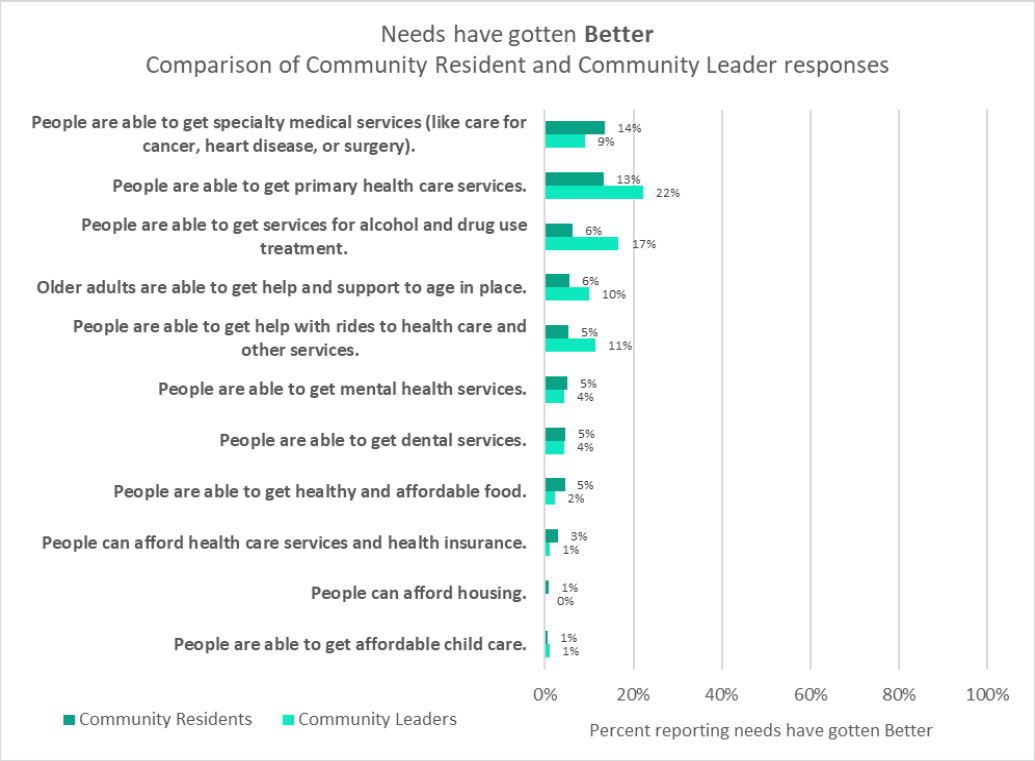


Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the needs are Better. Totals do not equal 100%, because the response choice of "Don't Know" is not displayed.

The two charts on the next page display comparisons of community residents and community leaders for the percentage of respondents who report needs have gotten better (Figure 5) and the percentage who report needs have gotten worse (Figure 6). In general, there is a high degree of agreement and consistency between the two response groups: agreement with regard to substantially more respondents reporting needs have gotten worse for each topic than those who report needs are better; and general consistency in the order of topics with the greatest number of respondents indicating a need has gotten worse (e.g., issues of affordability are at the top including housing, child care, health care, and food).

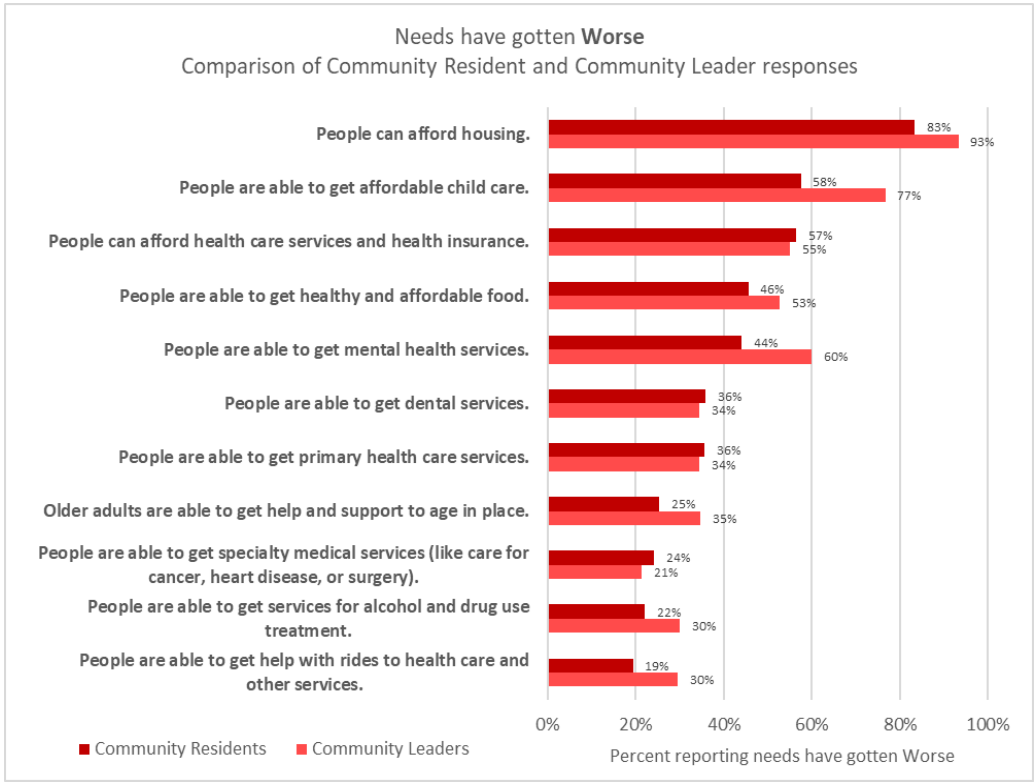
> *"Services are increasingly unaffordable - so even if people can get access to appointments and get there, they can't necessarily afford them."*
>
> *- Community Leader, Human Service sector*

| Figure 5 |



Note: Statements are shown in order of highest to lowest percentage of community resident respondents indicating the needs are Better.

| Figure 6 |

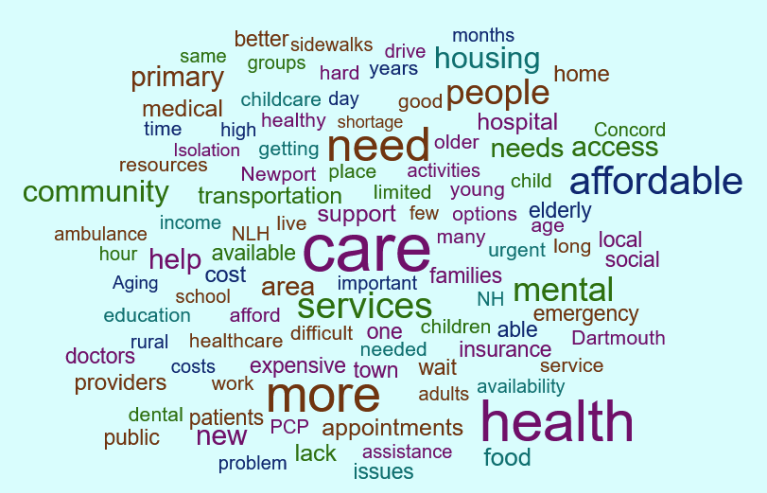


Note: Statements are shown in order of highest to lowest percentage of community resident respondents indicating the needs are Worse.

Also of note, community respondents were more likely to select “Don’t Know” for certain topics including child care, help with rides, substance use treatment and mental health services.

Both surveys also included an open-ended question following the list of historical priority areas asking, **"Are there other health needs that you think are important for your community to address now?".** A total of 455 comments were received in response to this question. The most common topic areas included:

1. Health care provider availability in general and primary care in particular; wait times, patient-provider communication and service delivery improvements (more than 25% of all comments addressed this area of concern);
2. Senior services and concerns of aging;
3. Availability of mental health services;
4. Opportunities and facilities for social interaction; activities for children, youth and families; reducing social isolation;
5. Affordable health care;
6. Affordable housing;
7. Improved access to transportation services;
8. Cost of living; basic needs
9. Emergency Medical Service capacity; ambulance response times
10. Improved communication of available services and resources
11. Affordable child care



> *"Experienced primary health care providers, as well as specialists are in very short supply locally! My experience in the last 20 years in this region is that newer less experienced professionals are coming and going!"*
>
> *- Community Resident Survey Respondent*

> *"Speaking as a senior citizen I feel affordability and accessibility are issues for health care, food and housing . . . . Of all the Healthcare needs I found vision care the least accessible and of reliable quality."*
>
> *- Community Resident Survey Respondent*

2. Characteristics of a Healthy Community

The Community Resident survey included a series of fourteen statements that collectively can describe characteristics of a healthy and resilient community. The statements addressed topics such as availability and affordability of basic needs, availability of health services, social opportunities, sense of community connection and perceptions of the community as a good place to live (e.g., a good place to raise children; a good place to grow old). Survey respondents were asked to think of the area they consider to be their community and to then indicate whether they Agree or Disagree with each statement.

Figure 7 displays the results for this set of questions. Community residents overall were most likely to agree that 'in my community':

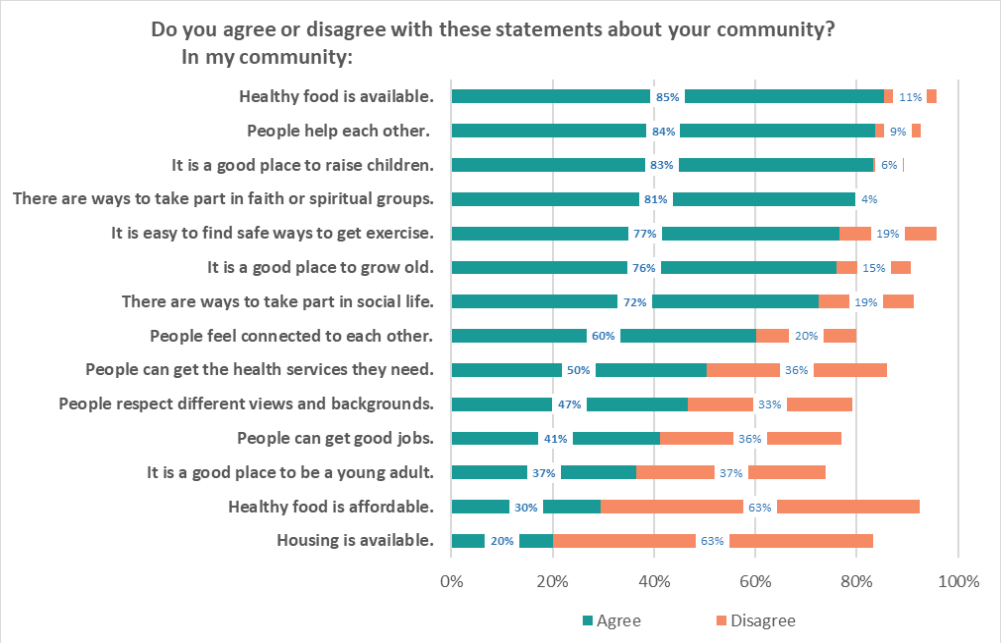
- Healthy food is available. (85% of survey respondents agree)
- People help each other. (84%)
- It is a good place to raise children. (83%)
- There are ways to take part in faith or spiritual groups. (81%)

Community residents overall were least likely to agree that 'in my community':

- It is a good place to be a young adult. (37%)
- Healthy food is affordable. (29%)
- Housing is available. (20%)

| Figure 7 |

Regarding access to health services, responses were mixed with 50% agreeing with the statement "People can get the health services they need" and 36% disagreeing with the statement (14% responded 'Don't know; Not sure).

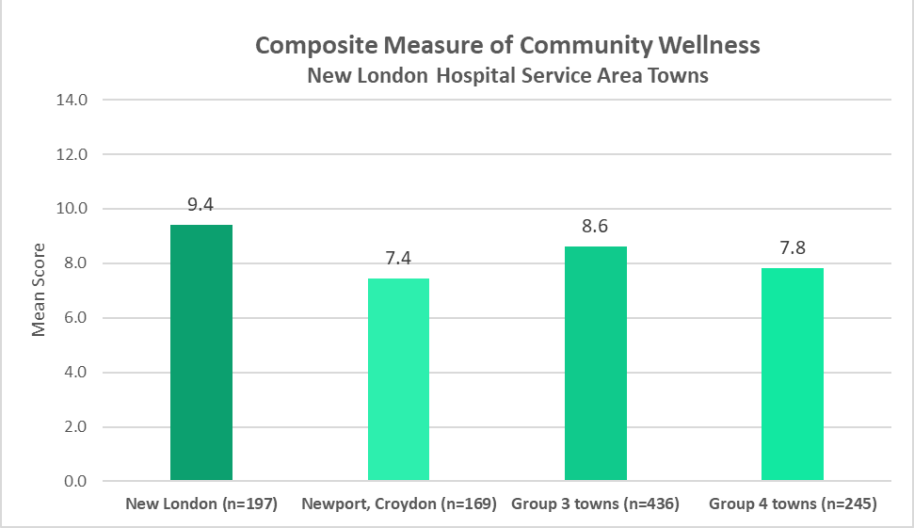


Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents who Agree with each statement. Totals do not equal 100%, because the response choice of "Don't Know" is not displayed.

Further analysis of this set of questions was conducted by calculating a composite measure of 'community wellness' for each respondent with possible scores ranging from zero to fourteen (14 questions, each question with possible values of 1 or 0) where a score of 14 results when a respondent indicates agreement with each of the 14 statements describing characteristics of a healthy and resilient community. Scores were then aggregated for 4 sets of communities within the New London Hospital service area: (1) New London, (2) Newport and Croydon (zip code 03773) (3) service area towns that are within 20 minutes drive time on average to New London Hospital (Andover, Grantham, Newbury, Springfield, Sunapee and Sutton); and (4) communities that are more than 20 minutes drive time to New London Hospital (Goshen. Danbury, Lempster, Bradford, and Washington). In addition to being further distance from New London Hospital, the latter group of towns also collectively have substantially lower median household income ($75,476) than the group of towns (group 3) in more proximity to New London Hospital ($108,957).

Figure 8 displays the mean Composite Measure of Community Wellness calculated from the responses from residents for each of these community groupings. The mean score for New London (9.4) is significantly different and higher than the mean scores for each of the other town groups (One-Way ANOVA, p<=.001). The mean score for the towns closer to New London Hospital (Group 3, 8.6) is significantly different (p<.001) and higher than the remaining town groups, while the difference in scores between Newport/Croydon (7.4) and the Group 4 towns (7.8) is not statistically significant. (Note: Data from respondents not reporting a residential location or indicating locations outside the NLH hospital service are not included in this analysis).

| Figure 8 |



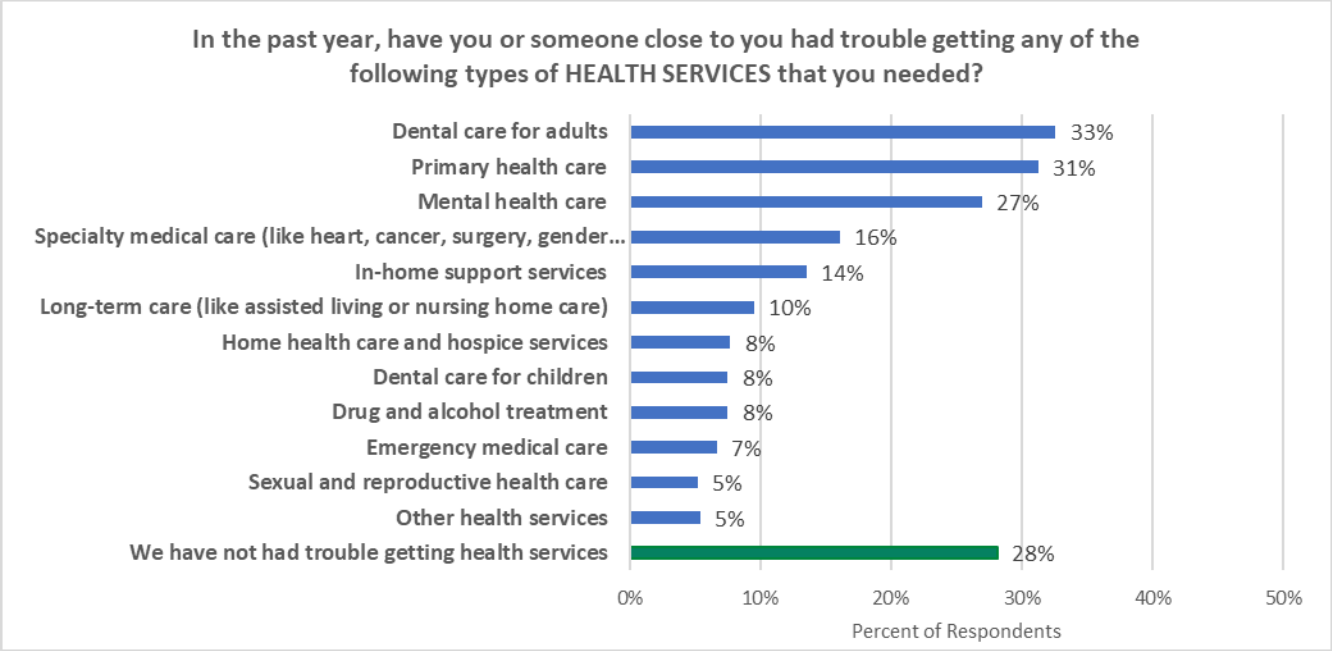
"I believe more focus needs to be paid to Newport Health Center and their patient population's unique needs, and building community there. Also, we need to work on creating opportunities to strengthen community and combat loneliness."

- Community Leader, Health care sector

3. Barriers to Services

Respondents to the Community Resident survey were presented with a list of potential health services and asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **health services** that you needed?"*. As displayed by the chart below, about 33% of respondents reported having difficulty getting 'Dental care for adults' and 31% had difficulty getting 'Primary health care' over the past year. Other more frequently cited services for access difficulty included 'Mental health care' (27%) and 'Specialty medical care' (16%).

