Central New Hampshire Health Partnership

2014 Community Health Assessment

Community Action Program Belknap-Merrimack Counties

Communities for Alcohol- and Drug-free Youth (CADY)

Genesis Behavioral Health

Mid-State Health Center

Newfound Area Nursing Association

Pemi-Baker Community Health

Speare Memorial Hospital

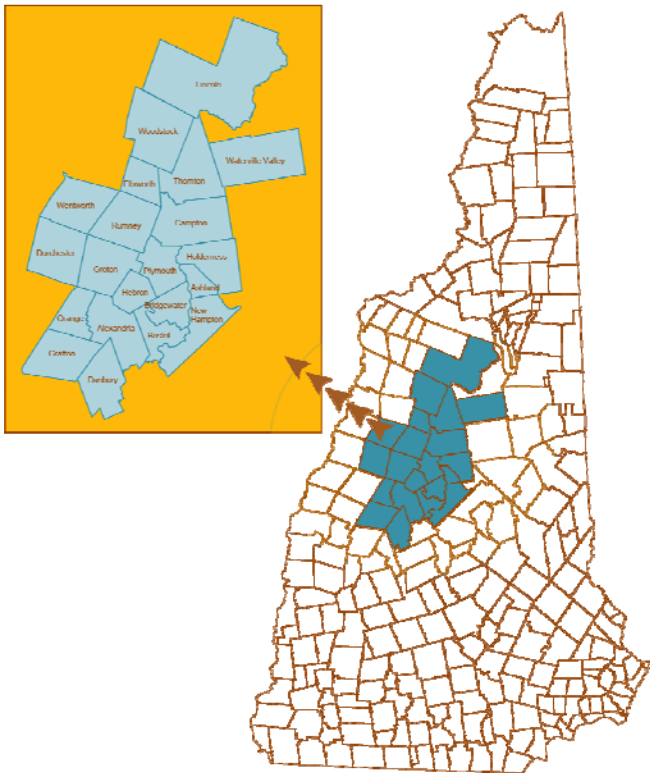
NH Community Health Institute – Technical Support

Central New Hampshire Health Partnership
2014 Community Health Assessment

Executive Summary

During the period March through July, 2014, an assessment of community health needs in the communities of the Central New Hampshire region was conducted by the Central New Hampshire Health Partnership. The purpose of the assessment was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. Methods employed in the assessment included a series of community discussion groups convened and moderated by members of the Central New Hampshire Health Partnership and a review of available population demographics and health status indicators to update a more comprehensive community health needs assessment completed in 2011.

For the purposes of this report, the **Central New Hampshire Region** (see map below) is comprised of the following 21 New Hampshire (NH) municipalities with a total resident population of 35,005**:** Alexandria, Ashland, Bridgewater, Bristol, Campton, Danbury, Dorchester, Ellsworth, Grafton, Groton, Hebron, Holderness, Lincoln, New Hampton, Orange, Plymouth, Rumney, Thornton, Waterville Valley, Wentworth and Woodstock. In some instances in this report, the most current data are available for the CNH *Public Health* Region, which is comprised of 16 of the 21 communities in the overall CNHHP region plus an additional town (Warren). In a few instances, data are only available at the county level (19 of 21 service area towns are in Grafton County), but are included because of the relevance and priority of the issue (e.g. childhood obesity).



The table below provides a summary of community health needs and issues identified through the survey of community health needs and priorities, the community health discussion groups, and the collection of indicators of community health status.

SUMMARY OF COMMUNITY HEALTH NEEDS AND ISSUES BY INFORMATION SOURCE		
Community Health Issue	**Community Discussion Groups**	**Community Health Status Indicators**
Access to Mental Health, Behavioral Health Care Services	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from Head Start, Senior and Education Communities in particular	About 16% of adults in the region report not receiving adequate social or emotional support; Rates of emergency department use for mental health conditions in the region are generally lower than rates for NH overall
Physical Activity, recreational opportunities, active living	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from Business, Faith and Head Start Communities in particular	About 1 in 5 adults in the CNHHP Region can be considered physically inactive – a rate similar to the rest of New Hampshire
Fragile families, family stress	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from Education and Business Communities in particular	All but one of the CNHHP Region communities have median household incomes less than the median household income for New Hampshire overall.
Diet and Nutrition, access to healthy foods	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from Mental Health and Business Communities in particular	About 70% of adults in the region self-report consuming less than 5 servings of fruits and vegetables each day. About 1 in 5 people can be considered to have limited access to healthy foods.
Education	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from the Faith Community in particular	About 9% of the population aged 25 and older in the region do not have a high school diploma (or equivalency)
Access to Health Insurance	Access to Health Insurance selected as a top priority for community health improvement by community discussion group participants and by participants from the Business Community in particular	About 1 in 7 people in the region (13.5%) did not have health insurance in 2012; and the uninsurance rate exceeded the overall rate for New Hampshire (10.5%) in the majority of communities in the service area
Access to Dental Care Services	Selected as a top priority for community health improvement by community discussion group participants overall and by participants from Mental Health and Senior Communities in particular	About 26% of adults in the region have not received dental care within the past year and about 15% can be considered to have poor dental health.
Poverty	Poverty selected as a top priority for community health improvement by community discussion group participants	Nearly a third (32.7%) of individuals in the region are living at or below 200% of the federal poverty level and about 1 in 7 children (13.8%) in the region are living in households below the poverty level.

Central New Hampshire Health Partnership

2014 Community Health Assessment

Table of Contents

Central New Hampshire Health Partnership

2014 Regional Health Data Update

Central New Hampshire Health Partnership

2014 Community Health Assessment

Part 1 - Regional Health Data Update

This report compiles a variety of data describing the health of the resident population served by health and human service agencies participating in the Central New Hampshire Health Partnership (CNHHP). Included in this data-based portrait are selected indicators of social and economic determinants of health, access to health services, health promotion and disease prevention, illness and injury, substance abuse and public safety. This report complements a previous community health assessment completed in 2011. It is not intended as an exhaustive set of all possible measures of population health and does not repeat information included in the 2011 report for which new data is not currently available such as some New Hampshire (NH) Hospital Discharge data.