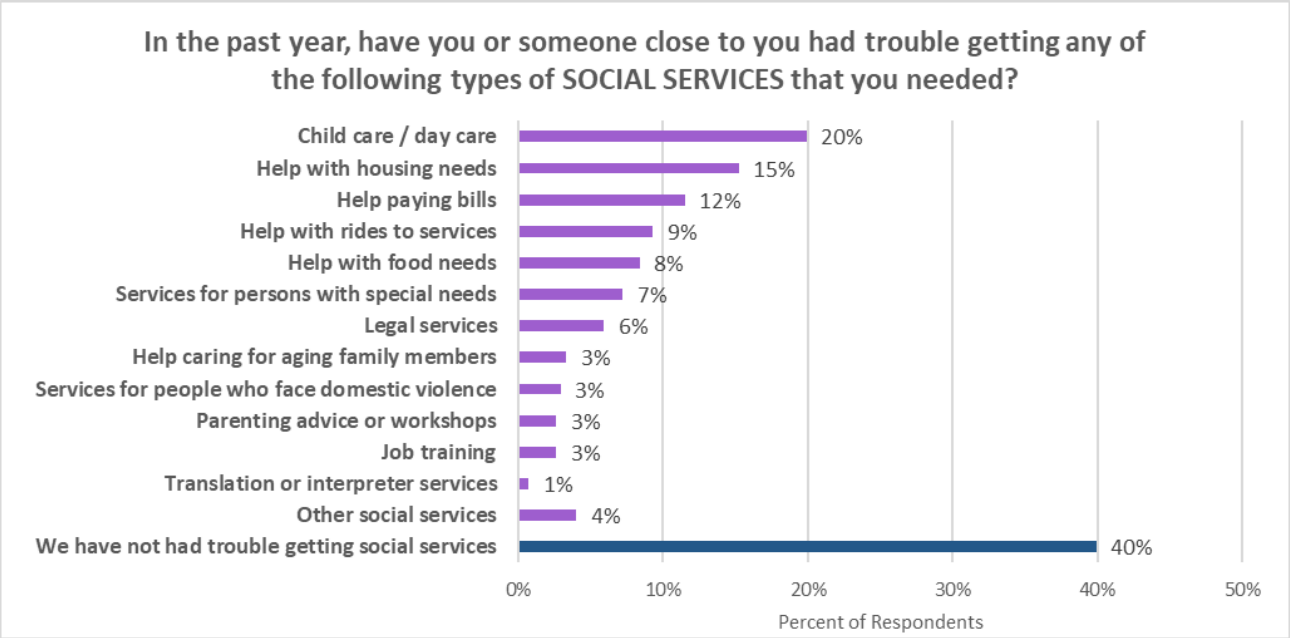
| Figure 9 |



On a similar question, the Community Resident survey asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **social services** that you needed?"*. As displayed by the chart on the next page, about 20% of respondents indicated having difficulty getting 'Child care / Day care' and 15% had difficulty getting 'Help with housing needs' over the past year. Other more frequently cited social services for access difficulty included 'Help paying bills' (12%) and 'Help with rides to services' (16%).

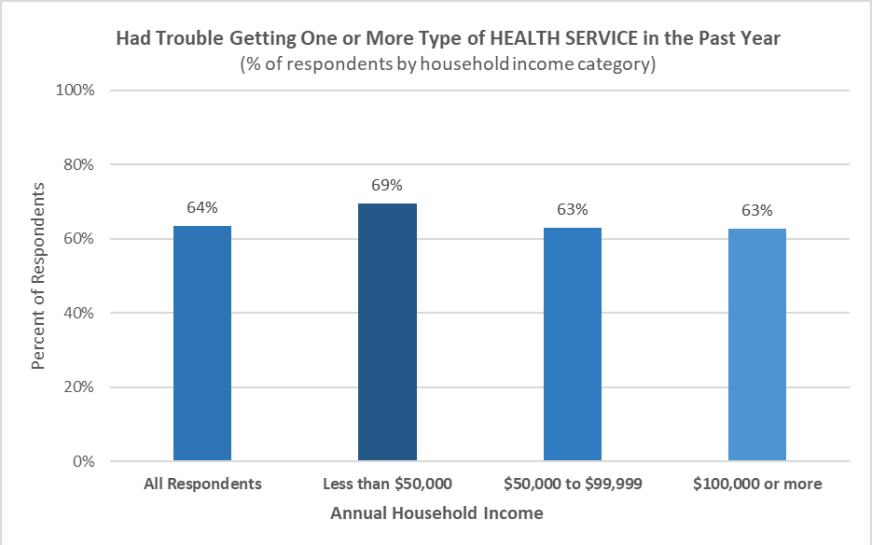
> *"Shortage and turnover of hygienists and many dentists retiring has caused the need to travel more than 40 minutes for dental care and the need to change practices twice in the same year!"*
>
> *- Community Resident Survey Respondent*

| Figure 10 |



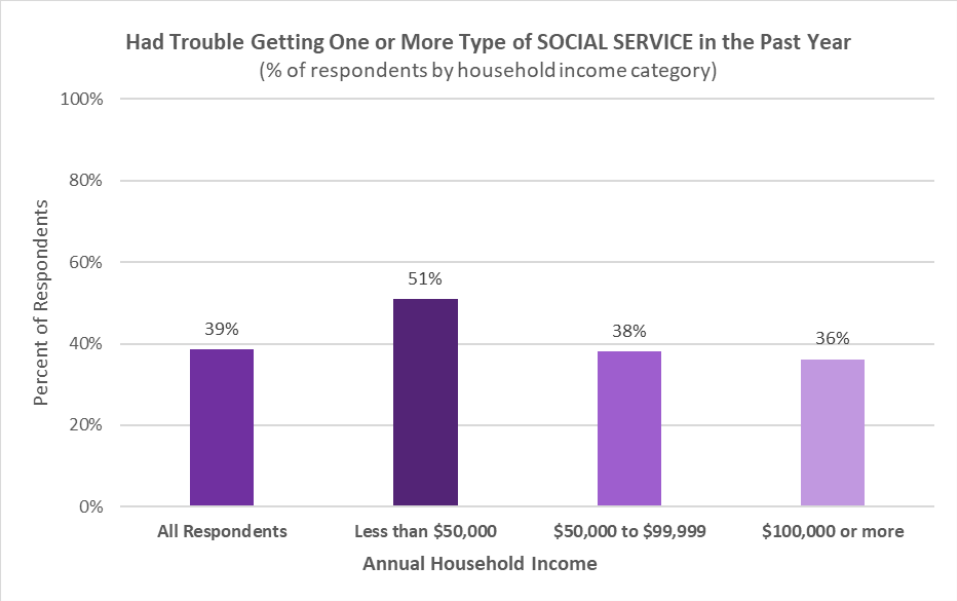
In general, survey respondents were more likely to report difficulties accessing health services than social services, which is presumably a function in part of different proportions of the population attempting to access health services or social services within a defined period of time. Overall, nearly two-thirds (64%) of all survey respondents reported having difficulty accessing at least one type of health service. Figure 11 displays the percentage of survey respondents reporting any access difficulty by income category. Respondents with household income less than $50,000 were slightly more likely to report difficulty accessing at least one type of health service, although this difference is not significant statistically.

| Figure 11 |



As displayed by Figure 12, about two of every five survey respondents (39%) reported having difficulty accessing at least one type of social service. About half of respondents (51%) with household income less than $50,000 reported difficulty accessing at least one type of social service, which is a statistically significant difference compared to households with higher incomes (p<.001).

| Figure 12 |



Survey respondents who reported difficulty accessing services in the past year for themselves or a household member were asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 7, "Wait time too long" was the most common reason cited for difficulty accessing each of the top four types of health care services including 76% of people who indicated difficulty accessing Specialty Medical Care services and 74% of those having difficulty accessing mental health services. Other common reasons consistently cited across service types were "Service not available" and "Not accepting new patients". Issues of cost were somewhat more commonly reported for Adult Dental Care with 42% of people reporting "Cost too much" and 40% reporting "No insurance or not enough insurance".

"We need more doctors, nurses and support staff to make delivery of health care better and at least as importantly, to remove some of the awful stress our providers suffer."

- Community Resident Survey Respondent

"Accessing mental health services is incredibly challenging for Sullivan County. Primary care providers are continually put in a position of filling dual roles to bridge the gap between specialties."

- Community Leader, Health care sector

| TABLE 7. Top Reasons Respondents Had Difficulty Accessing Health Care Services by Type of Service |

(Percentages are of those respondents who reported difficulty accessing a particular type of service)

DENTAL CARE FOR ADULTS (n=410, 33% of respondents)	PRIMARY HEALTH CARE (n=394, 31% of respondents)	MENTAL HEALTH CARE (n=340, 27% of respondents)	SPECIALTY MEDICAL CARE (n=203, 16% of respondents)
54% of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Wait time too long"** as a reason	**63%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Not accepting new patients"** as a reason	**74%** of respondents who indicated difficulty accessing Mental Health Care also selected **"Wait time too long"** as a reason	**76%** of respondents who indicated difficulty accessing Specialty Medical Care also selected **"Wait time too long"** as a reason
Not accepting new patients (42%)	**Wait time too long (63%)**	**Not accepting new patients (51%)**	**Service not available (41%)**
Cost too much (42%)	**Service not available (38%)**	**Service not available (49%)**	**Not accepting new patients (35%)**
No insurance or not enough insurance (40%)	**Cost too much (22%)**	**Cost too much (37%)**	**Cost too much (31%)**
Service not available (33%)	**No insurance or not enough insurance (21%)**	**No insurance or not enough insurance (34%)**	**No insurance or not enough insurance (26%)**

Other survey options included: Not open when I could go, Did not know where to go, Had no way to get there, No internet access, Language barriers, My race or ethnicity not welcome, My gender or sexual orientation not welcome, My culture or religion not welcome, Other reasons (write-in)

Survey respondents who reported difficulty accessing social services were similarly asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 8, "Cost too much" was the most common reason (73%) cited for difficulty accessing 'Child Care / Day Care' and also for 'Help with housing needs' (60%). About three of every five people who reported difficulty getting child care services also cited 'Not accepting new clients' (62%) and 'Service not available' (61%) as reasons.

The most common reason cited for difficulty getting 'Help with paying bills' was "Did not know who to call" (38%). About 22% of people who had difficulty getting 'Help with paying bills' also cited 'Shame or stigma' as a reason. Among people who needed 'Help with rides to services', the most common reason for access difficulty was 'Service not available' (74%).

> *"It can be hard for people suffering from poverty related issues to recognize the community level services that could support them. People don't always feel that their need is sufficient to justify outside support and there can be stigma attached to poverty."*
>
> - *Community Resident Survey Respondent*

| TABLE 8. Top Reasons Respondents Had Difficulty Accessing Social Services by Type of Service |

(Percentages are of those respondents who reported difficulty accessing a particular type of service)

CHILD CARE / DAY CARE (n=245, 20% of respondents)	HELP WITH HOUSING NEEDS (n=187, 15% of respondents)	HELP PAYING BILLS (n=141, 12% of respondents)	HELP WITH RIDES TO SERVICES (n=115, 9% of respondents)
73% of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason	**60%** of respondents who indicated difficulty accessing Help with Housing Needs also selected **"Cost too much"** as a reason	**38%** of respondents who indicated difficulty accessing Help Paying Bills also selected **"Did not know who to call "** as a reason	**74%** of respondents who indicated difficulty accessing Help with Rides to Services also selected **"Service not available"** as a reason
Not accepting new clients (62%)	**Service not available (44%)**	**Service not available (33%)**	**Did not know who to call (40%)**
Service not available (61%)	**Wait time too long (41%)**	**Cost too much (33%)**	**Cost too much (28%)**
Wait time too long (58%)	**Did not know who to call (27%)**	**Shame or stigma (22%)**	**Had no way to get there (27%)**
Not open when I could go (12%)	**Not accepting new clients (19%)**	**Wait time too long (19%)**	**Wait time too long (23%)**

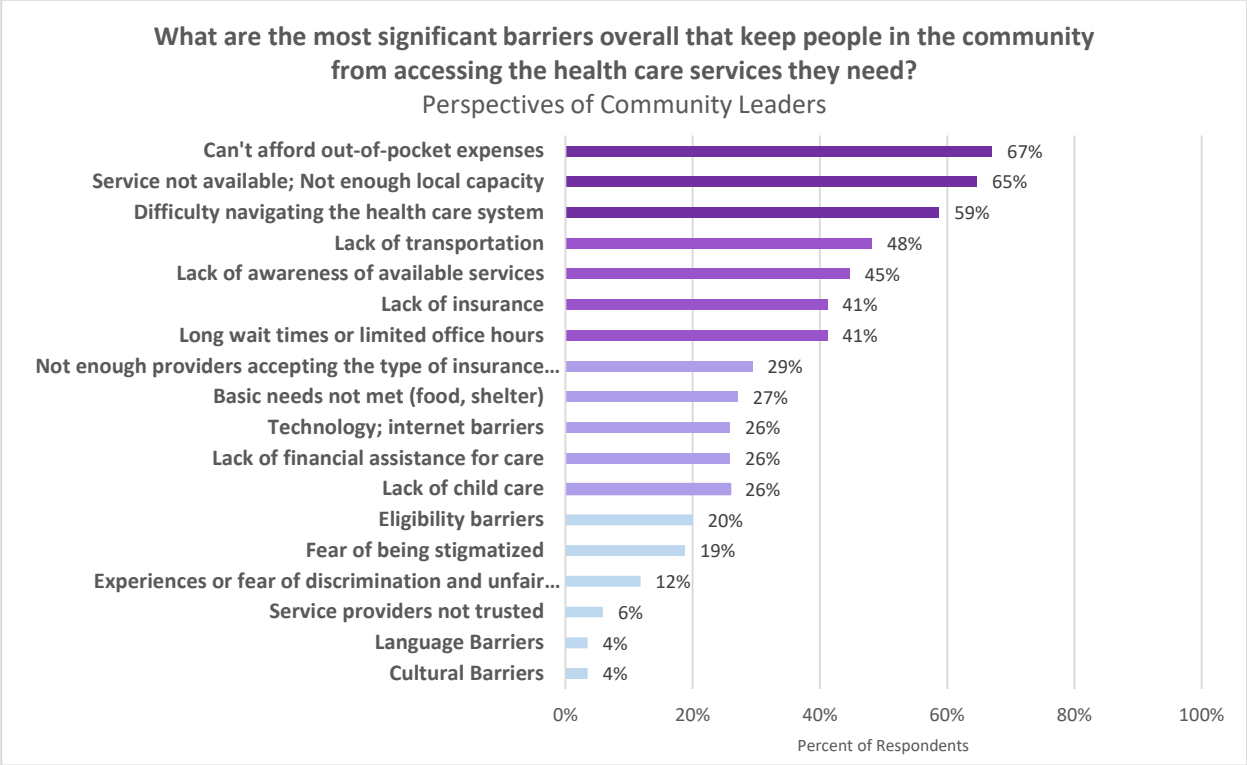
Other survey options included: No internet access, Language barriers, My race or ethnicity not welcome, My gender or sexual orientation not welcome, My culture or religion not welcome, Other reasons (write-in)

> *"(Need) Local transportation to more than just medical visits. Social isolation is a significant issue in our rural communities and lack of transportation plays a significant role in this."*
>
> *- Community Leader, Public Safety sector*

In a separate question, Community Survey respondents were asked: ***"In the past year, how often have you or someone close to you missed getting health care or social services because of unfair treatment?"***. Unfair treatment' was further specified as "discrimination or stigma based on your race, religion, ethnicity, gender, sexual orientation, age, disability, language, or education". Overall, 1.6% of respondents indicated that they or someone in their household had **"Often"** missed getting health care or social services because of unfair treatment, 8.8% indicated **"Sometimes",** and 89.7% 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 survey included a list of 18 potential barriers (and a write-in option) from which respondents were asked to select the top 4 barriers to health care access. The top issue identified by this group was 'Can't afford out-of-pocket expenses' (67% of community leaders chose this barrier), followed by 'Service not available; not enough local capacity' (65%) and 'Difficulty navigating the health care system' (59%).

| Figure 13 |

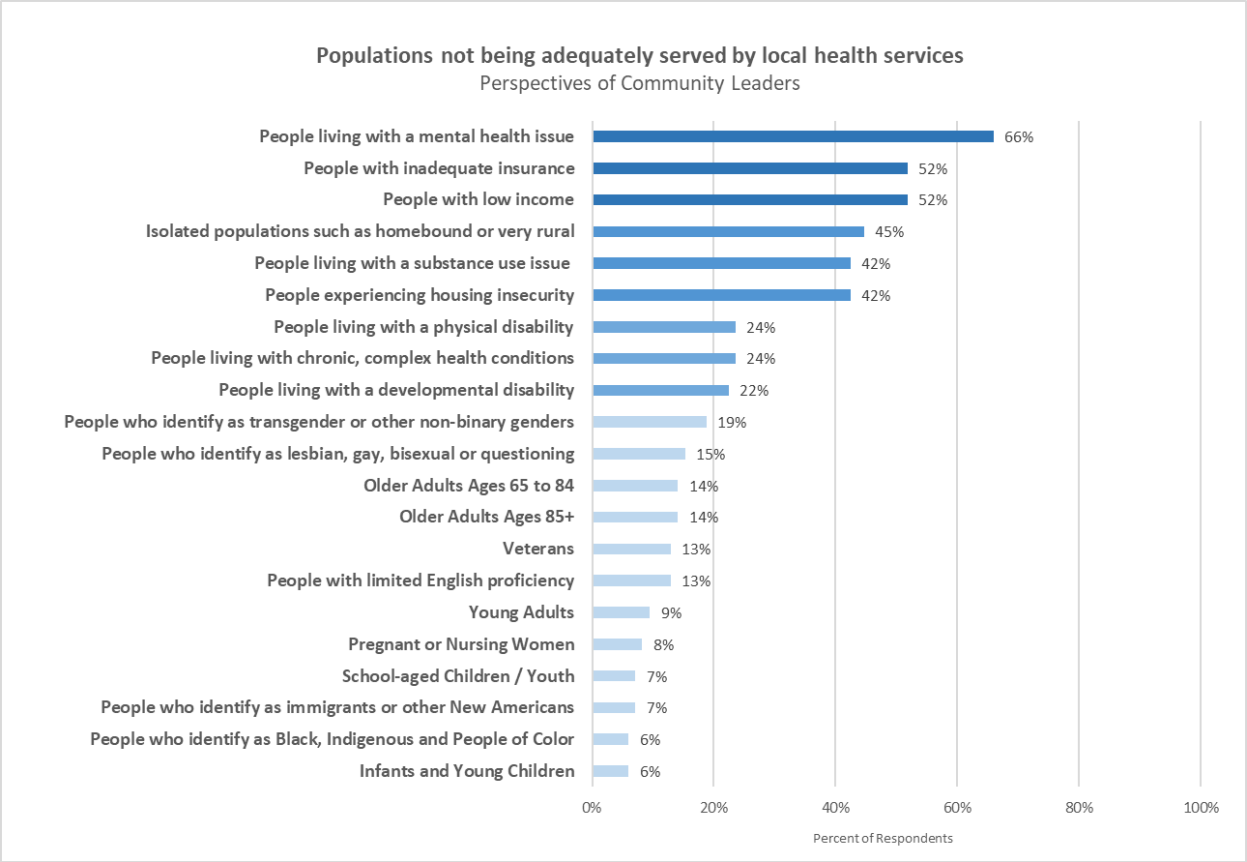


Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. As displayed by Figure 14, populations most frequently identified by Community Leader respondents as underserved were people living with a mental health issue, people with inadequate health insurance and people with low income.

In a related question, Community Leaders were asked, "Are there particular types of health providers, specialties or services that are needed in the community due to insufficient capacity or availability?" Nearly three-quarters of respondents (71%) responded affirmatively. By far, mental health was the most commonly cited service with insufficient capacity or availability (59% of those indicating any specific type of provider or service) followed by about 24% of community leader respondents reporting a need for additional primary care providers. These results for underserved populations and provider capacity needs are similar to the results of the 2021 Community Health Needs Assessment.

> *"We desperately need more counselors and mental health providers. We have so many patients on waiting lists for 1-3 years who need help now."*
> *- Community Leader, Behavioral health sector*

| Figure 14 |



"Mental health counselors are booking out months and months for appointments - that is not helpful for folks who need help now. There has to be a better way and more availability for the immediate needs that come up in this area."
- Community Leader, Business sector

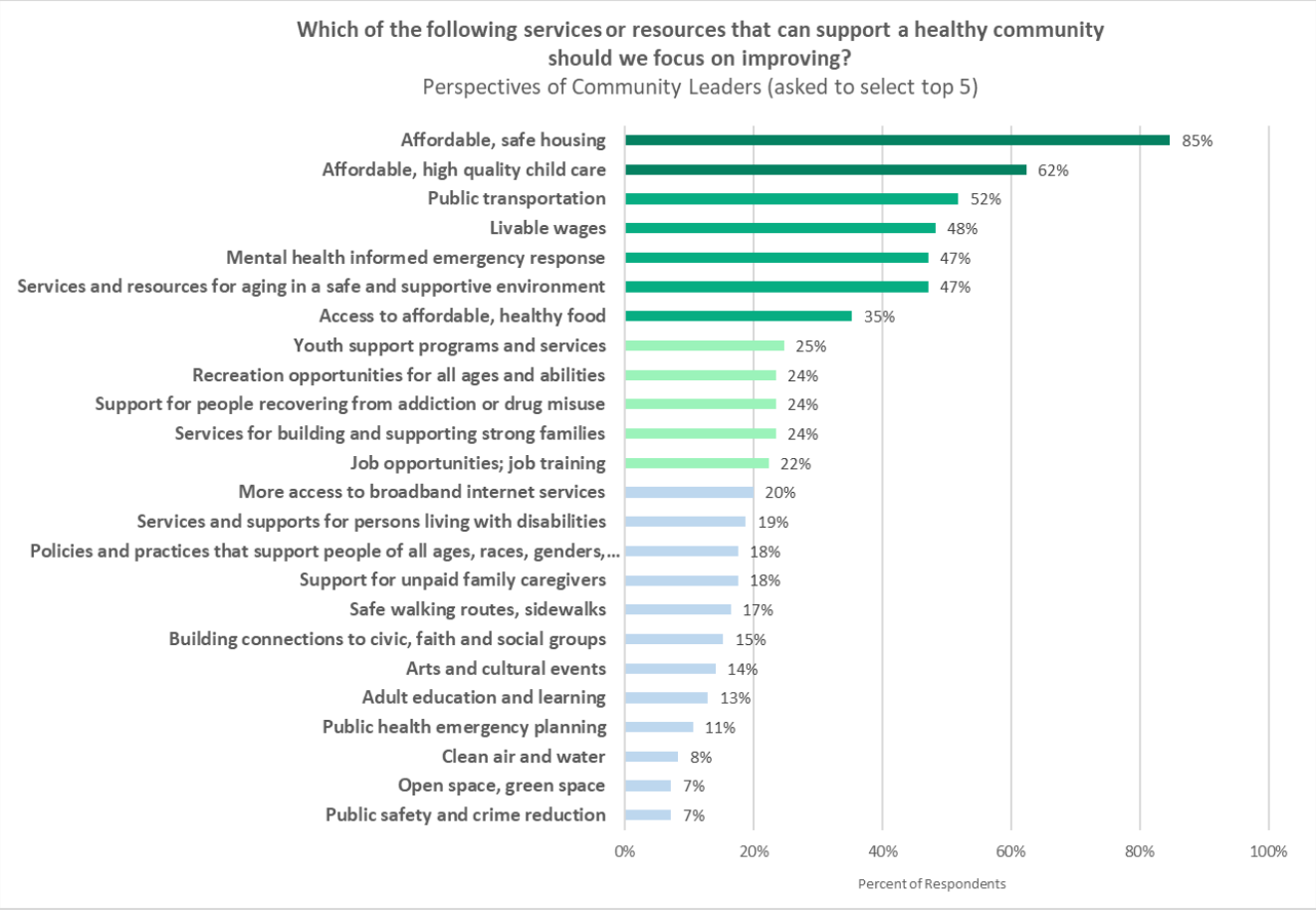
"(Need) Facilities/programs/services so that elders like me could age in place. It's heartbreaking when people who have been essential members of the community need elder care and have to be separated from all their connections and friends/families and their memories. Having an affordable 'senior cluster neighborhood' (a simpler version of Havenwood in Concord, with different levels of care, and strong community connections) would be immensely beneficial.
- *Community Resident Survey Respondent*

4. Services and Resources to Support a Healthy Community

Community leaders were asked to select the top 5 services or resources supporting a healthy community that should be focused on from a list of 24 potential topics (plus an open-ended 'other' option). Sometimes described as social drivers of health, the items included in this question generally describe underlying community attributes that indirectly support the health and well-being of individuals and families. On the survey instrument, the topics were organized into 6 overall conceptual groups described as follows: Basic Needs; Community Safety; Family Services and Supports; Infrastructure and Environment; Jobs and Economy; Welcoming Community. Survey respondents could select any of the individual topics from across the different topic groups.

As displayed by the chart, 'Affordable, safe housing' was by far the most frequently selected resource; identified by 85% of respondents as an area the community should focus on to support community health improvement. Other top focus areas are Affordable, high quality child care; Public transportation; Livable wages; Mental health informed emergency response; Services and resources for aging in a safe and supportive environment; and Access to affordable, healthy food.

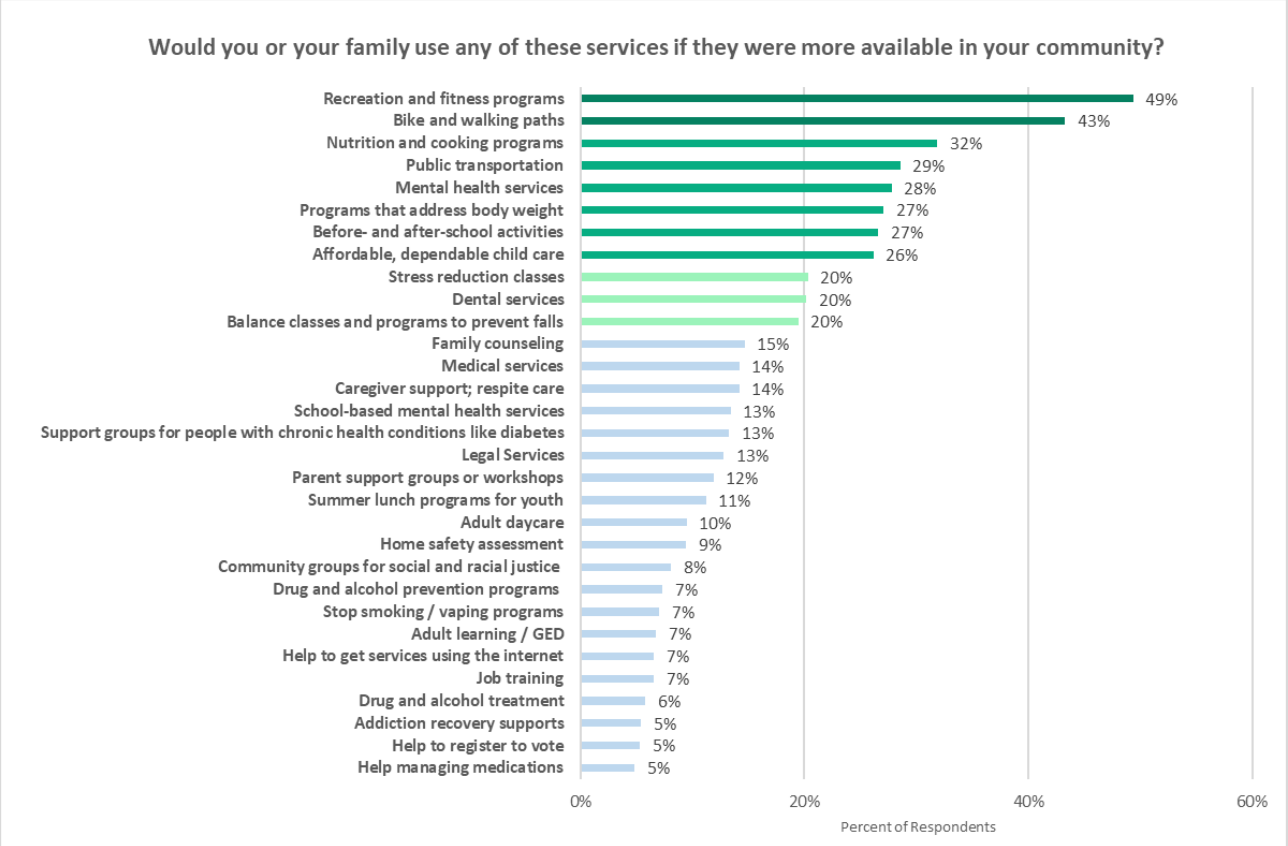
| Figure 15 |



5. 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, "**Would you or your family use any of these services if they were more available in your community?"** The survey instrument included a list of 31 topics organized into 6 overall conceptual groups as follows: Services for Children and Parents; Services for Older Adults; Healthy Living Programs; Counseling and Mental Health Services; Health Care Services; Community Services and Supports. Survey respondents could select any number of individual topics from across the different topic groups. As displayed by the chart, the highest amount of interest was reported for using Recreation and Fitness programs and Biking and Walking Paths. Other services most frequently mentioned were nutrition programs, public transportation, and mental health services. These results are very similar to the results from the 2021 Community Health Needs Assessment when the top 5 services or resources selected were the same.

| Figure 16 |



"I think creating areas for people to safely take walks, for various ages, is important since exercise is important. There are few towns with either sidewalks or parks to do this, forcing many to walk in parking lots or on roads where cars are driving too fast."

- *Community Resident Survey Respondent*

The table below displays the top programs or services of interest by age group. 'Recreation and Fitness programs' and 'Biking and Walking Paths' were frequently selected across age groups as resources that people would use if more available. Respondents under age 45 were more likely than older respondents to select 'Before- and after- school activities' and 'Affordable, dependable child care', while respondents age 65 and older were more likely to choose 'Public Transportation' and 'Balance classes / programs to prevent falls' than other potential items on the list of services. Table 9 also includes a breakout of responses from people with children (under 18) in their household. These results are similar in proportion and sequence to the results for the under 45 age group.

| TABLE 9. Top services or resources people would use if more available, by Age Group |

Age 18-44 (n=299)		Age 45-64 (n=438)		Age 65+ (n=442)		Households with children (n=383)	
Recreation and fitness programs	64%	**Recreation and fitness programs**	52%	**Recreation and fitness programs**	39%	**Recreation and fitness programs**	59%
Before- and after-school activities	60%	**Bike and walking paths**	44%	**Bike and walking paths**	32%	**Before- and after-school activities**	56%
Bike and walking paths	61%	**Nutrition and cooking programs**	38%	**Public transportation**	31%	**Bike and walking paths**	53%
Affordable, dependable child care	59%	**Mental health services**	34%	**Balance classes and programs to prevent falls**	31%	**Affordable, dependable child care**	49%
Mental health services	43%	**Programs that address body weight**	32%	**Nutrition and cooking programs**	21%	**Mental health services**	40%
Nutrition and cooking programs	40%	**Public transportation**	27%	**Programs that address body weight**	19%	**Nutrition and cooking programs**	35%
Programs that address body weight	33%	**Stress reduction classes**	25%	**Dental services**	14%	**Programs that address body weight**	30%

Table 10 on the next page displays results for the same question about services people would use if more available by the same groups of service area towns described previously for the analysis of a Community Wellness measure. The top three services for which people indicated interest are basically the same across town groups - Bike and walking paths, Recreation and fitness programs, Nutrition and cooking programs. More notable differences are observed for Dental Services, which is the 7th most frequently selected service type by residents of Newport/Croydon and the Group 4 towns (those more distant from NLH); and also for Affordable, dependable child care, which is the 4th most frequently selected service of interest by residents of the Group 3 towns (those closer to NLH). Respondents from Group 3 towns (closer to NLH) and Newport/Croydon were also more likely to select Before- and After-School Activities.

| TABLE 10. Top services or resources people would use if more available, by Town Group |

New London (n=202)		Newport, Croydon (n=179)		Group 3 Towns (n=454)		Group 4 Towns (n=251)	
Bike and walking paths	53%	**Recreation and fitness programs**	43%	**Recreation and fitness programs**	52%	**Recreation and fitness programs**	53%
Recreation and fitness programs	49%	**Bike and walking paths**	41%	**Bike and walking paths**	46%	**Bike and walking paths**	35%
Nutrition and cooking programs	33%	**Nutrition and cooking programs**	37%	**Nutrition and cooking programs**	30%	**Nutrition and cooking programs**	30%
Public transportation	31%	**Before- and after-school activities**	34%	**Affordable, dependable child care**	30%	**Programs that address body weight**	30%
Balance classes and programs to prevent falls	24%	**Public transportation**	31%	**Before- and after-school activities**	30%	**Mental health services**	30%
Programs that address body weight	23%	**Programs that address body weight**	31%	**Mental health services**	29%	**Public transportation**	26%
Mental health services	22%	**Dental services**	30%	**Public transportation**	28%	**Dental services**	26%

The 2024 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you think would improve health in your community, what would you change?"* A total of 659 survey respondents (49%) provided written responses to this question. Table 11 provides a summary of the most common responses by topic theme.

"Access to care - local hospitals and clinics seem understaffed so that it is difficult to get appointments and when you do they are stressed, rushed and under significant pressure to reduce costs and time to the facility, which negatively impacts quality of care to patients."
- Community Resident Survey Respondent

"Build more affordable housing for young people starting out. Hospital workers, teachers, restaurant workers have to travel to far from here for jobs in our community."
- Community Resident Survey Respondent

"Healthy Food is way too expensive. In the past few years prices have skyrocketed . . . . Without healthy food affordable to everyone, health will deteriorate and more will need health care and hospital care. That is the number one issue in my opinion. The cost of groceries is not sustainable."
- Community Resident Survey Respondent

"(Need) Information about services available. I found them, but it's a lot of looking and asking. One place with current (and correct) information would be nice."
- Community Resident Survey Respondent

| TABLE 11 |

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

Health care provider availability including primary care and other specialties; workforce shortages; health care delivery system improvements including wait times, patient-provider communication, quality and options	**155 comments (24% of total)**
Affordability of health care including prescriptions, low cost or subsidized services; health insurance costs; health care payment reform	**73 (11%)**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness	**57 (9%)**
Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition	**52 (8%)**
Affordable housing; workforce housing	**43 (7%)**
Caring community, culture; community diversity and acceptance; facilities and opportunities for social interaction; reducing social isolation	**33 (5%)**
Availability, affordability of mental health services; mental health awareness and stigma	**31 (5%)**
Senior services; concerns of aging; home health care, assisted living	**30 (5%)**
Basic needs including livable wages, cost of living, poverty and employment (note: comments specific to affordable food or affordable housing grouped separately above)	**29 (4%)**
Improved transportation services, public transportation; medical transportation	**27 (4%)**
Healthy lifestyle education; focus on wellness and prevention; resources for supporting healthy youth and families	**26 (4%)**
Affordable child care; before and after school programs	**19 (3%)**
Affordability, availability of dental services	**18 (3%)**
Community Safety; physical infrastructure and accessibility	**18 (3%)**
Improved awareness, communication of available services and resources	**13 (2%)**
Substance misuse prevention including tobacco; substance use treatment; illegal drug availability	**8 (1%)**
Emergency Medical Service Improvements	**6 (1%)**
Improve schools / educational system	**5 (1%)**
Address political division, political discourse	**5 (1%)**
No changes; other comments	**11 (2%)**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

1. Overview

Over the period from March to May 2024, the Community Health Needs Assessment Planning Committee worked with community partners to convene discussion groups and key informant interviews (KIIs) and with NH residents representing various communities of different lived experiences and perspectives.

In total, 12 discussion groups and/or KIIs were conducted, eight of which were specifically focused on the New London Hospital service area and four included a broader regional focus with residents from other cities and towns within the wider Dartmouth Health system's service area.

The discussion groups and KIIs sought to identify more in-depth qualitative input on common health needs and issues; to identify perceived improvements in services, supports, or resources; and to gather suggestions from participants about what healthcare organizations could do better to support our communities' health. As part of the discussion activities, priority issues from similar community conversations were shared and participants were asked if they thought those issues were still the most important and if there are new or different issues that are a higher priority. Those former priorities (informed by previous Community Health Needs Assessments) were:

- Cost of health care services, affordability of health insurance
- Availability of primary care and specialty medical services
- Availability of mental health services
- Alcohol and drug use prevention, treatment, and recovery
- Services for older adults including in-home supports for aging in place
- Social and economic factors affecting health (like affordable housing, transportation, food, and child care)

A total of 68 individuals participated in groups and interviews. An optional survey recording participant demographics was completed by 45 participants (66%). Table 12 shares the demographic composition of those participants.

| TABLE 12. Discussion Group Participant Demographics |

Gender (n=45)			Age (n=39)			
Woman	Man	Other gender identity	18-34	35-54	55-64	65+
55%	43%	2%	36%	31%	23%	10%

2. Health Concerns and Priorities – Main Themes

The following sections summarize the main health-related themes identified through the discussion groups and interviews. Anonymous comments are included to more directly illustrate important themes.