Demographics and Social Determinants of Health

The demographic and social characteristics of a population, including such factors as prosperity, education, and housing influence the health status of the population. Similarly, factors such as age, disability, language and transportation can have a determining role in the characteristics of health and social services needed by communities.

General Population Characteristics

Compared to the New Hampshire population overall, the population of the CNHHP Region is somewhat older, has not grown in recent years (an estimated decrease of 49 persons since 2010), and lives in a more rural setting (less densely populated).

General Population Characteristics

Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
CNHHP Region	35,005	611.7	57.3
New Hampshire	1,317,474	8,950.3	147.2

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates

Total Population, By Gender

Area	Male	Female	Percent Male	Percent Female
CNHHP Region	17,341	17,664	49.5%	50.5%
New Hampshire	650,048	667,426	49.3%	50.7%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

Population Trend and Selected age Categories

Area	Population Growth Trend 2010-2012	Percent of Population Age 65 Years and Over	Percent of Population Under 5 Years of Age
CNHHP Region	-0.1%	15.2%	4.3%
New Hampshire	+0.3%	13.7%	5.3%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates and 2000 Census.

INCOME, POVERTY AND UNEMPLOYMENT

The correlation between economic prosperity and good health status is well established. Inversely, the lack of economic prosperity, or poverty, can be associated with barriers to accessing health services, healthy food, and healthy physical environments that contribute to good health. All but one of the CNHHP Region communities have median household incomes less than the median for New Hampshire overall. A related observation is that a higher proportion of people compared to the state overall are living near or below the federal poverty level in 14 of the 21 towns in the region.

Median Income and Percent of Families in Poverty by Municipality

	Median Household Income	% of Families in Poverty
Orange	$71,719	5.3
State of NH	$63,270	6.7
New Hampton	$61,463	11.3
Dorchester	$60,625	9.8
Bridgewater	$60,104	5.5
Hebron	$58,333	18
Alexandria	$58,171	7.8
Holderness	$56,458	4.9
Thornton	$52,539	5.1
Waterville Valley	$52,159	3.5
Campton	$47,500	4.4
Danbury	$46,842	12.6
Grafton	$46,300	13.8
Bristol	$46,287	15.2
Woodstock	$45,781	7.6
Wentworth	$44,600	15.7
Rumney	$43,947	20.2
Ashland	$40,213	13.6
Ellsworth	$39,167	4.8
Groton	$37,361	9.6
Plymouth	$36,154	21.6
Lincoln	$33,958	23.6

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

Unemployment

Unemployment is measured as the percent of the civilian labor force, age 16 and over that is unemployed, but seeking work. The recent unemployment rate in the CNHHP region is similar to the overall state rate.

Area	Percent Unemployment	Total Unemployed
CNHHP	4.5%	815
New Hampshire	4.4%	32,790

NH Employment Security, June 2014.

Population Below 200% of Poverty Level

This indicator reports the percentage of the population living under 200% of the Federal Poverty Level. Consistent with the previous information describing median household income and individuals in poverty, a higher proportion of individuals in the service area are living below twice the federal poverty level and a higher proportion of children are living in poverty compared to the state overall.

Area	Population with Income Below 200% Poverty Level	Percent Population with Income Below 200% Poverty Level
CNHHP Region	11,470	32.7%
New Hampshire	281,775	22.0%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

Children in Poverty

'Children in poverty' is the percent of children under age 18 living below 100% of the Federal Poverty Line.

Area	Percent of Children Under Age 18 in Poverty
CNHHP Region	13.8%
New Hampshire	10.9%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

EDUCATION

Educational attainment is also considered a key driver of health status with lower levels of education linked to both poverty and poor health. CNHHP Region is similar to New Hampshire overall with about 9% of the adult population who do not have a high school diploma or equivalent.

Population with No High School Diploma

This indicator reports the percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher.

Area	Population Age 25+ with No High School Diploma	Percent Population with No High School Diploma
CNHHP Region	2,131	9.1%
New Hampshire	81,053	8.6%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

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 CNHHP Region is lower than the New Hampshire overall rate.

Area	Teen Birth Rate per 1,000 Women Age 15-19
CNHHP Region	10.6
New Hampshire	14.8

Data source: NH Division of Vital Records Administration birth certificate data; 2009-2010.
Rate is not statistically different than the overall NH rate

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).

Population with Limited English Proficiency

This indicator reports the percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well."

Area	Total Linguistically Isolated Population	Percent Linguistically Isolated Population
CNHHP Region	455	1.4%
New Hampshire	30,519	2.4%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

HOUSING

Housing characteristics, including housing qualities and location, cost burden as a proportion of income, transiency and community affinity can influence the health of families and communities. CNHHP Region has a higher homeownership rate and somewhat less transient population than New Hampshire overall.

Area	Home Ownership Rate	Living in Same House 1 Year or More	Percent of households with housing costs >= 35% of household income
CNHHP Region	76.2%	85.8%	30.5%
New Hampshire	70.9%	86.4%	29.7%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates.

TRANSPORTATION

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services and more challenges to leading independent, healthy lives.

Area	Percent of Workers 16 years and over in Households with No Vehicle Available Level
CNHHP Region	2.0%
New Hampshire	2.2%

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

DISABILITY STATUS

Disability is defined as the product of interactions among individuals' bodies; their physical, emotional, and mental health; and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. In an attempt to capture a variety of characteristics that encompass the definition of disability, the US Census Bureau (American Community Survey) identifies people reporting serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation.

Percent of Population with a Disability	New Hampshire	CNHHP Region
Percent of Total Population	11.8%	13.9%
Under 18 years	5.4%	7.1%
18 to 64 years:	9.5%	10.1%
65 years and over:	31.4%	37.9%

Data Source: U.S. Census Bureau, 2008-2012 American Community Survey 3-Year Estimates.

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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 and insurance coverage for services, provider capacity in relationship to population need and demand for services, and related concepts of availability, proximity and appropriateness of services.

HEALTH INSURANCE COVERAGE (2012 ESTIMATE)

The estimated proportion of the total population without health insurance is higher for the CNHHP Region (13.5% or about 4,620 people) than for New Hampshire overall (10.5%) and is higher than the state rate in 17 of the 21 towns in the region.

Area	Percent of the Total Population without Health Insurance Coverage
Dorchester	28.0
Ellsworth	27.4
Lincoln	22.5
Groton	21.6
Woodstock	20.8
Wentworth	19.4
Thornton	16.9
Rumney	15.9
Bridgewater	15.8
Alexandria	15.6
Ashland	15.2
Danbury	14.4
New Hampton	13.4
Grafton	13.4
Hebron	12.6
Campton	12.3
Bristol	12.2
State of NH	10.5
Holderness	10.0
Plymouth	7.9
Orange	6.1
Waterville Valley	5.0
Total CNHHP Region Health Uninsurance Rate	13.5%

American Community Survey Data 5 year estimates, 2008- 2012.

Ambulatory Medical Care Capacity

The first indicator below reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as a personal doctor or health care provider. The second indicator reports the percentage of adults who self-report a cost barrier to seeing a doctor. These indicators may highlight insufficient access or availability of medical providers, a lack of awareness or health knowledge or other barriers preventing formation of a relationship with a particular medical care provider.

Adults without a Personal Health Care Provider

Area	Percent of adults who report not having a personal doctor or health care provider
CNH Public Health Region*	14.1%
New Hampshire	12.7%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-12.
Regional rates are not significantly different than the overall NH rates.
**CNH Public Health Region includes 17 of the 21 towns in the CNHHP region.*

Adults Reporting a Cost Barrier to Seeing a Health Care Provider

Area	Percent of adults who report not being able to see a doctor because of cost
CNH Public Health Region*	18.5%
New Hampshire	13.7%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-12.
Regional rates are not significantly different than the overall NH rates.
**CNH Public Health Region includes 17 of the 21 towns in the CNHHP region.*

Preventable Hospitalization

Hospitalization for diagnoses treatable in outpatient services suggests that access to or quality of care in the outpatient setting was not optimal. The measure may also represent a tendency to overuse hospitals as a main source of care. Preventable hospital stays are measured here as the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees. This rate is lower for CNHHP Region than New Hampshire overall suggesting somewhat better access to or quality of primary care and other outpatient services.

Area	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Plymouth, NH HSA*	51.0
New Hampshire	56.0

Dartmouth Atlas of Health Care, 2010 Medicare data
The Plymouth NH Hospital Service Area includes 11 of 21 towns in the CNHHP region
Regional rate is not significantly different than overall NH rate

Behavioral Health Care Capacity

Emergency Department Utilization for Mental Health Conditions

Overutilization or dependence on emergency departments for care of individuals with mental health conditions can be an indication of limited access to or capacity of outpatient mental health services. Utilization of emergency departments for mental health conditions is lower overall for CNHHP Region communities compared to New Hampshire and this difference is statistically significant for the young adult population.

Mental Health Condition ED Visits and Observation Stays (per 100,000 people)				
Area	All Ages	Ages 15-24	Ages 25-34	Ages 75-84
CNHHP Region	566.9	**693.2***	**973.4***	606.3
New Hampshire	753.7	1259.6	1360.0	413.6

Data Source: NH DHHS Hospital Discharge Data Collection System, 2009-2010
*Rates are statistically different; rates in bold are significantly lower than the overall NH rate
(Other age ranges not displayed do not differ from the state rate at a threshold of statistical significance)

Adequate Social or Emotional Support

This indicator reports the percentage of adults aged 18 and older who self-report receiving sufficient social and emotional support all or most of the time. Social and emotional support is essential for navigating the challenges of daily life as well as for good mental health. Social and emotional support is also linked to educational achievement, economic stability and communities with high levels of social capital.

Report Area	Percent of Adults Reporting Adequate Social or Emotional Support	Estimated Population of Adults **Not** Reporting Adequate Social or Emotional Support
CNHHP Region	83.8%	4,790
New Hampshire	82.9%	176,302

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2012.

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.

Report Area	Annual Deaths, 2006-2010 Average	Age-Adjusted Death Rate (Per 100,000 Pop.)
CNHHP Region	4	12.2
New Hampshire	170	12.3

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010.

Oral Health Care Capacity

The next three indicators highlight insufficient access to preventive oral health care, a lack of health knowledge or other barriers preventing utilization of dental services by adults and children.

Dental Care Utilization (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year.

Report Area	Total Population (Age 18)	Number Adults without a Recent Dental Exam	Percent Adults with No Dental Exam
CNHHP Region	28,846	7,519	26.1%
New Hampshire	1,025,011	237,144	23.1%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-10.

Poor Dental Health

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection.

Area	Total Population (Age 18)	Number Adults with Poor Dental Health	Percent Adults with Poor Dental Health
CNHHP Region	28,846	4,176	14.5%
New Hampshire	1,025,011	148,774	14.5%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-10.

Children in Need of Dental Care

Area	Percent of 3rd Grade Students in Need of Dental Treatment	Percent of 3rd Grade Students in Urgent Need of Dental Treatment
Grafton and Carroll Counties	16.7%	2.5%
New Hampshire	12.0%	1.0%

Data Source: NH 2008-2009 Third Grade Healthy Smiles-Healthy Growth Survey, NH DHHS.
Data not available for a smaller geographic area.
Regional rates are not significantly different than overall NH rate.

Disease Prevention

Adopting healthy practices, such as immunization, and behaviors can prevent or control the effects of disease and injury. For example, regular physical activity not only builds fitness, but helps to maintain balance, promotes relaxation, and reduces the risk of disease. Similarly, eating a healthy diet rich in fruits, vegetables and whole grains can reduce risk for diseases like heart disease, certain cancers, diabetes, and osteoporosis.

Fruit and Vegetable Intake

Inadequate Fruit/Vegetable Consumption (Adult)

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

Area	Total Population (Age 18)	Estimated Population with Inadequate Fruit / Vegetable Consumption	Percent Population with Inadequate Fruit / Vegetable Consumption
CNHHP Region	28,846	19,497	69.5%
New Hampshire	1,025,011	727,326	71.5%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2005-2009.

Population with Low Food Access

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number of residents have low access to a supermarket or large grocery store. Limited access to retail food outlets is associated with higher expenditures and limited options for selecting nutritious foods.

Area	Total Population	Population with Low Food Access	Percent Population with Low Food Access
CNHHP Region	35,005	7,720	21.6
New Hampshire	1,317,474	372,117	28.3

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas: 2010.