These sections outline responses to the first three questions asked of discussion group and interview participants:

1. *What do people you know worry about most when it comes to their health and their family's health?*
2. *A few years ago, a similar round of community conversations helped to identify some high priority health issues for our region. Some of these priorities were:* (list displayed, reviewed) *Do you think these are still the most important health-related issues for our community to address?*
    - Cost of health care services, affordability of health insurance
    - Availability of primary care and specialty medical services
    - Availability of mental health services
    - Alcohol and drug use prevention, treatment, and recovery
    - Services for older adults including in-home supports for aging in place
    - Social and economic factors affecting health (like affordable housing, transportation, food, and child care)
3. *Are there other health issues that should be added to the list or are of a higher priority?*

Community participant responses to these questions have been summarized into six priority health sections based on common recurring discussion group themes:

- Access
- Provider Education and Cultural Competence
- Costs of Living
- Mental Health
- Community Resources and Services Awareness
- Process and Bureaucratic Limitations

Access

With regard to what people worry about most when it comes to their health, and what should be (or, in this instance, remains) a high priority, nearly all participants echoed the same concern in some form: *access*.

The issue of access in these discussions took the shape of two main motifs: accessibility, or ease of access, and availability. It was noted in nearly every discussion group that the availability of health-related services and resources was a major issue, with participants further indicating that accessing care of all kinds was a barrier to living their healthiest lives.

Accessibility. Healthcare access in general continues to be a recurring issue. Challenges concerning healthcare access included workforce shortages and recruitment challenges (especially in rural communities where this can be compounded by a lack of housing options, lack of entertainment/social opportunities, etc.), long wait times when scheduling appointments, and emergency room misuse. Several times primary care access was mentioned specifically, and participants indicated that either they or people they know are choosing to stay with a primary care physician (PCP) who does not understand/know them, who they do not trust, and/or who they do not feel supported by because they do not know if they will be able to find a new PCP in a timely manner – if at all. Other specific types of access issues that were frequently identified included:

> *"People are staying with providers who don't understand them or fit them. It boils down to being a trust issue – but they're not leaving them to find better care because access is so poor."*

- availability of mental health services
- dental care providers
- prenatal care
- diabetes management support programs
- specialty services in general

> *"Dental care is a real concern for patients; we'll see abscesses that they're embarrassed to get treated, their teeth are painful and that affects food intake, and their mental wellbeing deteriorates even more."*

Availability. Availability of general community services and resources that have a direct influence on health and well-being were discussed at length. These issues include:

- ***Senior care.*** Several groups noted that the availability of staff to help seniors age in place and remain in the home was severely limited, as well as concerns of whether available caregivers were properly trained. An accessibility issue identified among senior participants or participants who care for seniors was technology as the primary information medium. The use of patient portals and the reliance on online resource libraries and information acts as a barrier to seniors who do not have smart devices or computers, do not know how to use them or access those platforms, or may be physically incapable of utilizing these options due to issues with sight.
- ***Housing.*** Both the lack of available housing units and the increasing costs of rent and utilities were noted as major obstacles to overall well-being and people's ability to thrive. Options for lower-income housing that are safe and healthy were noted as being extremely limited in several discussion groups.

> *"The housing situation is, for lack of a better word, gross. It's unattainable, even for people in the mid- to higher-socioeconomic scale. Once something affordable comes up, it's grabbed immediately."*

- ***Food.*** Access to nutritious food and programs that increase availability and affordability of healthy foods was also central theme of many discussions. Expanding access to food

assistance programs (WIC, SNAP, food stamps, etc.) was a recurring suggestion to help mitigate the high costs of food.

- ***Child care.*** Noted as limited and extremely expensive, discussions centered around child care being a central concern to participants. Workforce shortages and the lack of adequate pay as a deterrent to staffing were noted as compounding problems.
- ***Public transportation.*** Lack of accessible transportation options underlay many health issues identified, with participants noting that this problem worsened the ability to access healthcare services, healthy foods, job opportunities, safe and/or affordable child care, etc. Lack of transportation as it relates to preventive healthcare is also an obstacle: "if services aren't accessible or within walking distance, folks don't go and the health concern can snowball into something worse and more expensive."
- ***Community spaces and programming.*** Access to communal spaces, programs, activities, and entertainment was discussed with increasing importance among participants. All of the communities in this service area are considered rural, and many lack social opportunities that more densely populated and/or urban communities have access to. This was a central discussion among parents/caregivers living in rural areas with more limited ability to form connections and friendships.

"Access" as a theme is broad. It encompasses many health issues that overlap and underlie each other: a lack of public transportation, for instance, can serve as a barrier to social supports and opportunities, which can increase mental health challenges and loneliness, which drives the need for mental health services to outpace the availability of mental health providers. Increased housing expenses can compound the cost of child care, which in turn affect a household's ability to afford healthy foods, which can lead to a deterioration of overall health. The discussions followed this sense of interconnectedness among access to health-related resources, services, and care. There are multiple examples of the ways in which the availability and ease of access to these priorities can influence community health and wellness, and the difficulties of addressing any one, singular issue without addressing this interconnectedness.

> *"It's incredibly frustrating when a parent asks for a reference to a provider who is knowledgeable and culturally competent and I can't give them one."*

Provider Education and Cultural Competence

The theme of provider education and cultural competence was also raised frequently in conjunction with issues of access and availability. The term 'providers' here not only refers to health care professionals, but also to community leaders who provide a service that influences health and well-being (teachers, counselors, school leadership, community program coordinators, etc.).

Provider stigmas and judgment. Ensuring all health care providers are thoroughly trained and equipped to provide care to minority populations was a priority among participants and specifically

discussed with respect to racial minorities, indigenous communities, the LGBTQIA+ community, and veterans.

Participants who are a part of one (or multiple) of the aforementioned communities spoke of feeling judged and/or misunderstood, occasionally with the sense that ensuring inclusive and understanding care is not a priority of their provider(s). Even when biases or judgment occur unintentionally or unconsciously, as participants noted most often are the case, it does not lessen the negative effects of the experience. Examples of such experiences include the use of stigmatizing language, not using or being aware of preferred pronouns, a lack of respect regarding individual privacy, and perpetuating hurtful stereotypes or misinformation. Several accounts of healthcare professionals projecting their personal beliefs, feelings, or assumptions onto patients/students/clients were shared, along with an abiding feeling of being invalidated by a professional's biases or lived experiences.

"Our communities are telling us who they are – we need to reflect that back to them."

Intersectionality. The need for providers to be trained on the many forms of intersectionality that their patients experience was repeated. Participants felt that healthcare professionals and community leaders (especially teachers/counselors) often don't understand the ways in which multiple forms of inequality, discrimination, or privilege could significantly affect a person's ability to navigate social situations, access effective health care services, or simply feel represented. Chronic minority stress was a continuing theme throughout these discussions.

"I get a lot of paperwork from PCPs that misgender a child, use the wrong pronouns, or are very insensitive to the young person's identity."

LGBTQIA+ education and representation. A population frequently referred to in the groups and interviews was the LGBTQIA+ community. Participants noted that students they know who are a part of this community often experience bullying, which is seen as a significant issue in some schools that are ill-equipped to address these problems. It was noted that well-intentioned teachers or counselors who want to help, but do not have appropriate training on how to work with LGBTQIA+ youth, can also cause mental and emotional damage.

"It's harder for people of color who are also queer, it's harder for people of color who are also queer and income insecure, etc. etc. This is not to say it's not hard for others, but intersectionality can compound already existing obstacles. Trans or queer experiences can differ tremendously depending on race, income, background, or other factors."

Healthcare for transgender individuals was also a common topic with emphasis on the need for keeping up with research / learning. "A lot of trans folks feel like they have to educate their doctors."

Education and training. Education and continuous training for providers of all forms was offered as one solution for many of the challenges participants face in this area. Topics for training opportunities, professional development, and increased awareness included:

- Patient-centered care
- Naming stigmas and discrimination/unconscious bias
- Intersectionality and minority stress
- Using supportive language
- Understanding Indigenous cultural practices
- Understanding queer relationships and signs of abuse
- Awareness of mental health issues experienced by veterans, exacerbated through service and unit dynamics

> *"Counselors that are well trained and won't perpetuate stereotypes and myths are needed more than ever."*

Costs of Living

Many participants cited costs as being a major barrier to achieving optimal health, including healthcare costs and the overall rising costs of living and basic needs.

Healthcare and insurance. When asked if participants felt any of the prior six health priorities were still important, '*Cost of health care services, affordability of health insurance'* was repeatedly identified as a significant issue. Individuals noted different insurance-related obstacles to paying for care, including the cost of private pay insurance being too high, limitations of Medicare coverage, the misalignment of what health insurance carriers cover and what types of insurance providers accept, and unreasonably high deductibles.

> *"Delayed care because of the cost of services only translates to increased costs due to a higher complexity of the care then needed."*

A common concern noted throughout groups and interviews was how many people will avoid getting medical care they need because of the costs associated, including the fear that their insurance may not cover certain prescriptions, procedures, or tests, leaving them with the bill. Avoidance of care due to cost concerns can erode a person's health, exacerbating health issues that could have been addressed or prevented before they become serious and more expensive to treat.

Social drivers of health. Another issue discussed throughout discussion groups and interviews revolved around the generally high – and rising – costs of what participants referred to as 'basic needs.' Specifics of these needs included many of the social drivers of health (SDOH): accessing and maintaining stable, healthy housing; the limited availability of quality low-income housing options; affording healthy foods; being able to pay for prescription medication, and; spending the majority of their monthly income on child care were all issues raised in the discussions. Issues associated with costs of living were common across all participants, though they were noted as being particularly acute and chronic for the unhoused population, those living with a substance use

disorder and seeking treatment options, seniors seeking home care or assisted-living options, Indigenous populations, and members of the LGBTQIA+ community.

Mental Health

Mental health as a priority is another widely-encompassing issue. "Availability of mental health services" was a priority identified during the previous community health needs assessment, and was the most frequent response to the question "*Do you think these [previously identified health priorities] are still the most important health-related issues for our community?"*

> *"Speaking to the mental health piece of it, psychiatrists cannot handle the mental health needs of our community. There has been so much effort. The need outpaces the workforce and our infrastructure."*

The other themed sections in response to discussion group questions encompass this topic in many ways: **access** to mental health services, **provider education** on mental health awareness, increased **awareness** of community mental health resources and services, and so on. But as mental health concerns were indicated in every discussion as an intrinsic and pervasive need, the topic merits its own designation.

Throughout the discussion groups and interviews, the need for mental health services and *culturally competent* providers was perceived as being higher than ever. This was especially distinct among four populations: youth, veterans, Indigenous peoples, and individuals with a substance use disorder.

Youth. The mental health of young people – as well as the availability of mental health professionals for young people – was a chronic concern among discussion groups. Finding pediatric and adolescent mental health resources was described as challenging, and many participants who had lived experience trying to access these said they were most often referred outside the local area for services (virtual care as a sole option was also noted, though whether this was viewed as a positive or negative was unclear). Other challenges included:

- Extremely long waitlists for even intake appointments (before knowing if a provider is a good fit for a child/teen)
- High costs associated with care and barriers to ensuring insurance coverage
- A lack of culturally competent providers (e.g. providers trained in how to work with children of queer parents, how to work with LGBTQIA+ children, gender-affirming care, etc.)
- A theme of intersectional trauma being a rising concern was clear, with a need for providers who can work

> *"Accessing culturally responsive mental health services is such an enormous issue. Kids have to split themselves into pieces to get any kind of help - they'll talk about depression with a therapist, but not gender identity or body dysmorphia. The emotional experience and message that sends to our young people is so damaging."*

with young people in full context of their identity (race, class, ability, gender identity, sexual orientation, body size, etc.)

Participants who were providers or parents/caregivers themselves remarked on how youth are increasingly feeling overwhelmed and don't have the assurance that things will get better. Many identified the COVID-19 pandemic as a cause or aggravating factor, lending to mental and behavioral health issues for students who were taken out of school during developmentally formative years.

Veterans. The need for mental health care among veterans was the focus of several group conversations. It was noted that the VA tends to have very long wait times and lacks services for specific conditions, both making it challenging for needs to be met in a reasonable timeframe.

> *"The veteran population… is about 20-30 years behind the cultural shift in accepting mental health and behavioral health services, yet the need is substantial… the stigma is more intense than in the general population."*

Another focus was regarding mental and behavioral health stigmas among veterans that stem from military culture. One contributor discussed at length challenges associated with the feeling of needing to be 'mentally tough' for the military unit. This included the sense that mental health challenges may be perceived as a burden to unit cohesion, and this may condition individuals to feel like they can't admit to, discuss, or seek help for mental health concerns. Participants noted feeling as though they needed to mask any potential vulnerabilities, whether physical, emotional, mental, or spiritual.

Ensuring providers are equipped to work with veterans who experienced such conditions is essential, as is raising awareness and acceptance of mental health care among veterans and active duty members.

Indigenous communities. Conversations with members of Indigenous communities revealed the necessity of mental health care among this population. Providers lacking the context and nuances of Indigenous culture can negatively impact their patients, and deter them from seeking further help. A shortage of mental health care options for Indigenous individuals was also highlighted as an issue, with care related to the transition from reservation life to living off reservation being of heightened importance. Many individuals who go through this transition struggle with losing existing services they received, making new connections, and adjusting to their new environment.

Individuals with Substance Use Disorder (SUD). Stigmas surrounding addiction and a general misunderstanding of substance use disorders was noted as a priority, as was the effect these issues have on the mental health of someone living with an addiction or disorder. The lack of appropriately trained mental healthcare providers aggravates this growing need, and the issues triggered by untreated mental health issues among this community were flagged as unmistakable and significant.

Community Resources and Services Awareness

A chronic problem identified through all discussions concerned community resources and services – both in terms of their general availability (or lack thereof) and regarding lack of awareness of what is available.

Awareness. Many participants expressed challenges with understanding what services and resources were available to them locally. Specific struggles identified among groups included:

- Alcohol and drug use – participants were unaware of what services supporting prevention, treatment, and harm reduction exist in their communities, how to find that information, or how to access any existing services (finding places to live that are close to services or have transportation options to them).
- Parent/guardian resources – participants with young children or school-aged kids were not sure of community resources they could utilize to find child care services and payment support, afterschool programming, supplemental educational resources, and more. They also expressed a lack of efficient communication from schools, noting situations where they would receive conflicting information either from teachers directly, school administration, school websites or newsletters.
- Caregiver support – caregivers expressed they were unaware if resources existed that may be available to help support their families (financially, emotionally, socially, etc.) as well as to support their own mental, social, and emotional needs. Whether support groups for caregivers exist or how to find those was noted as well.
- Senior services – throughout the discussion groups, adults with senior parents, caregivers, providers, and seniors alike all shared a frustration with existing senior services not being advertised or shared widely. Examples of services they were only recently made aware of include ambulatory assistance programs for seniors who are prone to falls (e.g., stand assist lift), Meals on Wheels eligibility, access to well person checks, etc.

Availability. Many of the frustrations surrounding resource awareness outlined above were echoed when participants discussed availability of similar services within their communities. Discussions included a lack of services or resources relating to:

- Alcohol and drug use – specifically harm reduction services and the asynchronous delivery of substance misuse treatments (e.g., Naloxone being available at one facility but not another).
- Caregiver support – participants who provide care to loved ones expressed a lack of support services, both for their loved ones and to help them cope with caregiver stress and fatigue, including caring for their mental, social, and emotional needs.

- Senior services – the limited availability of personal, non-medical care services for seniors who need or want to stay in their home (dressing, bathing, food prep, etc.) was discussed, noting long wait lists and a lack of qualified caregivers. Programs that help transport seniors to and from medical appointments and social opportunities – and largely rely on a dwindling pool of volunteers – are in great demand, and can help to decrease overall medical costs, increase overall health, and combat loneliness and isolation.

> *"Being in a rural community and having lacking transportation options can limit where folks can go, who they can see, what they can do, etc. and create more barriers and challenges."*

- Social opportunities – many groups discussed feeling isolated in their communities due to a lack of social opportunities where they might make connections and interact with people in similar stages of their lives. This was especially relevant among young adult participants living in very rural communities due to the lack of other housing options or employment. Creating those opportunities through groups, events, programs, etc. could generate a sense of community and belonging, as well as improve mental health.

Participants emphasized the importance of both increasing the availability of these services and resources as well as making sure they are being properly advertised. Additionally, encouraging folks to ask about and seek out these resources in a non-stigmatizing way was identified as a priority.

Process and Bureaucratic Limitations

A common theme across several discussion groups is that access, quality, and breadth of care are frequently undermined by process barriers and external, bureaucratic limitations. These issues took shape in two ways: problems with existing healthcare processes and legislative changes.

Red tape and process challenges. An underlying problem experienced by participants has to do with unnecessary 'red tape' and challenges within healthcare processes.

Coordination of healthcare services was one example that was recurring. How organizations and systems 'talk' to one another slows down care delivery, creates unnecessary barriers, and can deter individuals seeking specialty care from receiving that care. Follow-through and follow-up are hindered as a result and people can 'fall through the cracks'.

These issues were noted as especially difficult for individuals undergoing substance use treatment. The process of transitioning back into the community can be difficult and unsupported, and the person can experience isolation following discharge because coordination of next steps between various entities (recovery centers, harm reduction services, treatment centers, hospitals, etc.) seems unclear and undefined.

Accessing personal medical information, communicating with a doctor's office, or finding community resources or services were generally referred to as challenging, and the process 'very confusing.' Most participants felt that websites, patient portals, and electronic communications can often be confusing. These issues were noted as only being amplified for most seniors.

> *"The websites or other locations of where to go for community supports is either very confusing, or very challenging to access. There's a lack of clear and accessible information. People feel like they need to look hard to find the right information, and streamlining these services would be helpful."*

Overall, the theme of various systems and platforms being disjointed was prevalent, and participants shared frustration with how nothing felt integrated.

Legislation. Discussions brought up how recent changes to healthcare legislation can pose great risks to accessing the care that they or someone they know may need. This was predominantly referencing legislation regarding LGBTQIA+ care (specifically transgender care) and medication access. Participants shared fears about potential delays or denials of medically necessary care such as gender-affirming surgeries and/or not being able to access essential medication. These types of laws are perceived as compounding existing challenges transgender individuals face, such as discrimination, isolation, poor mental health, and being able to feel safe in their communities.

> *"Regional Public Health Network catchment is different than regional catchment, which is different than schools' catchment. It's so difficult to know who should be doing what, and how to combine efforts."*

Catchment area variations. Participants who are service and care providers – specifically within the New London Hospital service area – identified conflicting catchment areas as a recurring barrier to providing their services. Common challenges took root in the form of geographic misalignment: some school districts are spread throughout multiple Regional Public Health Networks, which are also different from regional provider catchment, which can be different from various community funding sources, and so on. This makes collaborating with partners across organizations and departments difficult, muddles funding availability, leads to service responsibility confusion, and hinders resource allocations. And when trying to address these inconsistencies, data for smaller regions often don't exist or aren't reliable.

3. Perceived Improvements

Participants in the discussion groups and interviews were asked "*Have you noticed any improvements in the past few years on any of the issues we have talked about?"* Perceived improvements identified by participants can be generally summarized in three categories:

- Community Resources and Services
- Substance Use
- Health Communication and Provider Transparency

Community Resources and Services

While challenges were described previously with regard to availability and awareness of community resources and services, several improvements were also noted.

Awareness. Discussion groups cited improved community awareness of certain resources and services, specifically regarding the following:

- Substance use disorders – while stigma and misinformation about substance use are still abundant, participants also shared perceived improvements in this area. Several groups noted that awareness of the issue itself has increased, as well as public education regarding substance use disorders, prevention (Narcan/Naloxone), and treatment (Harm Reduction), as well as awareness of resources providing these types of services and care.
- Mental health – the 988 Suicide and Crisis Lifeline and 211.org were mentioned specifically in relation to increased public support and more open conversations about mental health, and a clear improvement in the advertisement of these resources as well. Participants noted that businesses and employers were also more willing to engage on this subject, and have provided various opportunities for education or training.

Availability. Participants discussed improvements in access to and availability of various resources and services in their communities:

- Funding – an increase in funding sources and opportunities for programs and services like Family Court, substance use treatment, child care, etc. Many participants did note that a lot of the increased funding came in the form of grants. This was noted as an improvement with the caveat that it is important to acknowledge reliance on grants for funding services is not sustainable.
- Food access – increased availability of support for food access was identified, specifically around community resources and initiatives such as the Mobile Food Pantry and feeding the unhoused population.
- Virtual support and services – the availability of virtual resources such as telehealth was noted as being of great help to rural communities and people with few transportation options.

Substance Use

Improvements in substance use prevention, treatment, and awareness were common responses to this question in discussion groups. Participants noted a greater willingness throughout communities to support substance use prevention and treatment, greater understanding and education around substance use disorders, expanded training opportunities on the topics for healthcare professionals and service providers, and education about the positive impacts of Harm Reduction strategies. An increase in state funding was also identified as an improvement that has allowed for SUD treatment resources and for the Community Health Navigators to be possible.

Health Communication and Provider Transparency

Several discussion groups identified that health communications have improved in the past several years, seeking to increase community resources awareness across a variety of health issues and topics (substance use, mental health, veteran care, etc.). The increased use of social media was noted as an improvement, as it helps to amplify healthcare messages, raise awareness around available services, and provides a sense of transparency between providers and patients.

Some participants also noted that they felt their needs were better understood by their doctors thanks to coordinated communication between providers and Community Health Workers.

4. Loneliness and Social Isolation

The 2024 Community Health Needs Assessment included a special focus on the topic of loneliness and how it can affect health, both mentally and physically. Participants were asked whether they think the issue of loneliness is a big concern in their community and, if so, what they perceived to be the root causes. They were also asked if they had opinions about what should be done to address loneliness. (*Loneliness here was specified to refer to feeling a lack of connection with other people, and a desire for more, or more satisfying social relationships.)*

Every group that discussed this question agreed that loneliness and isolation are big issues for them personally, people they know, and/or their communities as a whole.

Perceived Sources of Loneliness

Transitioning post-COVID. Navigating the 'post-COVID' world was repeatedly flagged as a significant source of loneliness and isolation – nearly every group that discussed these questions mentioned lasting impacts from the COVID-19 pandemic.

Participants shared that staying at home due to the pandemic drastically altered the way they interact with friends, peers, and their communities. The experience of socializing virtually was a stark change that needed to happen abruptly, and finding our way back to in-person events and interactions has been very challenging for many. The pandemic also affected what people's jobs look like: groups mentioned knowing people who either lost their jobs due to COVID and have not been able to get them back or people who now work from home entirely, both born of individual

preference and workplace policy. For many, going to work was one of the main outlets for socializing in their day-to-day life, and because some companies seized the opportunity to reduce overhead costs by giving up office space, they are no longer able to do that.

> *"Technology and social media have a lot of benefits, but can also be a filler for in-person, more meaningful connections. People tend to lean more on their phones but are often missing a lot of elements to fulfilling conversations and connections."*

Youth and children. Participants noted that young people and children were a group heavily affected by the COVID-19 pandemic. Youth are already very attached to their phones and to social media, and the increased reliance on technology due to the need for virtual classrooms only exacerbated that. Additionally, removing the many physical spaces that schools provide for students to learn how to interact with their peers seems to have been detrimental to many students' social and emotional development. Group participants with children or who are care providers for teens and children noted a distinct increase in social anxiety among this population.

Seniors. Seniors have often been the group that experiences social isolation and loneliness the most. This was echoed in many group discussions. Barriers to social opportunities included not being able to drive and a lack of transportation problems, a lack of virtual programming offered in place of in-person events in rural communities, and a lack of willingness to admit that they may be lonely.

Community considerations and volunteerism. Another common thread identified among participants as a possible cause of loneliness had to do with the composition – geographic and abstract – of their communities.

Geographic composition. As noted throughout the previous questions and responses, group participants almost wholly lived in rural communities. The lack of physical closeness to people, gathering places, and recreational spaces was repeatedly mentioned as a cause of loneliness. Limited or nonexistent public transportation aggravates this issue further. Many noted that even where their communities and neighborhoods *are* physically close, there's a clear deficit of social opportunities, activities, and programming in the area.

Sense of Community. A limited sense of the experiential makeup of the participants' communities was an underlying contributor to loneliness. Groups discussed a decrease in community volunteerism (e.g. many transportation programs or community supports in the area rely on volunteers), social and cultural barriers to community connectedness (e.g. language barriers for minority groups), and a stunted sense of belonging among certain demographics (e.g. young professionals or young adults with children not having a community to lean on).

Burnout. The general sense of being overwhelmed that many families feel was another identified cause of loneliness. Participants shared that the rising costs of living (food, childcare, housing, etc.) and demanding schedules prevented them from being able (or willing) to socialize. Many made mentions of feeling burnt out or overwhelmed from day-to-day stresses (work, chronic illnesses, children's schedules and extracurriculars, etc.), and remarked that adding another thing to their list – even making time for themselves to socialize and connect with others – felt too hard. Another barrier mentioned was the cost typically associated with socializing, like going to restaurants, movies, concerts, comedy shows, and so forth.

"Sometimes being on your phone and staying home can feel less draining than going out and doing activities."

Potential Solutions

Groups had many suggestions for how to improve community connection and reduce isolation and loneliness. Suggestions included:

- Adding transportation programs and investing in public transportation
- Increasing virtual programming for seniors
- Creating peer-to-peer support groups and outreach programs for young professionals, young parents, LGBTQIA+ individuals, Indigenous individuals, etc. to foster neighborhood connection
- Getting providers involved
    - Establishing easy referral systems across doctor's offices, organizations, community programs, etc.
    - Utilizing loneliness screenings at doctor's appointments
    - Providing resources at the end of appointments that point patients towards existing programs, resources, and community services
    - Encouraging patients to talk about their social/emotional/mental health, especially among demographics or groups who may be uncomfortable admitting vulnerability (veterans, senior men, etc.)

D. Community Health Status Indicators

This section of the 2024 Community Health Needs Assessment report provides information on key data indicators and measures of community health status. Some measures that are associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specific to the 15 town primary service area of New London Hospital. In some instances, data are only available at the county level or the Public Health Network (PHN) region level.

As displayed by Table 13, ten of the 15 towns comprising the New London Hospital primary service area are part of the Greater Sullivan Public Health Region as defined by the NH Department of Health and Human Services, accounting for 50% of the population of that public health region. The remaining 5 towns distributed across 4 other public health regions. Consequently, this report references health statistics for the Greater Sullivan Public Health Region when those data are available.

In some cases, population health data are only available at the county level, particularly from national sources. Seven of New London Hospital service area towns are in Merrimack county (accounting for just 10% of the total population in Merrimack County), while 8 service area towns are in Sullivan county (representing 41% of the total Sullivan County population). For statistics included in this report at the County level, the data should be considered in the context that a majority of the population contributing to the statistic are geographically outside the hospital's primary service area.

| TABLE 13. Service Area Breakdown by County and Regional Public Health Network |

County	Town/City	Regional Public Health Network
Merrimack County	Andover	Capital Area
	Bradford	
	Danbury	Winnipesaukee
	New London	Greater Sullivan
	Newbury	
	Sutton	
	Wilmot	
Sullivan County	Croydon	
	Goshen	
	Lempster	
	Newport	
	Springfield	
	Sunapee	
	Grantham	Upper Valley
	Washington	Capital Area

1. Demographics and Social Drivers of Health

Social drivers of health are the conditions in which individuals are born, age, work, and live and how these factors can influence health, wellness and quality of life. As described earlier in this report, drivers of health include a number of nonmedical factors that can have direct or indirect influence on health outcomes such as economic status, community infrastructure and access to quality housing, food, and education. Similarly, factors such as age, disability, and language can influence the types of health and social services needed by communities in order to thrive.

General Population Characteristics

The prevalence of many health conditions varies by age and different age groups can have different health-related needs and priorities. Awareness of the age distribution within a population can help to anticipate healthcare needs, allocate resources appropriately, and plan for future healthcare demand.

According to the 2022 American Community Survey, the population of the New London Hospital service area has a higher percentage of people age 65 and older compared to New Hampshire overall. The service area map on the next page displays the percent of the population 65 years of age and older by town.

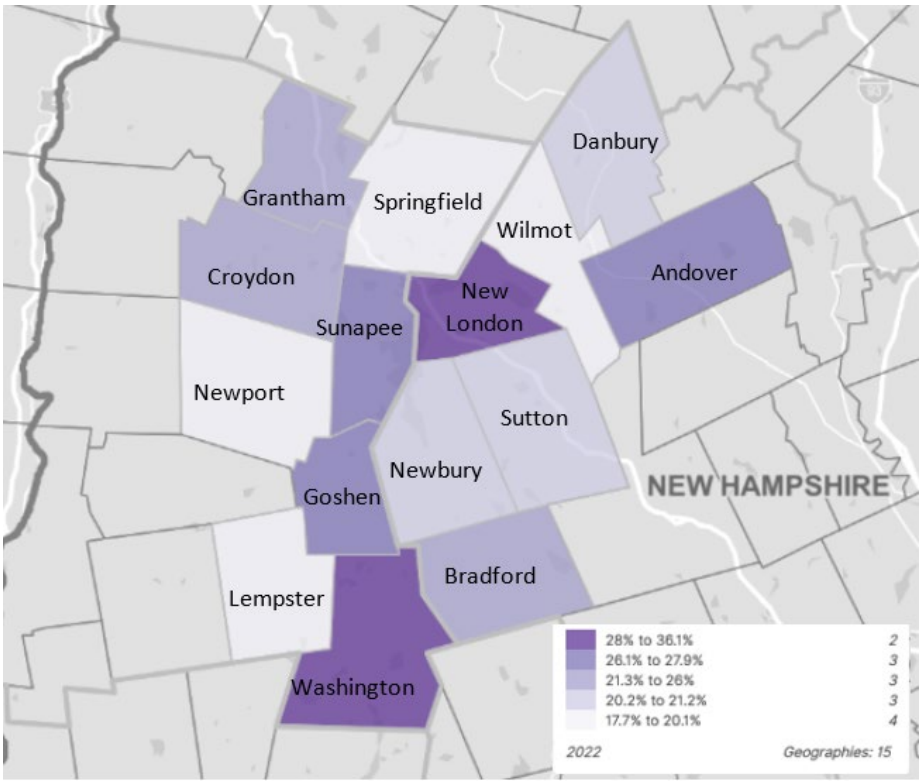
Between 2021 and 2024, the population of the service area grew by an estimated 0.4% (or about 120 people); a slower pace than overall population growth in New Hampshire. Within the service area, however, there are some notable shifts for population estimates with Grantham and Sutton each gaining an estimated 400 or more residents over the past decade, while Springfield and Andover are each estimated to have decreased in population by 300 to 400 residents.

| TABLE 14 |

Indicators	New London Hospital Service Area	New Hampshire
Total Population	33,192	1,379,610
Age under 5 years	3.4%	4.6%
Age 5 to 17 years	12.5%	14.0%
a Age 65 and older	24.3%	19.0%
Age 85 and older	3.1%	2.1%
Change in population (2021 to 2024)	+0.4%	+2.3%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 - 2022

| Figure 17. Percent of Service Area Population 65 years of age and older |



The estimated percentage of service area residents age 65 years and older ranges from about 18% in Springfield and Newport to 36% in New London.

Education

Educational attainment is also considered a key driver of health status, with lower levels of education correlated with both poverty and poor health. As displayed by the next table, the percentage New London Hospital service area residents ages 25 and older who have earned at least a high school diploma is equivalent to the percentage across New Hampshire overall.

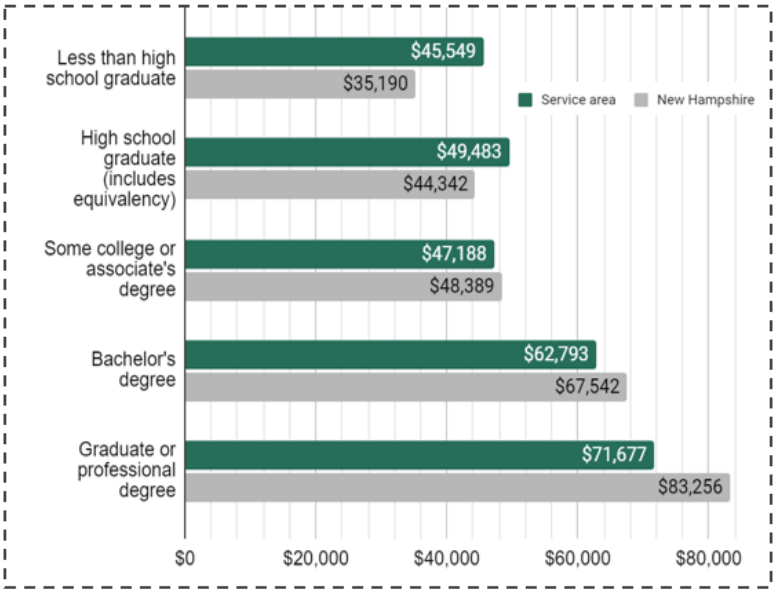
| TABLE 15 |

Percent of Population Aged 25+	New London Hospital Service Area	New Hampshire
High School Diploma (or Equivalent) and Higher	94%	94%
Some College or Associate's Degree	25%	28%
Bachelor's Degree and Higher	41%	39%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

One reason education level is historically associated with better health status is that adults with more education tend to have more opportunities for earning higher income and access to more comprehensive health-related benefits. Figure 18 displays the relationship between education and income where the amount earned (in 2022 inflation-adjusted dollars) by residents with Bachelor's degrees or higher is greater than those with less educational attainment.

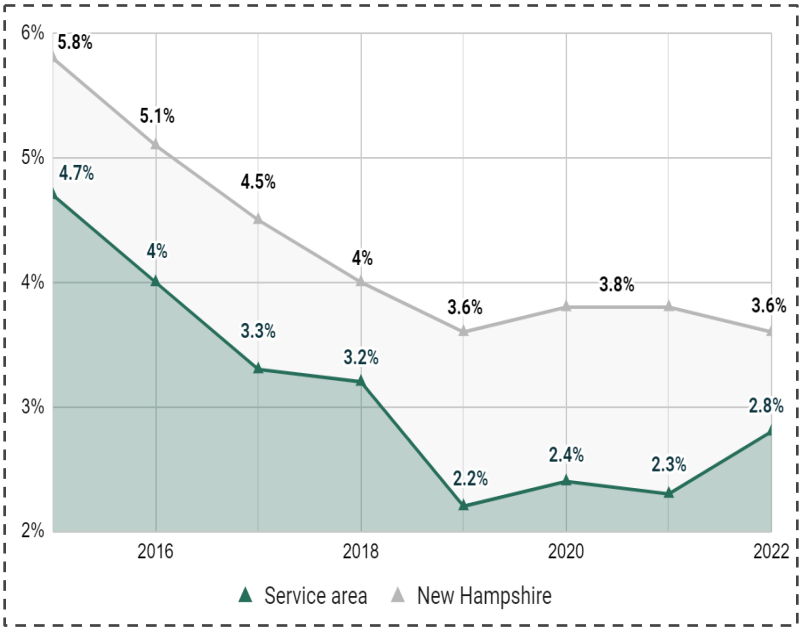
| Figure 18. Median Earnings by Educational Attainment |



Employment

Stable employment can help ensure financial security including the ability to purchase food, pay for housing and utilities and access healthcare services. Employment can also provide health insurance and other benefits such as paid time off, family medical leave, and wellness benefits. Steady employment can also contribute to mental health by providing opportunities for social interaction, decreased isolation, and sense of purpose.

| Figure 19. Annual Unemployment Rate, 2015 – 2022 |



The unemployment rate of the New London service area (about 3%) over the period 2018 to 2022 (which includes impacts of the COVID-19 pandemic) was similar to the overall state rate (4%). Since 2015, the New London service area has had a consistently lower unemployment rate than the state (Figure 19).

Income and Poverty

The strong connection between economic well-being and good health is widely recognized. Conversely, the absence of economic prosperity or poverty can lead to obstacles in obtaining health services, nutritious food, and a healthy physical environment, all of which are essential for maintaining good health.

Some information describing household income and poverty status was included in the first overview section of this report. The table below presents the percent of people in the hospital service area living in households with income below the Federal Poverty Level (FPL), the percent of children under age 18 in households with income below the FPL, and the percent of adults 65+ years in households with income below the FPL. Two service area towns are estimated to have more than 20% of children in households with income below the poverty level – Croydon (22%) and Danbury (26%). For context, the Federal Poverty Level for an individual in 2023 was $14,580 and for a family of four was $30,000.