Physical Activity

Physical Activity and Inactivity (Adult)

This indicator reports the percentage of adults aged 18 and older who self-report leisure time physical activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". Lack of physical activity can lead to significant health issues such as obesity and poor cardiovascular health. About 1 in 5 adults in CNHHP Region can be considered physically inactive – a rate similar to the rest of New Hampshire.

Area	No Physical Activity or Exercise in Past 30 Days, % of adults
CNH Public Health Region	21.0%
New Hampshire	20.3%

Data Source: NH Health WRQS, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-2012.

Vaccine Preventable Diseases

Pneumonia and Influenza Vaccinations (Adults)

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

Area	**Adults 18 years and older** who have received a flu *shot in past 12 months* and **Adults 65 years and older** who *ever* received a pneumococcal vaccination	
	Influenza Vaccination Adults 18 and older	Pneumococcal Vaccination Adults 65 and older
CNH Public Health Region	40.8%	72.3%
New Hampshire	39.5%	72.0%

Data Source: Influenza - NH DHHS, Health WRQS Behavioral Risk Factor Surveillance System 2011-2012. Pneumococcal - Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-12 Differences are not statistically significant.

Illness and Injury

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

Premature Mortality

An overall measure of the burden of disease is premature mortality or years of potential life lost. The indicator below expresses premature mortality as the rate of death, regardless of cause, where age is less than 65 years at the time of death. During the period 2009 and 2010 (the most current information available), the rate of premature death in the CNHHP Region was similar to the rate for New Hampshire overall.

Area	Premature Mortality (Deaths per 100,000 People Under Age 65)
CNHHP Region	169.8
New Hampshire	159.3

Data source: NH Division of Vital Records Administration death certificate data; 2009-2010.
Rate is not statistically different and higher than the overall NH rate

Obesity

Excess weight has become a prevalent problem in the United States. Being overweight or obese can indicate an unhealthy lifestyle that puts individuals at risk for a variety of further health issues including hypertension, heart disease and diabetes.

Adult Obesity

These indicators report the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) or greater than 25.0 (overweight or obese). The chart at the bottom of the page displays the recent trend in the CNHHP Region toward increasing prevalence of obesity in the adult population.

Area	Total Population 18 and older	Percent Obese	Percent Overweight or Obese
CNH Public Health Region	28,846	25.1%	52.9%
New Hampshire	1,025,011	27.0%	62.1%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011 and 2012. Regional rates are not significantly different than the overall NH rates.

Childhood Obesity

Healthy lifestyles begin at an early age and can be linked to a number of factors including the social and physical environment. The societal trend toward unhealthy body weight has also occurred among children. The indicator below displays the rates of obesity for children from lower income families in Grafton County (19 of 21 CNHHP towns are in Grafton County) who are served by federally funded WIC and maternal and child health programs. The indicator on the next page displays the results of a sample of third grade students from Grafton and Carroll Counties combined.

Area	Low Income Children, ages 2-5	Percent Obese	Percent Overweight or Obese
CNHHP Region	555	15.9%	34.3%
New Hampshire	8,249	14.6%	31.5%

Data Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System,2011

Area	Third Grade Students (sample)	Percent Obese	Percent Overweight or Obese
Grafton and Carroll Counties	402	17.7%	34.6%
New Hampshire	3,082	18.0%	33.4%

Data Source: NH 2008-2009 Third Grade Healthy Smiles-Healthy Growth Survey, NH DHHS.
Regional rates are not significantly different than overall NH rate.

Heart Disease

Coronary heart disease is a leading cause of death in the United States and is closely related to unhealthy weight, high blood pressure, high cholesterol, and heart attacks.

Heart Disease Prevalence

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

Area	Total Population (Age 18)	Number of Adults with Heart Disease (self-reported)	Percent of Adults with Heart Disease (self-reported)
CNH Public Health Region	48,919	2,676	2.7%
New Hampshire	1,026,180	43,534	4.1%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2011-2012
Regional rates are not significantly different than overall NH rate.

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High Blood Cholesterol

High levels of total cholesterol and low density lipoprotein-cholesterol (LDL-C) and low levels of high density lipoprotein-cholesterol (HDL-C) are important risk factors for coronary heart disease. Periodic cholesterol screening for adults, particularly those with other risk factors, is a beneficial procedure for early identification of heart disease that can be treated with preventive therapy. The table below displays the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had high blood cholesterol.

Area	Percent of adults who report having been told they have high blood cholesterol
CNHHP Region	35.6%
New Hampshire	39.2%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2011-12.

Heart Disease Morbidity and Mortality

The rate of inpatient hospital utilization due to heart disease is lower among CNHHP Region residents compared to the New Hampshire population overall, while the rate of emergency department utilization resulting from heart disease is similar. The rate of death due to heart disease among CNHHP Region residents is also similar to the overall rate for New Hampshire.

Heart Disease-Related Emergency Department and Inpatient Utilization (per 100,000 people)		
Area	Heart Disease Inpatient Discharges, age adjusted	Heart Disease ED Visits and Observation Stays, age adjusted
CNHHP Region	**181.4***	64.4
New Hampshire	271.5	49.9

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
**Denotes regional rate is significantly different than overall NH rate.*

Heart Disease Deaths (per 100,000 people)	
Area	Overall, age adjusted
CNHHP Region	128.3
New Hampshire	140.4

Data Source: NH DHHS Hospital Discharge Data Collection System, 2009-2010
Regional rate is not significantly different than overall NH 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 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. Nearly 1 in 10 adults in the CNHHP Region, equivalent to more than 2,900 people, report having been told by a health professional that they have diabetes.

Adults with Diabetes, Percentage (Age-Adjusted)		
Area	Total Estimated Adult Population with Diabetes (age 20+)	Percent of Adults with Diabetes
CNHHP Region	2,915	9.2%
New Hampshire	94,415	9.1%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2011-2012
Regional rate is not significantly different than overall NH rate.

Diabetes-related Morbidity and Mortality

The rate of emergency department utilization due to diabetes is among CNHHP Region residents is similar to the New Hampshire population overall. Inpatient utilization resulting from diabetes is also similar in the CNHHP Region compared to the New Hampshire population overall, while inpatient utilization for *diabetes-related* conditions is lower. The rate of death due to diabetes among CNHHP Region residents is also similar to the overall rate for New Hampshire.