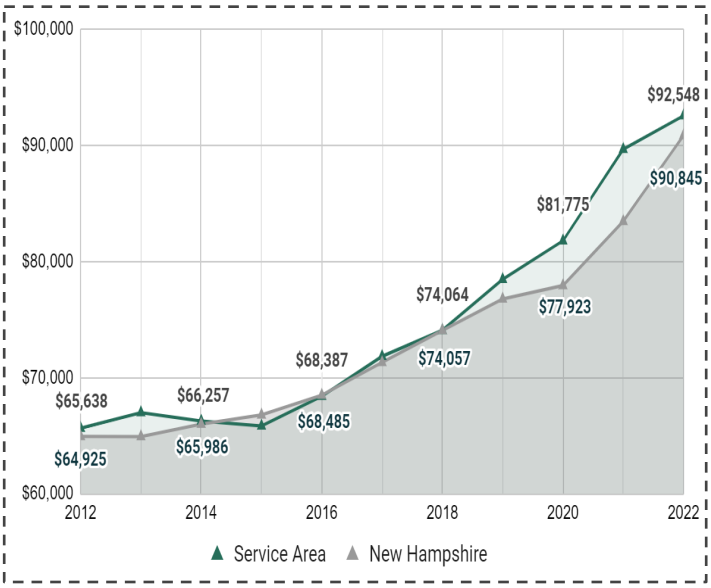
| TABLE 16 |

Percent of people in households with income below the Federal Poverty Level (FPL)		
Population Group	**NLH Service Area**	**New Hampshire**
All people with household income below the FPL	7.3%	7.3%
Children (under 18) in households with income below the FPL	6.0%	8.5%
Adults 65+ years in households with income below the FPL	8.1%	7.0%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

| Figure 20. Median Household Income: 2012 – 2022 |

As displayed by Figure 20, the median household income for the New London Hospital service area has essentially tracked the median for the state overall over the time period from 2012 to 2022 (data not adjusted for inflation).



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). Implications can range from limiting access to appropriate healthcare services; difficulty navigating health systems; reduced preventive care due to a difficulty in understanding health-related information, and medication misunderstandings including instructions, dosage, side effects. Language barriers can contribute to feelings of isolation, frustration, and anxiety; especially when unable to effectively express health concerns or understand information provided by healthcare professionals.

The U.S. Census Bureau tracks over 1,300 languages that are further categorized in 42 language groups. The table below reports the most common languages other than English spoken at home in the NLH service area along with the corresponding percentages in NH overall. The most recent estimates from the Census Bureau for the NLH service area are that zero percent of households are limited-English speaking households. A limited English speaking household is defined as one in which no member 14 years old and over either speaks only English or speaks a non-English language and speaks English very well.

| TABLE 17 |

Languages Spoken at Home	NLH Service Area	New Hampshire
English only	96.3%	**89.7%**
German	1.1%	0.5%
Spanish	0.8%	2.9%
French, Haitian, or Cajun	0.7%	2.2%
Other Languages	1.1%	4.7%
Limited English Speaking Households	**0.0%**	**1.2%**

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

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 can experience financial strain, with less resources available for essential needs such as food, healthcare, education, transportation and clothing. Other implications of high housing cost burden include housing insecurity and sub-standard living conditions.

Similarly, physical housing conditions can contribute to health hazards. Some examples include inadequate ventilation, which can lead to exposure to mold, pests, or lead-based paint; incomplete kitchen facilities, which can limit nutritional options, increase reliance on heavily processed foods, limit food safety, and reduce hygiene and sanitation; and lacking complete plumbing facilities, which can cause sanitation and hygiene challenges, lead to sewage or waste exposure, increase vector-borne diseases, and limit access to clean water.

The table below presents data on the percentage of occupied housing units in the service area that have characteristics of sub-standard housing such as lacking complete plumbing facilities or complete kitchen facilities.

The table also displays the percentage of households with housing costs (with or without a mortgage) or rental costs exceeding 30% of household income. The U.S. Department of Housing and Urban Development defines affordable housing as housing on which the occupant is paying no more than 30 percent of gross income for housing costs including mortgage or rent, utilities, taxes and insurance. More than 1 in 4 owner occupied housing units and over 40% of renters in the service area have housing costs exceeding this threshold.

| TABLE 18 |

Percent of Households with High Cost Burden, Substandard Housing or No Internet Access	NLH Service Area	New Hampshire
Housing Costs >30% of Household Income (%)	**26.3%**	25.1%
Rental Costs >30% of Household Income (%)	**42.7%**	46.8%
Occupied Housing Units Lacking Complete Plumbing Facilities (%)	**0.4%**	0.5%
Occupied Housing Units Lacking Complete Kitchen Facilities (%)	**0.7%**	0.7%
Without Internet Subscription	**10.4%**	8.8%
No Computer in the household	**5.4%**	5.0%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

As shown by Table 19, the median price of single family homes has increased at a substantially higher rate than median household income over the past decade. Over the same time frame, median gross rent has essentially kept pace with median household income.

| TABLE 19. Housing Affordability, Change in Median Home Price, Gross Rent, and Household Income |

Percent Change From 2012 to 2022			
Area	**Median Price of Single Family Homes**	**Median Gross Rent**	**Median Household Income**
Merrimack	123%	31%	36%
Sullivan	111%	35%	32%
New Hampshire	**118%**	**37%**	**40%**

Source: New England Real Estate Network Historical Statewide & County Reports and the U.S. Census American Community Survey, 5-Year Estimates, 2012-2022

Another attribute of housing that can have implications for the health of families and communities is the age of structures. This could be due to the type of materials used to build the structure (insulation, paint, plumbing, etc.), inadequate ventilation systems, structural integrity, accessibility and safety.

New Hampshire has a high percentage of older structures in general, with about 53% of occupied housing units being within structures that were built in 1979* or earlier (the NLH service area has a similar percentage at about 51%).

| TABLE 20. Housing Units – Year Structure was Built |

Area	1939 or earlier	1940 to 1959	1960 to 1979*	1980 to 1999	2000 to 2019	2020 or later
NLH Service Area	21%	9%	21%	30%	19%	0.2%
New Hampshire	20%	10%	23%	30%	17%	0.3%

Data Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates.

**The use of lead paint and asbestos-containing materials, including pipe and block insulation, were banned in 1978.*

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.

| TABLE 21 |

Area	Percent of Households with No Vehicle Available
New London Hospital service area	3.8%
New Hampshire	4.6%

Data Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates.

About 4% of households in the service area report having no vehicle available, a percentage estimate similar to New Hampshire overall. Towns with the highest estimates for households with no vehicle available are New London (7%), Goshen (7%), Danbury (6%) and Newport (6%).

Disability Status

Disability is defined by the U.S. Census Bureau as a person who has any of the following long-term conditions: (1) deafness serious difficulty hearing; (2) blindness or serious difficulty seeing (3) cognitive difficulty Because of a physical, mental, or emotional problem (4) serious difficulty walking or climbing stairs, (5) difficulty with self-care such as dressing or bathing, or (6) difficulty living independently such as being able to do errands or visit a doctor's office alone.

Compared to NH overall, a somewhat lower percentage of residents across age groups in the New London Hospital service area report having at least one disability.

| TABLE 22 |

Total Population (Noninstitutionalized) with a Disability		
Age Group (in years)	**NLH Service Area**	**New Hampshire**
Percent Disabled <18	**3.2%**	4.7%
Percent Disabled 18-64	**8.9%**	10.5%
Percent Disabled 65+	**25.6%**	29.4%
Total	**11.9%**	12.9%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2018 – 2022

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 relation to population need and demand for services, and related concepts of (7%)availability, proximity and appropriateness of services.

Insurance Coverage

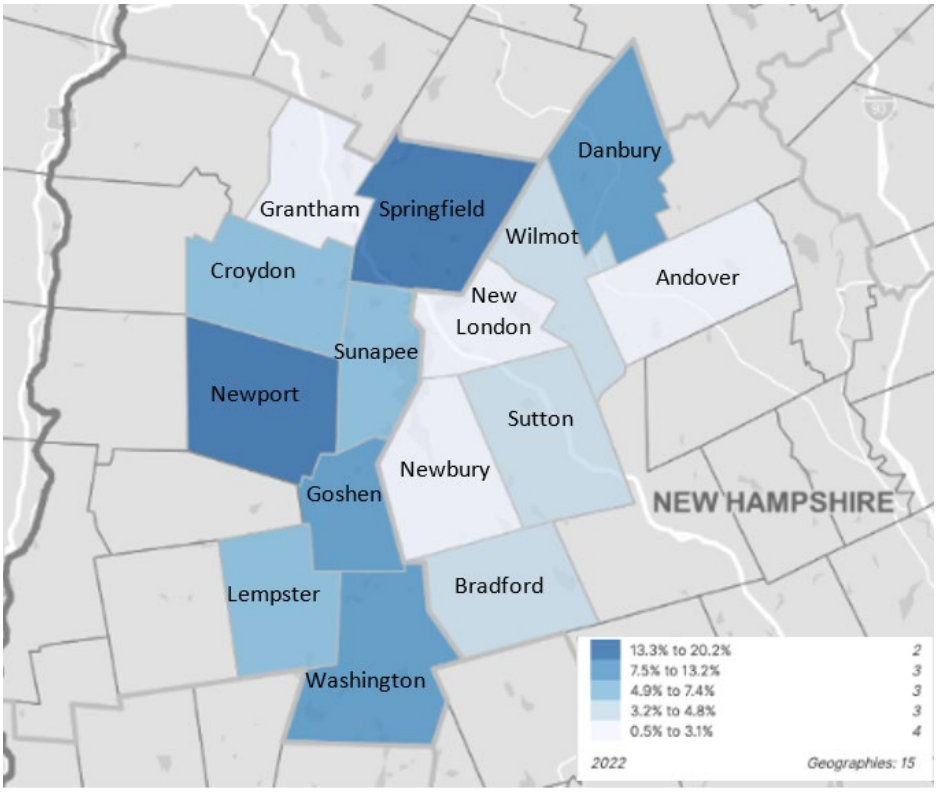
Table 14 displays town level estimates of the proportion of residents in the New London Hospital Service area who do not have any form of health insurance coverage, as well as the proportion of residents with Medicare, Medicaid or Veterans Administration coverage. Overall, the percentage of the service area population with no insurance (7%) is similar to the percentage in the state overall (6%).

| TABLE 23: Health Insurance Coverage Estimates |

Area (in order of highest to lowest % uninsured)	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage	Percent with Medicaid Coverage	Percent with VA health care coverage
Springfield	20%	19%	2%	7%
Newport	14%	22%	19%	4%
Danbury	13%	24%	17%	4%
Washington	8%	29%	9%	7%
Goshen	8%	34%	20%	2%
Sunapee	7%	30%	21%	2%
NLH Service Area	**7%**	**25%**	**12%**	**3%**
New Hampshire	**6%**	**20%**	**13%**	**2%**
Lempster	5%	21%	13%	3%
Croydon	5%	28%	17%	7%
Wilmot	5%	19%	4%	3%
Sutton	4%	19%	4%	2%
Bradford	3%	23%	15%	2%
Newbury	3%	22%	6%	3%
New London	3%	33%	5%	3%
Andover	3%	30%	8%	2%
Grantham	1%	24%	14%	1%

Data Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates, 2018-2022.

| Figure 21: Percent of NLH Service Area Population Who Are Uninsured |



The estimated percentage of service area residents with no health insurance coverage ranges from 1% in Grantham to 20% in Springfield.

Delayed or Avoided Care Due to Cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a healthcare 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. In the Greater Sullivan region, about 15% of respondents to the NH Behavioral Risk Factor Survey reported being unable to see a doctor because of cost.

| TABLE 24 |

Area	Percent of Population Who Could Not See a Doctor because of Cost
Greater Sullivan Public Health Region	15.1%
New Hampshire	11.4%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2019

Provider Capacity

Access to high-quality, cost-effective healthcare is influenced by adequate physician availability in balance with population needs. The first table below reports the number of Full Time Equivalent (FTE) primary care physicians and dentists in active practice as of 2022. The Greater Sullivan Public Health Region has the lowest ratio of Primary Care Physician FTEs in the state (the next lowest is the Winnipesaukee region with a PCP to population ratio of 22.0). It is likely that this observation is influence by proximity to the Upper Valley region that has the highest PCP to population ratio in the state. The Greater Sullivan region also has the lowest dental provider FTE to population ratio in NH.

The second table below displays a variation on this measure – population to provider ratio – at the county level from a different data source and includes mental health providers. Sullivan County has the second highest ratio of NH counties for population per mental health provider after Coos County.

| TABLE 25 |

Area	Primary Care FTE per 100k Population	Dental Provider FTE per 100k Population
Greater Sullivan Public Health Region	18.7	30.0
New Hampshire	42.6	49.7

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2019-2020 data

| TABLE 26 |

Area	Ratio of Population to Primary Care Physicians	Ratio of Population to Dentists	Ratio of Population to Mental Health Providers
Merrimack County	1,015:1	1,279:1	195:1
Sullivan County	1,404:1	2,585:1	449:1
New Hampshire	1,149:1	1,302:1	263:1

Data Source Area Health Resources Files, US DHHS via County Health Rankings, 2021-2022

The next table displays the percentage of NH adults who self-reported not having a primary care provider (PCP). About 1 in 6 residents (16%) of the Greater Sullivan region responded on the NH Behavioral Risk Factor survey that they do not have a 'personal doctor or health care provider'.

| TABLE 27 |

Area	Percent of Population (18+) Without a PCP
Capital Area Public Health Region	15.8%
New Hampshire	11.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2019

Travel Time

The NH State Office of Rural Health (SORH) classifies Public Health Network regions throughout the state as rural or non-rural including the Greater Sullivan PHN, which is classified as rural. The SORH has also reported that health disparities exist between rural and non-rural populations as measured by select primary care-associated health indicators including primary care access.[3] One measure of access to primary care is travel time to health care visits. As displayed by the table below, about twice as many primary care visits for rural populations – including for residents of the Greater Sullivan region - require one-way travel time of 30 minutes or more compared to non-rural populations. Among the 13 PHN regions across the state, the Greater Sullivan region had the third highest percentage on this measure after the Winnipesaukee and Carroll County regions.

| TABLE 28 |

Area	Percentage of primary medical care visits with travel times greater than 30 minutes, one way
Greater Sullivan Public Health Region	30.8%
All Rural New Hampshire	27.5%
All Non-Rural New Hampshire	15.3%

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2019 data

Preventable Hospital Stays

Preventable Hospital Stays are hospital discharges for diagnoses potentially treatable in outpatient settings, also known as ambulatory care sensitive conditions, such as diabetes, hypertension, asthma and chronic obstructive pulmonary disease. 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. This measure is reported below for Medicare enrollees. The rates of preventable hospital stays in Merrimack County and Sullivan County in 2021 were similar to the overall state rate.

| TABLE 29 |

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Merrimack County	2,209
Sullivan County	2,350
New Hampshire	2,478

Data Source: Centers for Medicare & Medicaid Services; accessed through County Health Rankings, 2021 data

[3] Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection, NH State of Rural Health and Primary Care, December 2022.

Prevention quality indicators (PQIs) are a similar measure of acute (e.g., bacterial pneumonia, urinary tract infection) and chronic (e.g., diabetes, COPD or asthma) inpatient admissions that could have been avoided with proper access to primary care. The NH State Office of Rural Health reports PQI rates for inpatient admissions of adults (ages 18+) for Public Health Regions. Interestingly, the rates of PQIs are statistically higher in non-rural NH compared to rural regions of NH. In other words, non-rural residents are more likely to be admitted to the hospital for preventable medical complications than their rural counterparts. As displayed by the table below, PQI rates for the Greater Sullivan region are generally higher than rates observed in all of rural NH, while the chronic composite and overall PQI composite measures are lower (better) than observed for non-rural regions of the state.

| TABLE 30 |

Preventive Quality Indicators: Inpatient Admissions (age-adjusted per 100,000, NH adults 18+)			
Area	**Overall Composite**	**Acute Composite**	**Chronic Composite**
Greater Sullivan Public Health Region	779.3	219.8	559.5
All Rural New Hampshire	646.9	165.7	481.2
All Non-Rural New Hampshire	837.7	208.4	629.3

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2020 data

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. About one-third of adults in the service area report not having had a dental visit in the past year (2018 data, most recent available).

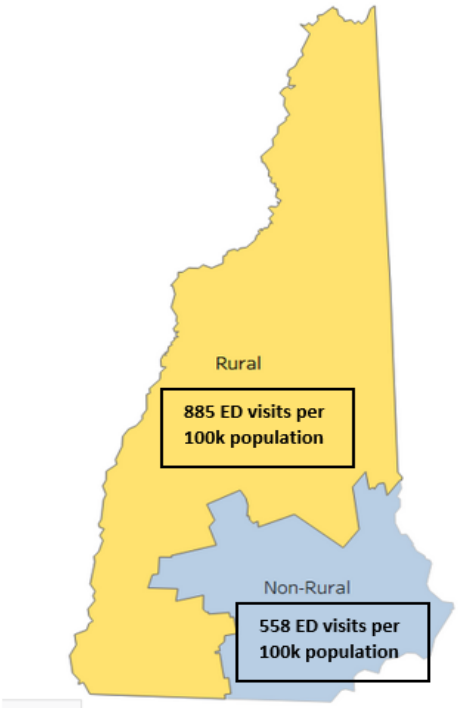
| TABLE 31 |

Area	Percent of adults who visited a dentist or dental clinic in the past year
Greater Sullivan Public Health Region	63.2%
New Hampshire	68.9%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2018

The Greater Sullivan Public Health Region experiences significantly more hospital emergency department visits for non-traumatic reasons (i.e., not resulting from an acute injury) than across the state overall. This measure provides an estimate of unmet dental needs where timely primary dental care can prevent the need for emergency care. Ambulatory care sensitive dental conditions represent approximately 3% of all emergency department visits in New Hampshire. As displayed by the map, there is a significant difference on this measure across all of the more rural regions of New Hampshire where the rate of ED visits for non-traumatic dental conditions is nearly 60% higher than non-rural regions of the state.

Non-traumatic dental conditions emergency department visits); Rural/Non-Rural comparison; All ages, age-adjusted rate; 2017 - 2021



| TABLE 32 |

Area	Emergency Department visits for non-traumatic dental condition; Age-adjusted rate per 100,000
Greater Sullivan Public Health Region	992**
New Hampshire	636

Data Source: NH Hospital Discharge Data, 2017-2021,
***Regional rates are significantly different and higher than the state rate*

3. Health Promotion and Disease Prevention

Embracing healthy lifestyle habits and behaviors can effectively prevent or manage the impact of diseases and injuries. Regular physical activity, for instance, promotes equilibrium, relaxation, and lowers the risk of developing chronic diseases. Adopting a nutrient-dense diet rich in fruits, vegetables, and whole grains can significantly decrease the likelihood of heart disease, certain cancers, diabetes, and osteoporosis. Adopting healthy behaviors, such as not smoking and limiting alcohol intake, can prevent or control the effects of disease and injury.

This section encompasses both environmental conditions and individual behaviors that influence personal health and well-being. It also highlights indicators of clinical prevention practices, including cancer and heart disease screenings, which will be further discussed in a later section that addresses population health outcomes in those specific areas.