Diabetes ED Visits and Observation Stays (per 100,000 people)	
Area	Overall, age adjusted
CNHHP Region	139.3
New Hampshire	150.2

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
Rate is not significantly different than overall NH rate

Diabetes and Diabetes-Related Inpatient Utilization (per 100,000 people) Overall, age adjusted			
Area	Diabetes Inpatient Discharges,	Diabetes Related Inpatient Discharges	Diabetes Related Lower Extremity Amputation Inpatient Discharges
CNHHP Region	95.1	**1,073.7***	14.5
New Hampshire	99.0	1,380.2	16.4

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
**Rate is statistically different and lower than the overall NH rate*

Deaths due to Diabetes or Diabetes as an Underlying Cause (per 100,000 people, age adjusted)		
Area	Diabetes Deaths	Diabetes Underlying Cause and Related Deaths
CNHHP Region	13.1	51.5
New Hampshire	16.2	60.5

Data Source: NH DHHS Hospital Discharge Data Collection System, 2009-2010
Rates are not statistically different; than the overall NH rate

Asthma

Asthma is a prevalent condition that can be exacerbated by poor environmental conditions including air and housing quality.

Asthma Prevalence

This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma, equivalent to nearly 5,000 people in the CNHHP service area.

Area	Number Adults with Asthma	Percent Adults with Asthma
CNH Public Health Region	4,854	18.3%
New Hampshire	150,044	14.6%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2011-2012
Regional rate is not significantly different than overall NH rate.

Asthma-related Morbidity

The rate of utilization of the emergency department for asthma care can indicate a variety of concerns including poor environmental conditions, limited access to primary care, and difficulties with asthma self-management skills. The rate of emergency department utilization for asthma care by CNHHP Region residents is significantly higher than for the overall New Hampshire population and is significantly higher for every age bracket except young children (ages 0-4), adolescents and young adults (ages 15-34).

Asthma ED Visits and Observation Stays (per 100,000 people)	
Area	All Ages
CNHHP Region	**691.3***
New Hampshire	493.3

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
Rate is Significantly Different and Higher than the overall NH rate.

Emergency Department Utilization and Injury

Rates of Emergency Department utilization have been displayed previously as indicators of health care access and the burden of disease for several conditions and categories of health including mental health, heart disease and asthma. The chart below shows the top 5 most common reasons for emergency department utilization in the CNHHP Region and compares the utilization rates for those conditions to the state rates. The CNHHP Region experiences significantly higher utilization of the Emergency Department for skin contusions, wounds and spinal disorders, while utilization is lower for acute respiratory infections and abdominal pain (note: crude rates are not adjusted to account for variations in the age profile of comparison populations).

Emergency Department Utilization

Most Common Reasons for ED Visits and Observation Stays Per 100,000 People by Condition (All Ages)

Outpatient Condition	CNHHP Region Crude Rate	New Hampshire Crude Rate	Difference
Contusion with intact skin surface	2,029.4	1,881.6	**Significantly Higher**
Open wound, excluding head	1,866.6	1,579.9	**Significantly Higher**
Acute upper respiratory infection, excluding pharyngitis	1,471.4	1,633.0	***Significantly Lower***
Abdominal pain	1,455.1	1,579.3	***Significantly Lower***
Spinal Disorders	1,434.4	1,209.7	**Significantly Higher**

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
Significant=Difference between regional rate and overall NH rate is statistically significant

Unintentional Injury

As shown by the table below, unintentional injuries causing emergency department visits and observation stays are significantly higher for CNHHP Region residents overall and for every age category except young adults (ages 25-34; and for the age 15-24 group where the utilization rate is lower compared to the state overall) and the elderly (75 and older). Causes of unintentional injury leading to emergency department utilization include such injuries from falls, striking or being struck by an object (e.g. striking furniture, falling objects, sports injuries), suffocation (e.g. choking on a foreign object), lacerations, burns, poisoning and motor vehicle accidents.

Unintentional Injury ED Visits and Observation Stays per 100,000 People by Any Cause/Mechanism; 2008–2009

	CNHHP Region		New Hampshire		
	Adjusted Rate	Events	NH Adjusted Rate	NH Events	Statistical Test
Overall	11,537.8	7,451	10,451.1	275,227	Sig
	Age-Specific Rate	Events	Age-Specific Rate	Events	Statistical Test
0 To 4	13,651.2	418	11,856.8	17,584	Sig
05 To 14	14,887.1	1,015	11,390.6	37,454	Sig
15 To 24	12,233.9	1,540	13,717.9	54,128	Sig
25 To 34	13,104.8	1,040	13,555.2	41,010	Not Sig
35 To 44	12,134.1	999	9,975.5	38,772	Sig
45 To 54	9,106.5	958	7,782.2	35,199	Sig
55 To 64	7,407.8	655	6,249.5	21,625	Sig
65 To 74	7,303.5	393	6,353.3	12,446	Sig
75 To 84	9,079.1	280	8,875.9	10,411	Not Sig
85 Plus	14,011.0	153	12,858.1	6,598	Not Sig
Total Crude	11,029.4	7,451			

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009

SUBSTANCE ABUSE

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

Adult Substance Abuse

Excessive drinking

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

Engaged in Binge Drinking in Past 30 days, Percent of Adults	
Area	All Ages
CNH Public Health Region	20.7%
New Hampshire	18.0%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012.
Regional rate is not significantly different than the overall NH rates.

Heavy Alcohol Use Risk Factor, Percent of Adults	
Area	All Ages
CNH Public Health Region	7.3%
New Hampshire	7.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012.
Regional rate is not significantly different than the overall NH rates.

Substance Abuse-related Morbidity

The rate of utilization of the emergency department for substance abuse-related conditions can indicate a variety of concerns including prevalence of substance abuse in the community, community norms, and limited access to treatment. The rate of emergency department utilization for substance abuse related mental health conditions by CNHHP Region residents is significantly lower than the overall New Hampshire rate, including among young adults.

Substance Abuse Related Mental Health Condition ED Visits and Observation Stays (per 100,000 people)		
Area	All Ages	Ages 15-24
CNHHP Region	**319.3***	**315.1***
New Hampshire	482.0	797.2

Data Source: NH DHHS Hospital Discharge Data Collection System, 2009-2010
**Rate is significantly different and lower than overall NH rate*

Cigarette Smoking

Tobacco use is a primary contributor to leading causes of death such as lung cancer, respiratory disease and cardiovascular disease. This indicator reports the percentage of adults aged 18 and older who self-report currently smoking cigarettes some days or every day.

Area	Number of Adults who are Current Smokers	Percent of Adults who are Current Smokers
CNH Public Health Region	5,829	21.2%
New Hampshire	186,235	18.1%

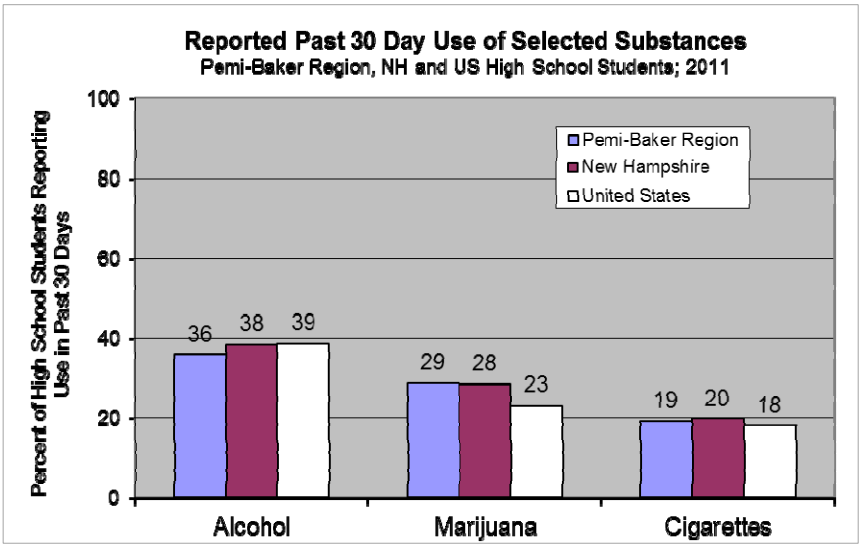
Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2011-2012.
Regional rate is not significantly different than the overall NH rates.

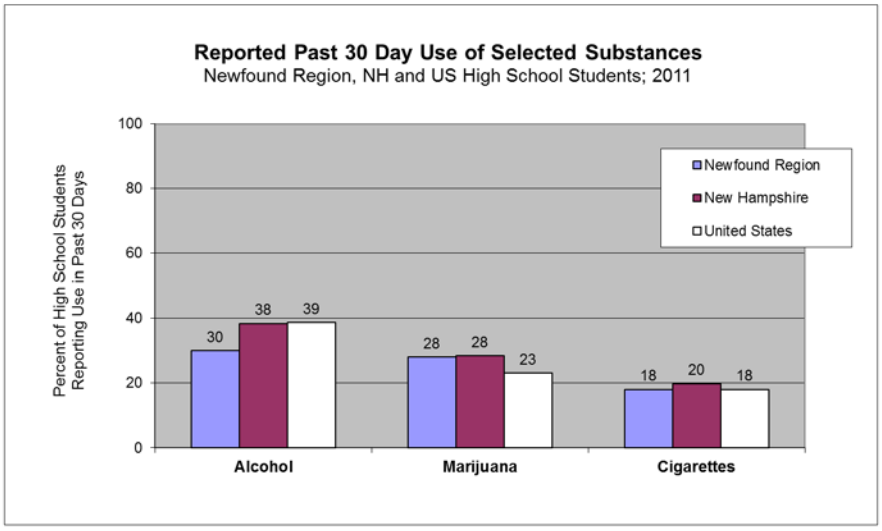
Youth Substance Abuse

In New Hampshire and nationally, significant attention is placed on early prevention of substance abuse problems through youth education to instill understanding of risks and skill building to promote risk reduction and resiliency strategies and abilities. A source of measurement of youth attitudes and practices regarding substance abuse in recent years in the CNHHP Region has been the Teen Assessment Project (TAP) Survey. The TAP Survey has been administered biannually in the Pemi-Baker and Newfound Regional School Districts.