Food Insecurity

Food insecurity is described by the United States Department of Agriculture as the lack of access, at times, to enough food for an active, healthy life. About 1 in 10 people in NH and in the service area experienced food insecurity in the past year (2022 data) defined as the percentage of households unable to provide adequate food for one or more household members due to lack of resources.

| TABLE 33 |

Area	Percent of Residents Experiencing Food Insecurity
Merrimack County	9.8%
Sullivan County	11.7%
New Hampshire	9.7%

Data Source: Feeding America, Map the Meal Gap, 2022

The table below shows the percentage of households in NH receiving support through the Supplemental Nutrition Assistance Program (SNAP). About 4% of households in the New London Hospital service area receive SNAP support. Among these households about 34% have children in the household and about 40% have at least one household member age 60 year or older.

| TABLE 34 |

Area	Percent of All Households Receiving SNAP	With Children Under 18 (% of total households receiving SNAP)	With one or more people in the household 60 years and over (% of total households receiving SNAP)
NLH Service Area	3.6%	33.6%	40.2%
New Hampshire	6.0%	45.1	37.2%

Data Source: Data Source: U.S. Census Bureau, 2021 American Community Survey 5-Year Estimates

Physical Inactivity (Adults)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. About 1 in 5 adults self report lack of physical activity ('past month').

| TABLE 35 |

Area	Percent of Adults Participating in Physical Activity Outside of Work, past month
Merrimack County	80%
Sullivan County	76%
New Hampshire	81%

Data Source: BRFSS via County Health Rankings, 2021

Pneumonia, Influenza and COVID-19 Vaccinations (Adults)

The table below displays the percentage of adults who self-report that they received an influenza vaccine (either shot or sprayed in their nose) in the past year (at the time of the survey) or have ever received a pneumococcal vaccine. 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.

| TABLE 36 |

Area	^Had Flu Vaccine in Past 12 Months (all adults)	^Ever Had a Pneumococcal Vaccination, ages 65+
Greater Sullivan Public Health Region	43.9%	73.9%
New Hampshire	48.1%	76.5%
Area	**^^Percent of Medicare enrollees receiving an annual flu vaccine**	
Merrimack County	54%	
Sullivan County	42%	
New Hampshire	51%	

^Data Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2019
^^Data Source: Centers for Medicare & Medicaid Services via County Health Rankings, 2021

Substance Misuse

Substance misuse, involving alcohol, illicit drugs and misuse of prescription drugs, or combination of these behaviors, is associated with a complex range of negative health consequences – not just for individuals, but for families and communities. Detrimental effects range from physical health issues, both acute and chronic; mental health disorders such as depression, anxiety, and psychosis; addiction and dependence; destructive social conditions such as family dysfunction, lower prosperity, domestic violence, social isolation, and more; impaired cognitive functioning including memory, attention, and decision-making deficits; financial strain; and much more.

Alcohol

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking 15 or more drinks per week for men or eight drinks or more per week 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 where one occasion equals 2-3 hours), can lead to increased risk of health problems such as liver disease or unintentional injuries.

The table below shows the percentage of adults who reported binge and heavy alcohol use. The Greater Sullivan region has somewhat higher percentage estimates for both binge and heavy alcohol use compared to the rest of NH although the percentage estimates are not significantly different.

| TABLE 37 |

Area	Binge Alcohol Use			Heavy Alcohol Use, All Adults
	All Adults	Adult females	Adult males	
Greater Sullivan Public Health Region	19.3%	15.9%	22.8%	9.3%
New Hampshire	17.0%	13.4%	20.6%	7.8%

Data Source: NH DHHS Behavioral Risk Factor Surveillance System, 2022

Although underage drinking is illegal, alcohol is the most commonly used and misused drug among youth (with marijuana a close second in recent years). On average, underage drinkers also consume more drinks per drinking occasion than adult drinkers.

In the Greater Sullivan Public Health Region, the percentage of high school aged youth who self-report recent binge drinking is similar to the overall state rate, as is the percentage of high school students who feel it would be very easy to get alcohol.

| TABLE 38 |

Area	High School Students		
	Currently Drink Alcohol (in past 30 days)	Reported Binge Drinking (in past 30 days)	Think it would be very easy to get alcohol
Greater Sullivan Public Health Region	21.7%	11.2%	26.8%
New Hampshire	23.1%	11.6%	28.5%

Data Source: NH Youth Behavior Risk Survey (YRBS), 2023

| TABLE 39 |

Area	High School Students: Approve/Strongly Approve of someone their age having one or two drinks of alcohol nearly every day		
	Total	Female	Male
Greater Sullivan Public Health Region	6.7%	4.8%	8.4%
New Hampshire	6.1%	4.5%	7.6%

Data Source: NH Youth Behavior Risk Survey (YRBS), 2023

Prescription Drugs & Opioids

New Hampshire has been significantly affected by the prescription drug and opioid crisis, much like many other states in the United States, experiencing a surge in opioid-related addiction and overdose deaths. This crisis involves the misuse, addiction, and overdose of prescription opioids, as well as illicit opioids like heroin and fentanyl. Several factors have contributed to the crisis, including:

- *Over-prescription of Opioids*: 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.
- *Transition to Heroin and Fentanyl*: As prescription opioids became harder to obtain due to increased awareness of their addictive potential, individuals turned to illicit opioids like heroin.

Moreover, the rise of synthetic opioids like fentanyl, which is much more potent than other opioids, has contributed to a spike in overdose deaths.

- *Lack of Treatment and Suppo*rt: Access to addiction treatment services, including medication-assisted treatment (MAT), counseling, and support programs, has not always been readily available to those who need it. This has made it difficult for individuals struggling with opioid addiction to receive the help they need.
- *Stigma and Misunderstanding*: Opioid addiction is often accompanied by stigma and misconceptions, deterring individuals from seeking help and contributing to an environment where people with addiction issues are not receiving the support they require.

The table below shows the percentage of adults who have ever taken prescription pain relievers and, among those respondents, the percentage who also reported having ever used a prescription pain medication more frequently or in higher doses than directed by their doctor.

| TABLE 40 |

Area	Ever taken prescription pain relievers	Ever used pain relievers in higher doses than prescribed (% of total ever prescribed pain relievers)
Greater Sullivan Public Health Region	20.0%	4.0%
New Hampshire	23.9%	2.2%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2019

The NH Youth Risk Behavior Survey (YRBS) monitors a variety of health and wellness indicators including drug use, behaviors, and perceptions among NH high school students. Below are selected results from the 2023 YRBS regarding prescription drugs and other opioids.

About 8% of high school students in the Greater Sullivan Public Health Region reported having ever taken a prescription drug without a doctor's prescription and about 6% reported having done so at least once in the 30 days prior to the survey administration. About 3% of high school students reported having used cocaine in the past 30 days.

| TABLE 41 |

Area	High School Students	
	Ever took prescription drugs without a doctor's prescription	Took a prescription drug without a doctor's prescription, in past 30 days
Greater Sullivan Public Health Region	7.9%	5.8%
New Hampshire	8.9%	5.2%

Data Source: NH Youth Risk Behavior Survey, 2023

| TABLE 42 |

Area	High School Students		
	Used Cocaine, in past 30 days	Every Used Heroin	Ever Used Inhalants
Greater Sullivan Public Health Region	3.4%	2.7%	8.4%
New Hampshire	3.0%	2.2%	7.1%

Data Source: NH Youth Risk Behavior Survey, 2023

Marijuana

The tables below explore data from the 2023 Youth Risk Behavior Survey. About 1 in 5 students self report having used marijuana in the past 30 days prior to survey administration. A similar proportion of high school age youth report having been offered, sold, or given an illegal drug on school property.

| TABLE 43 |

Area	High School Students	
	Currently use marijuana	Ever used synthetic marijuana
Greater Sullivan Public Health Region	19.5%	9.3%
New Hampshire	19.8%	9.6%

Data Source: NH Youth Risk Behavior Survey, 2023

| TABLE 44 |

Area	High School Students	
	Tried marijuana for the first time before age 13 years	Were offered, sold, or given an illegal drug on school property
Greater Sullivan Public Health Region	6.5%	19.4%
New Hampshire	4.6%	19.9%

Data Source: NH Youth Risk Behavior Survey, 2023

Cigarette Smoking / Tobacco Use

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.

The percentage of adults who currently smoke cigarettes in the Greater Sullivan region is somewhat higher although not statistically different than in NH overall. The percentage of high school students who reported smoking cigarettes in the past 30 days – about 5% - is also similar to high school age students across the state overall.

| TABLE 45 |

Area	Percent of High School Students Who Currently Smoke Cigarettes	Percent of Adult Population Who Currently Smokes Cigarettes
Greater Sullivan PHR	4.8%	13.9%
New Hampshire	3.9%	11.2%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2022; NH Youth Risk Behavior Survey (YRBS), 2023

As displayed by the table below, about 16% of high school students report current use of an electronic vapor product in the past 30 days.

| TABLE 46 |

Area	Percent of High School Students Who Currently Use an Electronic Vapor Product
Greater Sullivan Public Health Region	16.3%
New Hampshire	16.7%

Data Source: NH Youth Risk Behavior Survey (YRBS), 2023

Rural residents have historically had higher rates of smoking during pregnancy than their non-rural counterparts. This observation is reflected in the table below, where about 1 in 7 females in the Greater Sullivan region who were pregnant between 2018 and 2022 reported smoking during pregnancy.

| TABLE 47 |

Area	Percent of Female Population that Reported Smoking During Pregnancy (all ages)
Greater Sullivan Public Health Region	14.6%**
New Hampshire	7.1%

Data Source: NH Vital Records Birth Certificate Data, 2018-2022

***Rate is significantly different and higher than the state rate.*

Smoking during pregnancy has a significant impact on preterm birth and other birth outcomes. The table indicates the percent of preterm births associated with tobacco use.

| TABLE 48 |

Area	Percent of preterm births associated with smoking during pregnancy
Greater Sullivan Public Health Region	12.8%
New Hampshire	13.1%

Data Source: NH Vital Records Birth Certificate Data, 2017-2021

Pregnancy

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) had 12,322 NH children enrolled in 2022 including 413 children in Sullivan County and 1,519 children in Merrimack County. The WIC program provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

This indicator reports the percentage of newborns considered to have a low birthweight (<2,500g or about 5.5 pounds) born by pregnant women enrolled in the WIC program. For some infants, a low weight at birth can contribute to complications for healthy development. Sullivan County has a higher percentage of children born with low birthweight among mothers enrolled in WIC than the state overall.

| TABLE 49 |

Area	Full term low birthweight among WIC enrolled pregnant women	Low and Very Low Birthweight among WIC enrolled pregnant women, all births
Merrimack County	4.8%	6.9%
Sullivan County	8.8%	11.8%
New Hampshire	6.4%	9.3%

Data Source: Data Source: NH Pregnancy Nutrition Surveillance System (PNSS), 2022

Prenatal Care

Prenatal care is the medical care and guidance provided to pregnant individuals before the birth of their baby. It plays a crucial role in ensuring the health and well-being of both the pregnant person and the baby. Prenatal care involves regular visits to healthcare professionals, such as obstetricians,

midwives, and other medical experts, to monitor the progress of the pregnancy, address any potential complications, and provide essential guidance. Prenatal care is essential for a variety of reasons, including monitoring fetal development, providing nutritional and exercise guidance, screening for complications, providing emotional and mental health support as well as educational support, and reducing maternal and infant mortality. Regular medical check-ups, screenings, and guidance from healthcare professionals contribute to a healthier pregnancy, a smoother childbirth experience, and better long-term outcomes for both the mother and the baby.

The table below indicates the percentage of females who have given birth who received no or late prenatal care. Late prenatal care refers to the initiation of prenatal medical care after the first trimester. Over the time period 2017 to 2021, the Greater Sullivan Public Health Region had a lower (better) percentage of females who received no or late prenatal care of any region (2.0%) compared to the state overall (3.5%).

| TABLE 50 |

Area	Percent of Female Population that Received No or Late Prenatal Care
Greater Sullivan Public Health Region	2.0%*
New Hampshire	3.5%

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2017-2021
**Statistic is significantly different and lower than the state statistic.*

Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rate in the Greater Sullivan region is higher than the rate in NH overall, particularly among female teens ages 18-19.

| TABLE 51 |

Area	Teen Birth Rate (per 1,000 female teens)		
	Total (ages 15-19)	Ages 15-17	Ages 18-19
Greater Sullivan Public Health Region	9.8**	3.6	16.6**
New Hampshire	6.1	2.1	11.9

Data Source: NH Vital Records Birth Certificate Data, 2018 - 2022

Child Safety

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

| TABLE 52 |

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Screened-in reports of child maltreatment, rate per 1,000 children under age 18
Merrimack County	5.9	73.1
Sullivan County	6.5	124.9
New Hampshire	4.7	63.0

Data source: Annie E. Casey Foundation, Kids Count Data Center, 2020 data

*Screened-in refers to the number of children who had an abuse or neglect case opened for review by child protection agencies, whereas substantiated refers to the number of confirmed victims of child maltreatment.

Sullivan County also has a greater rate of children ages 0 to 17 who have entered foster care when compared to Merrimack County and the state.

| TABLE 53 |

Area	Foster Care Entries, rate per 1,000 children
Merrimack County	3.5
Sullivan County	5.7
New Hampshire	2.7

Data source: U.S Department of Human Services, Children's Bureau, Adoption and Foster Care Analysis and Reporting System (AFCARS), 2023

Childhood Blood Lead Level Testing

Lead is a toxic metal that can have severe and long-lasting effects on children's health and development. Ensuring children are tested for blood lead levels is crucial, especially given children, particularly infants and young children, are more vulnerable to the harmful effects of lead, as their bodies are still developing. Lead can interfere with the growth and development of certain organs, including the brain and nervous system. Lead exposure can also have significant negative effects on neurological and cognitive development. Even low levels of lead exposure have been associated with learning disabilities, lower IQ scores, attention deficits, and behavioral problems. Early detection and intervention are essential to minimize the potential for long-term cognitive and developmental impairments. Efforts to reduce lead exposure and prevent elevated blood lead levels include measures such as identifying and remediating lead hazards in the

environment, promoting lead-safe practices, improving nutrition to mitigate lead's effects, and advocating for the removal of lead from consumer products and infrastructure.

New Hampshire is a universal pediatric blood lead level testing state, requiring all children, with parental consent, to have a blood lead level (BLL) test at age one, and a second test at age two. New Hampshire's 'action level' under state statute a blood lead level of 5 micrograms per deciliter (µg/dL) for a child 72 months and younger. When a child has a blood lead level of 5µg/dL or higher, this triggers nurse case management and an environmental investigation. In 2021, the Centers for Disease Control established a screening reference level for blood lead in young children at 3.5 µg/dL.

In 2022, the NH Healthy Homes & Lead Poisoning Prevention Program reported that 25% of all NH children aged 6 years and under - and 31% in the Greater Sullivan Public Health Region - had been tested for elevated BLL. Of the children tested in the Greater Sullivan region, 69 children (10%) had BLL of 3.5µg/dL or higher and 3% had EBLL of 5µg/dL or higher. These percentages were substantially higher than the state percentages of 4% and 1% respectively.

| TABLE 54 |

Area	Percent Tested	% EBLL 3.5µg/dL or higher	% EBLL 5µg/dL or higher
Greater Sullivan Public Health Region	31%	10%	3%
New Hampshire	25%	4%	1%

Source: NH DHHS, Division of Public Health Services, Healthy Homes & Lead Poisoning Prevention Program, 2022

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.

Overweight and Obesity

Being overweight or obese can have a significant impact on an individual's health, and lead to a wide range of physical and psychological complications such as cardiovascular conditions (heart disease, hypertension/high blood pressure, stroke, etc.), diabetes, mental health issues, joint issues, or respiratory problems.

The tables below report the percentage of adults (age 18 and older) and high school students who self-report characteristics of age, sex, height, and weight that are indicative of obesity. Overweight in adults is defined as Body Mass Index (BMI) between 25.0 and 29.9 kg/m² and obesity is defined as BMI >=30.0 kg/m². For people under the age of 19, obesity is defined as body mass index at or above the 95th percentile on standardized growth charts for age and sex.

About two-thirds of all adults in the region and across the state are considered overweight or obese. Among high school students, a higher percentage of males than females are considered obese and in the Greater Sullivan region a higher percentage of males are considered obese than high school age males across New Hampshire.

| TABLE 55 |

Area	Percent of adults who are obese	Percent of adults who are overweight
Greater Sullivan Public Health Region	29.9%	39.0%
New Hampshire	28.5%	36.7%

Data Source: NH DHHS Health Data Portal, BRFSS survey, 2022

| TABLE 56 |

Area	High School Students Considered Obese	Female High School Students	Male High School Students
Greater Sullivan Public Health Region	18.3%**	13.2%	23.1%**
New Hampshire	13.3%	10.1%	16.2%

Data Source: NH DHHS Health Data Portal, 2021 & NH Youth Behavior Risk Survey, 2021

***Rate is significantly different and higher than the state rate.*

Heart Disease

Heart disease is the leading cause of death in New Hampshire and the second leading cause of death in the Greater Sullivan region after all forms of cancer. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance misuse including tobacco use.

Heart Disease Risk Factors: Awareness of heart disease risk factors includes periodic screening for hypertension and high blood cholesterol. Nearly 1 in 3 adults in the region self-report that they have been told by a doctor that they have high blood pressure and a large majority of adults have been screened for blood cholesterol level within the past 5 years.

| TABLE 57 |

Area	Percent of adults told by a health professional they have high blood pressure	Percent of adults who had their blood cholesterol checked within the past 5 years
Greater Sullivan Public Health Region	32.1%	85.3%
New Hampshire	30.1%	87.8%

Data Source: NH DHHS Behavioral Risk Factor Surveillance System, 2021

The table below estimates the number of hospitalizations for congestive heart failure – often a consequence and end stage of various heart diseases. Congestive heart failure (CHF) is a leading principal diagnosis for Medicare hospital claims. Approximately 75% of persons with CHF have antecedent hypertension.