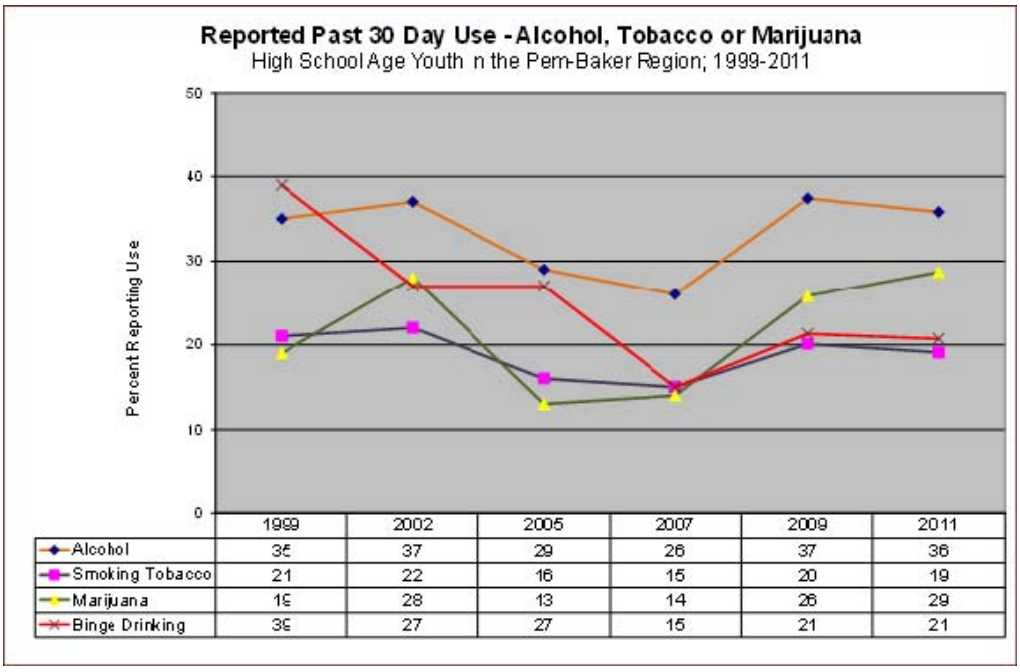
Past 30 Day Substance Use

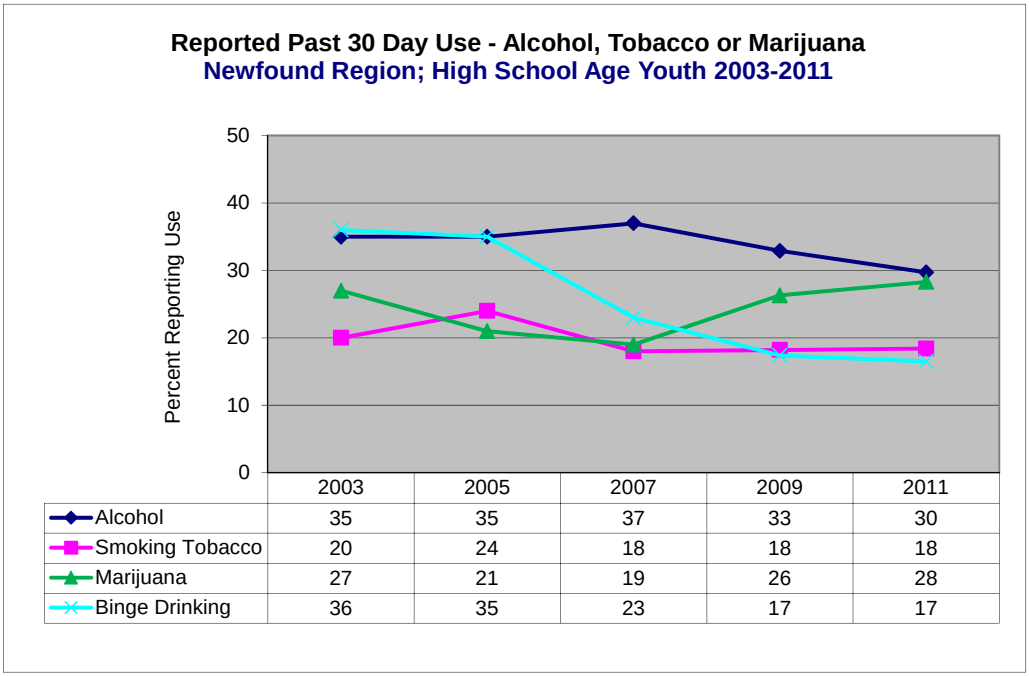
The graphs below display the percentage of high school students who reported using certain substances at least once in the 30 days prior to the survey administration date. In each case, it can be noted that the rates of reported substance use among high school age youth in the the CNHHP Region youth are similar to state and national rates for cigarette use, somewhat higher for marijuana use, and in the case of Newfound region, somewhat lower for current alcohol use.





The graphs below display trends in each sub-region for past 30 day use of cigarettes, marijuana, and alcohol including binge drinking. In each case, there have been significant decreases in the prevalence of binge drinking behavior over time, but a generally increasing trend in marijuana use.



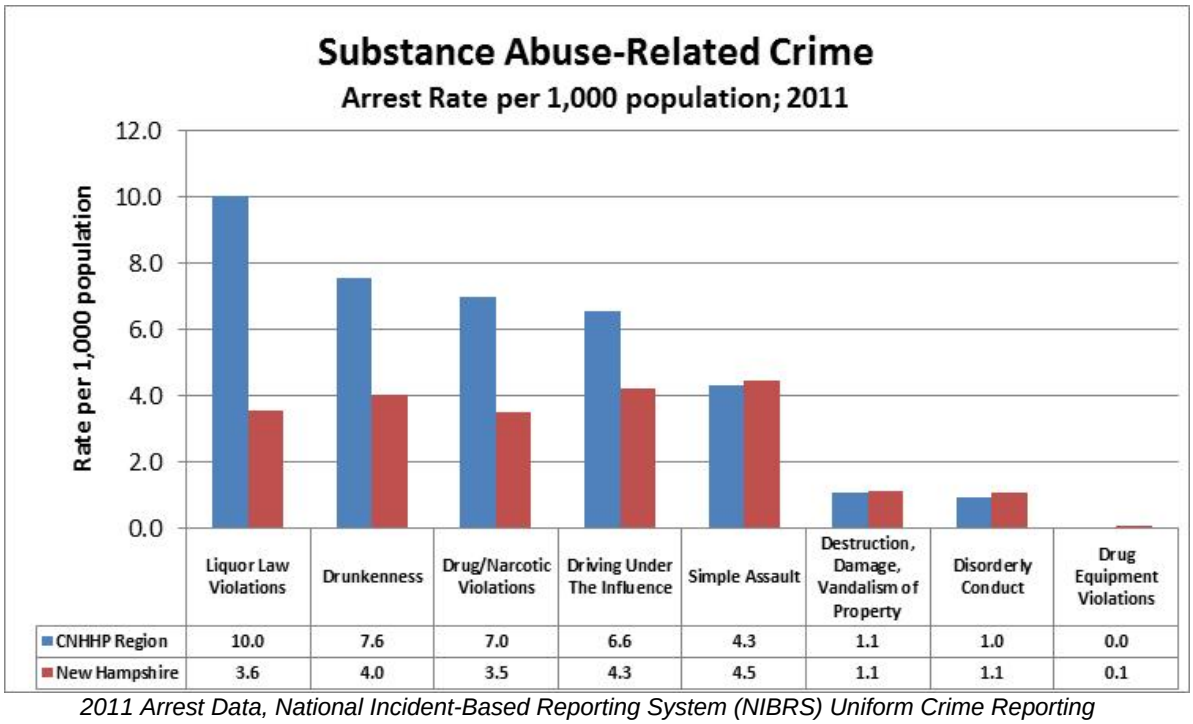


Public Safety

Community health and public safety are closely intertwined in that many of the same social and environmental factors which correlate with health and wellbeing also correlate with variation in crime rates. The sense of a safe community is associated with higher levels of social capital and social organization. Inversely, the effects of higher rates of crime and reduced perceptions and experiences regarding personal and public safety include negative consequences for acute as and chronic measures of physical and mental health.