The rate of hospital inpatient discharges for CHF was significantly higher in the Greater Sullivan Public Health Region compared to the rest of the state over the period 2017 to 2021. Over the same time frame, the region had somewhat higher rate of hospitalizations for acute myocardial infarction (commonly called a heart attack) although this difference was not statistically significant.

| TABLE 58 |

Area	CHF hospitalizations (inpatient) age-adjusted rate per 100,000	Heart attack hospitalizations (inpatient) age-adjusted per 100,000
Greater Sullivan Public Health Region	14.1**	168.8
New Hampshire	3.6	153.7

Data Source: NH Hospital Discharge Data Set for NH Residents, 2017 to 2021

***Rate is significantly different and higher than the state 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.

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. The mortality rates for coronary heart disease and cerebrovascular disease in the region are similar to the overall NH rates.

| TABLE 59 |

Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Greater Sullivan Public Health Region	93.9	27.9
New Hampshire	84.9	29.4

Data Source: NH Vital Records Death Certificate Data, 2018-2022
***Rate is significantly different and higher than the state rate.*

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, physical activity 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. The proportion of people with a diabetes diagnosis increase substantially with age.

| TABLE 60 |

Area	Age	Percent of Adults Diagnosed with Diabetes by Age Group, age adjusted rate
Sullivan County	All adults aged 20 and older	**7.4%**
	Ages 20 - 44	2.3%
	Ages 45 - 64	10.8%
	Ages 65+	16.6%
Merrimack County	All adults aged 20 and older	**6.9%**
	Ages 20 - 44	2.2%
	Ages 45 - 64	10.1%
	Ages 65+	15.5%
New Hampshire	**All adults aged 20 and older**	**7.3%**

Data Source: United States Diabetes Surveillance System (USDSS), 2021

Diabetes-Related Hospitalization: As the number of those with diabetes has increased, diabetes related hospitalizations are increasing accordingly. Complications such as cardiovascular disease, kidney failure, amputations, and ketoacidosis frequently require hospitalization.

The table below shows the age-adjusted rates of inpatient hospitalizations between 2017 and 2021 for diabetes-related discharges (primary or secondary diagnosis) and hospital admissions for long term complications of diabetes (primary diagnosis).

| TABLE 61 |

Area	Diabetes-Related Hospital Discharges; age adjusted rate per 100,000	Diabetes Long -Term Complications - Inpatient, age adjusted rate per 100,000 population, 18+ years of age+
Greater Sullivan Public Health Region	1,514	62
New Hampshire	1,544	60

Data Source: NH Uniform Healthcare Facility Discharge Dataset, 2017-2021 (+2018 data only, NH DPHS Office of Primary Care and Rural Health)

Regional rates are not significantly different than the state rates.

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus in the Greater Sullivan region was similar to the state overall over the period 2018 to 2022.

| TABLE 62 |

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Greater Sullivan Public Health Region	22.8
New Hampshire	19.8

Data Source: NH Vital Records Death Certificate, 2018-2022

Regional rate is not significantly different than the state rate.

Cancer

Cancer is currently the leading cause of death in the Greater Sullivan Public Health Region and the second leading cause of death in New Hampshire overall. Although not all cancers can be prevented, risk factors for some cancers can be reduced. It is estimated that about 42% of cancer cases and 45% of cancer deaths in the U.S. are linked to modifiable risk factors.[4] These risk factors and health behaviors include tobacco use and secondhand smoke, body weight, alcohol consumption, a lack of physical activity, and poor nutrition. Cigarette smoking ranks as the highest risk factor, contributing to 19% of all cancer cases in the U.S. and nearly 29% of cancer deaths.

Cancer Screening: The table below displays screening rates for several of the most common forms of cancer including colorectal cancer, breast cancer, cervical cancer and prostate cancer. In 2022, the percentage of females who self-reported having a mammogram to screen for breast cancer was higher in the Greater Sullivan region than in NH overall.

| TABLE 63 |

Cancer Screening Type	Greater Sullivan PHR	New Hampshire
Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2022)	67.8%	67.0%
Females ages 50-74 who had a Mammogram in the past 2 years (2022)	92.3%**	80.8%
Females ages 21-65 who have had a pap test in the past 3 years	79.1%	84.1%
Males age 40+ who had a PSA test in the past 2 years+	22.4%	30.8%

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) accessed via NH DHHS Wisdom, 2022; +accessed via NH WRQS, 2018
***Rate is statistically different and higher than the overall NH rate*

[4] Proportion and Number of Cancer Cases and Deaths Attributable to Potentially Modifiable Risk Factors in the United States; Farhad Islami et al. CA Can J Clin DOI, Jan;68(1):31-54.

Cancer Incidence: The table below shows cancer incidence rates for the cancer types that account for the majority of new cancer cases (incidence). The overall cancer incidence rate and rates for specific cancer types in the Greater Sullivan region are similar to rates across the state.

| TABLE 64 |

Cancer Incidence by Type per 100,000 people, age adjusted rate		
Cancer Type	**Greater Sullivan PHR**	**New Hampshire**
Overall cancer incidence (All Invasive Cancers)	483.0	472.3
Cancer Incidence by Type		
Breast (Female)	139.3	138.9
Prostate (male)	106.4	116.9
Breast (all sexes)	71.8	72.5
Lung and Bronchus	65.7	59.2
Colorectal	37.2	34.2
Melanoma of Skin	36.4	29.9
Melanoma of Skin In Situ	36.4**	27.1
Uterus (female)	29.4	29.6
Bladder	27.8	26.0
Breast (Female) In Situ	18.7*	32.9
Kidney and Renal Pelvis	17.1	17.1
Thyroid	16.9	13.2
Non-Hodgkin Lymphoma	16.3	20
Pancreas	13.3	13.6
Leukemia	13.3	13.7

Data Source: NH State Cancer Registry, 2017-2021

***Rate is statistically different and higher than the overall NH rate;*

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

Cancer Mortality: The table below shows the overall cancer mortality rate and the cancer mortality rate for types that account for the majority of cancer deaths. The overall cancer mortality rate and rates for specific cancer types in the Greater Sullivan region are similar to rates across the state. The overall mortality rate in NH from all cancer causes has decreased steadily over the past several decades – from about 195 per 100,000 people in 2001 to a rate of about 141 per 100,000 in 2022.

| TABLE 65 |

Cancer Mortality per 100,000 people, age adjusted		
Cancer Type	**Greater Sullivan PHR**	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	153.7	143.7
Cancer Mortality by Type		
Lung and bronchus	33.8	32.9
Prostate (male)	20.9	18.8
Colorectal	15.2	11.1
Breast (female)	11.5	17.6
Pancreas	10.5	11.5
Esophagus	6.8	4.7
Ovary (female)	5.6	6.1

Data Source: NH State Cancer Registry, 2018 - 2022
Regional rates are not significantly different than overall NH rates

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. In 2022, about 18% of adults responding to the Behavioral Risk Factor Survey from the Greater Sullivan Public Health Region reported they currently have asthma. This percentage is notably higher than the overall state estimate of 11% although not statistically significant.

| TABLE 66 |

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Greater Sullivan Public Health Region	*Not available*	18.3%
New Hampshire	5.3%	13.1%

**Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2022*
Regional rate is not significantly different from the state rate.

Asthma-Related Hospitalizations: The table below displays rates of emergency department visits and inpatient hospitalizations for complications of asthma. The rate of emergency department visits for asthma were higher in the Greater Sullivan region than across the state overall during the 2017 to 2021 time frame.

| TABLE 67 |

Area	Asthma Emergency Department Visits, age adjusted rate per 100,000	Asthma Inpatient Hospitalizations age adjusted rate per 100,000
Greater Sullivan Public Health Region	371**	34
New Hampshire	285	28

NH Uniform Healthcare Facility Discharge Dataset, 2017-2021
***Rate is significantly different and higher than the state rate.*

COVID-19

COVID-19 is a disease resulting from the infection of a novel strain of coronavirus called SARS-CoV-2, which had not been previously observed in humans prior to 2019. Coronaviruses belong to a large family of viruses known to cause various illnesses, ranging from common colds to more severe conditions like Severe Acute Respiratory Syndrome (SARS). This highly contagious virus led to a global pandemic, causing sickness and fatalities across the world (pandemic). Although most individuals with COVID-19 experience mild symptoms, some can develop severe illness.

In New Hampshire, the first cases of COVID-19 were reported in March 2020. Since then, the state has identified over 382,000 cases of COVID-19 infection, resulting in 3,344 deaths (as of May 2024). The rate of cumulative COVID-19 related deaths in the Greater Sullivan Public Health Region is substantially is similar to the state overall.

| TABLE 68 |

Area	Cumulative COVID-19 Cases, per 100K population+	Cumulative Deaths with COVID-19 as a Contributing Factor, per 100K population++
Greater Sullivan Public Health Region	27,336	246
New Hampshire	27,396	241

Data Source: NH Department of Health and Human Services, COVID-19 Response Dashboard +data as of May 2023 when population level case counting ended; ++data as of May 2024

Intentional and Unintentional Injury

Accidents and unintentional injury are the third leading cause of death in the region and 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.

Unintentional Injury Deaths: Injuries can happen when a place is unsafe or when people engage in unsafe behaviors. Injuries may be intentional or unintentional. Intentional injuries are usually related to violence caused by oneself or by another. Unintentional injuries are accidental in nature.

The table below reports the total Unintentional Injury Mortality Rate, which is the number of deaths that result from accidental injuries per 100,000 people. This measure includes injuries from causes such as motor vehicle accidents, falls, drowning and unintentional overdose). The rate of Unintentional Injury Mortality over the period 2018 to 2022 was similar in the region compared to the state overall.

| TABLE 69 |

Area	Unintentional (accidental) Injury Mortality, all causes Age adjusted rate per 100,000
Greater Sullivan Public Health Region	66.3
New Hampshire	60.2

Data Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom 2018-2022
***Rate is significantly different and higher than the state rate.*

Older Adult Falls: More than one third of adults aged 65 years or older report falling at least once over the past 12 months. Nearly 40% of falls among older adults result in a need for medical treatment or restricted activity. Many conditions contributing to falls can be prevented such as addressing home hazards, balance and strength training exercise, vision correction and appropriate medication management. The next table displays statistics for the percent of residents age 65 years and older who self-report having experienced a fall in the past 12 months and the rate of fall-related ED visits.

| TABLE 70 |

Area	Percent of people age 65+ who report having experienced a fall in the past 12 months	Fall-related Emergency Dept. visits (per 100.000 people age 65 and older)
Greater Sullivan Public Health Region	31.8%	6,188*
New Hampshire	28.5%	6,844

Data Sources: NH Behavioral Risk Factor Surveillance System, 2020. NH Hospital Discharge Data Set for NH Residents, 2017-2021
**Rate is significantly different and lower than the state rate.*

Opioid Use-related Emergency Department Visits, Hospitalization: The table below displays rates of hospitalization due to accidental overdose from opioid use. Opioid misuse includes prescription opioid pain relievers, heroin, and synthetic opioids such as fentanyl. The Greater Sullivan Public Health Region experienced a significantly lower rate of emergency department utilization due to accidental opioid overdose compared to the state overall over the 5 year period from 2017 to 2021.

| TABLE 71 |

Area	Opioid Overdose Emergency Dept. visits; Age-adjusted rate per 100,000	Opioid Overdose Hospitalizations (inpatient) age-adjusted per 100,000
Greater Sullivan Public Health Region	69.2*	14.5*
New Hampshire	134.3	23.9

Data Source: NH Hospital Discharge Data Set for NH Residents, 2017-2021

**Rate is significantly different and lower than the state rate.*

Drug Overdose Mortality: The table below displays the rate of opioid overdose mortality for the Greater Sullivan region between 2018 and 2022. A total of 66 deaths due to opioid overdose occurred among residents of the region during that time period. In 2023, the NH Office of the Chief Medical Examiner reported 430 deaths in New Hampshire caused by drug overdose (all drug types). The age group with the largest number of drug overdose deaths was 30-39 years.

The table also displays the rate of alcohol-related overdose deaths (defined as having ICD-10 codes: X45, Y15, T51.0, T51.1, T51.9 (alcohol poisoning), X65 (suicide by and exposure to alcohol), and R78.0 (excessive blood level of alcohol) as the underlying cause).

| TABLE 72 |

Area	Opioid Overdose Deaths, age-adjusted per 100,000	Alcohol-related overdose deaths, age-adjusted per 100,000
Greater Sullivan Public Health Region	32.6	5.4
New Hampshire	28.3	4.9

Data Source: NH Division of Vital Records Death Certificate Data, 2018 to 2022

Self Harm-related Emergency Department Visits and Hospitalization: The table on the next page displays rates of emergency department (ED) visits and inpatient hospitalizations by sex for injury recorded as intentional, including self-intentional poisonings due to drugs, alcohol, or other toxic substances. Between 2017 and 2021, the rate of ED visits involving self-inflicted harm among males in the Greater Sullivan Public Health Region was significantly higher than the state rate. Rates of ED visits and hospitalizations related to self-harm are significantly higher among females than males in the region and across the state.

| TABLE 73 |

Sex	Area	Suicide or self harm-related hospital visits (ED), age-adjusted rate per 100,000	Suicide or self harm-related hospitalizations (inpatient), age-adjusted rate per 100,000
Male	Greater Sullivan Public Health Region	**162.9****	43.4
	New Hampshire	128.5	41.7
Female	Greater Sullivan Public Health Region	268.8+	57.4+
	New Hampshire	239.2+	64.1+
All Sexes	Greater Sullivan Public Health Region	**215.4****	50.3
	New Hampshire	182.8	52.7

Data Source: NH Hospital Discharge Data Set (HDDS) for NH Residents, 2017 to 2021
***Rate is significantly different and higher than the state rate.*
+Female rate is significantly different and higher than male 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 and other community supports. Between 2018 and 2022, the suicide mortality rate in the Greater Sullivan Public Health Region was not significantly different than in New Hampshire overall. However, the suicide mortality rate is significantly higher for males than females in the region and across the state.

| TABLE 74 |

Area	Suicide Mortality, age-adjusted rate per 100,000		
	Total	Female	Male**
Greater Sullivan Public Health Region	16.1	7.8	24.9
New Hampshire	16.9	7.2	26.8

Data Source: NH Vital Records Death Certificate Data 2018 to 2022
Regional rates are not significantly different than the state rates.
***Rates among males are significantly different and higher than among females.*

Infant Mortality

Infant mortality rate is a significant public health indicator, measuring the number of deaths of infants under the age of one year per 1,000 live births. This rate can be used to measure the health and wellbeing of a population, along with the accessibility and quality of healthcare and social services. Infant mortality is an indicator of maternal health, community nutrition and wellness, health inequalities, and access to social support systems.

New Hampshire has historically had a low infant mortality rate relative to other states and the nation. The mortality rate for infants in the Greater Sullivan Public Health region was somewhat higher, but not different statistically than the overall state rate during the period 2018 to 2022.

| TABLE 75 |

Area	Infant Mortality Rate per 1,000 Live Births
Greater Sullivan Public Health Region	4.81
New Hampshire	3.77

Data Source: NH Vital Records Birth Certificate Data, 2018-2022

Leading Causes of Death

The leading cause of death in the Greater Sullivan Public Health Region was malignant neoplasms (cancer) accounting for 604 deaths over the five year span of 2018 to 2022. Diseases of the heart (e.g., congestive heart failure, coronary heart disease, heart attack) was the second leading cause of death in the region and the leading cause of death across the state. Accidents were the third leading cause of death in the region and the state.

Compared to the state, the leading causes of death in the region are similar to the overall in rank order and rates, although the rate of mortality due to Alzheimer's Disease was lower in the region compared to New Hampshire overall.

| TABLE 76. Top 10 Leading Causes of Death | (age-adjusted rate per 100,000)

Cause of Death	Greater Sullivan PHR	New Hampshire
Malignant neoplasms	153.7	144.1
Heart diseases	148.4	148.7
Accidents (unintentional)	66.3	60.2
Chronic lower respiratory disease	34.6	37.3
Cerebrovascular diseases	27.9	29.4
Diabetes mellitus	22.8	19.8
COVID-19	22.0	26.6
Alzheimer's disease	19.7*	25.9
Intentional self-harm (suicide)	16.1	16.9
Chronic liver disease	11.2	12.6
Unknown/Other	133.6	144.0

Source: NH Vital Records Death Certificate Data, 2018 – 2022

**Regional rate is significantly different and lower than state rate.*

Life Expectancy at Birth

Life expectancy at birth is a commonly used measure of the overall health of people in a particular location or with demographic characteristics in common. The measure estimates an average number of years a person is expected to live and can be influenced by many factors including access to quality health care and public health services, economic development, as well as personal factors

such as occupation and biological sex. Over the last century, life expectancy has increased substantially due to widespread improvements in sanitation and access to clean water, adequacy of food and nutrition, advances in prevention of infectious disease, and other advances in medicine and clinical care, particularly with respect to infant and maternal mortality. In the current age, women generally have a higher life expectancy than men. It is important to note that in small geographic areas with very few deaths, very low population, or an unusual age distribution, estimates may not be reliable or stable over relatively short time frames.

| TABLE 77. Life Expectancy at Birth (years) and by Sex |

Census Tract	Life expectancy	Male	Female
042500 (Andover, Salisbury**)**	81.6	78.9	85.0
040500 (Bradford, Newbury, Sutton)	83.5	80.7	87.1
975200 (Croydon, Grantham, Springfield)	84.0	80.0	89.4
041500 (Danbury, Wilmot, Hill**)**	78.3	77.1	N/A
97550 (Goshen, Lempster, Washington)	79.5	75.6	84.4
041000 (New London)	84.9	83.4	86.2
975400 (Newport)	77.5	73.3	81.8
975300 (Sunapee)	82.7	81.9	83.8
New Hampshire	**79.5**	**77**	**82.1**

Source: NH Vital Records, death data, 2016 - 2020

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. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. Sullivan County had a higher rate of premature mortality than in New Hampshire overall during the period 2019 to 2021.

| TABLE 78 |

Area	Years of Potential Life Lost before age 75, age-adjusted rate per 100,000
Merrimack County	6,512
Sullivan County	8,048**
New Hampshire	6,499

Data source: National Center for Health Statistics via County Health Rankings; 2019-2021
***Rate is significantly different and higher than the state rate.*

Summary

The 2024 New London Hospital Community Health Needs Assessment provides a comprehensive overview of the health needs and priorities within the service area. Through analysis of community input from multiple methods and channels, and assembly of demographic data and health indicators, the assessment highlights key health challenges and priorities for health improvement. The report identifies high priority health issues such as health care availability and capacity challenges, cost of care concerns, behavioral health needs, and disparities in access to services. Additionally, the assessment includes information on broad determinants of health including socioeconomic factors that influence community well-being. This assessment will hopefully serve as a useful resource for planning program and service improvements, for guiding targeted interventions, and for strengthening collaborative partnerships to improve overall health and wellness in the New London Hospital service area.

> *"We are lucky to live in this region of New Hampshire. We have access to . . . fantastic outdoor recreation opportunities & assets, great local hospitals and emergency support services, resources for senior citizens, young adults and families that aren't always utilized but they are available. We live in a great community built on relationships and collaboration with many different regional organizations which enhances opportunities and our overall quality of life."*
>
> *- Community Leader / Volunteer*