Substance Abuse-Related Crime

As described in the prior section, substance abuse behavior contributes to criminal behavior. The chart below displays the rate of arrests per capita in 2011 for selected substance-abuse related crimes. A comparison of the CNHHP Region (10 of 21 municipalities reporting representing 62% of the service area population) with the overall New Hampshire rates shows that the CNNHP region had higher per capita rates in 2011 of liquor law violations, drunkenness, drug/narcotic violations and DUI. Arrest rates for other substance abuse related crimes are similar to the overall state rates.



	Liquor Law Violations	Drunkenness	Drug/Narcotic Violations	Driving Under The Influence	Simple Assault	Destruction, Damage, Vandalism of Property	Disorderly Conduct	Drug Equipment Violations
CNHHP Region	10.0	7.6	7.0	6.6	4.3	1.1	1.0	0.0
New Hampshire	3.6	4.0	3.5	4.3	4.5	1.1	1.1	0.1

2011 Arrest Data, National Incident-Based Reporting System (NIBRS) Uniform Crime Reporting

Assault

Emergency department utilization by CNHHP Region residents where “assault” is listed as the cause of the visit or observation stay is significantly lower than the overall state rate, including for the young adult age group.

Assault Injury ED Visits and Observation Stays (per 100,000 people)		
Area	All Ages	Ages 15-24
CNHHP Region	**219.0***	**469.5***
New Hampshire	261.8	689.6

Data Source: NH DHHS Hospital Discharge Data Collection System, 2008-2009
**Rates are Significantly Lower*

Central New Hampshire Health Partnership

2014 Community Health Assessment

Part 2 - Community Discussion Groups Summary

Summary of Community Health Discussion Groups Themes and Findings

A series of six focus groups were convened in the Spring of 2014 as part of an effort by the members of the Central New Hampshire Health Partnership to understand the health-related needs of the community and to plan programs and services that address those needs. The purpose of the discussions was to get input on health issues that matter to the community and thoughts and perceptions about the health of the community. Discussion groups were formed representing a variety of important community sectors and perspectives. A total of 40 community members participated in discussion groups representing the following sectors:

- **Head Start Community (4 participants)**
- **Senior Community (7 participants)**
- **Mental Health Community (11 participants)**
- **Education Community (10 participants)**
- **Business Community (5 participants)**
- **Faith Community (3 participants)**

High Priority Issues

The highest priority issues overall identified by the discussion groups were:

1. *Access to Mental Health/Behavioral Health Care Services*
2. *Physical Activity, recreational opportunities, active living*
3. *Fragile families, family stress*
4. *Diet and Nutrition, access to healthy foods*
5. *Education*
6. *Access to Health Insurance*
7. *Access to Dental Care Services*

These issues are displayed in the first chart following page 41 by their relative weight in total. The highest priority issues for each group separately are also displayed on this chart.

Summary of Discussion Group Themes and Recommendations

1. Discussion group participants comprehended and described a comprehensive, holistic perspective on health and well-being.

   "(We) need to look at the big picture. Wellbeing is not just one thing – healthy finances, relationships, community, spiritual, intellectual, physical, political, economic."(Faith Leader)

   "We are all connected and we impact each other." (Education Leader)

   "Healthy individuals create healthy communities" (Mental Health Community Participant)

2. Participants had mixed feelings about the overall health of the community. There is a perception that health is better in towns with more concentration of resources and less in more rural areas. There is also an understanding of the relationship between income and health regardless of geography.

   "There is no consistent community cohesion. There are sub-communities that are healthy; different health in different towns." (Faith Leader)

   "Plymouth is healthier than outlying rural towns." (Mental Health Community Participant)

   "Transportation is a huge stumbling block. Distance, isolation, rural nature of our communities." (Head Start Parent)

   "Younger people are more aware of nutrition and health." (Business Leader)

   "Physical health is improving in this area." (Education Leader)

3. Participants identified a wide variety of community strengths and resources that promote health including specific health and human service organizations, health fairs, outdoor activities and formal events such as sponsored races, and informal social networks.

4. Participants identified a range of barriers to promoting good health in the community including the need for more awareness of available resources, more education, financial pressures on individuals, families, schools and community service organizations, mental and emotional health, and variability in access to services.

   "Emotional Safety – families are just surviving. And the emotional wellbeing is a secondary concern." (Education Leader)

   "The people in the middle; the haves, have-nots, and in between. Haves: access to community resources and transportation to get to resources Have-nots: linked to services because of court/legal issues, children, DCYF but don't use resources because they don't want to. In betweens: falling through cracks, don't have resources linked to them (because not linked with agency) and can't access them either (transportation/financial barriers)" (Mental Health Community Participant)

   "Some don't know where services are or how to access them" (Senior Community Participant)

5. Participants were asked about their awareness of programs or activities that have focused on priority issues that had been identified by CNHHP in 2011 including:

    - Improving access to health insurance; access to care: Participants were most likely to cite the Affordable Care Act and to some extent local efforts to assist people in accessing health insurance connected to health reform.

    - Availability of transportation: Transport Central was identified by at least some participants in four of the six groups. The participants had mixed reviews regarding noticeable improvements in transportation availability.

    - Healthy eating and physical activity: Participants identified efforts for improving school nutrition, nutrition education activities, and local foods initiatives. Efforts to improve physical activity were generally not identified in the discussions.

    - Substance abuse prevention: The CADY organization was identified in three of the discussion groups and, in general, the education and mental health communities were most aware of a range of initiatives in this area.

    - In response to this set of questions, some participants identified a need to create more awareness in the community at large of resources and activities.

      "(There is) no connection between programs and community. How can people know about these things?" (Faith Leader)

6. As previously noted, discussion group participants identified a number of priorities for improving community health. It is important note that there was variation across the groups with respect to the highest priorities (see first table following this narrative), but overall the groups shared priorities in the areas of: Access to Mental Health/Behavioral Health Care Services (identified by 5 of 6 groups); Physical Activity, recreational opportunities, active living (5 of 6); Fragile families, family stress (5 of 6); and Diet and Nutrition, access to healthy foods (4 of 6).

7. With respect to what organizations could be doing better to support or improve community health, participants identified needs for enhanced health education in schools, increased awareness of available resources, improved communication and coordination between agencies, and socio-economic improvements.

   "Getting into the schools more. Providing educational programs about healthy living and wellness (mental, physical, and emotional) to create a stronger and healthier community." (Mental Health Community Participant)

   "More awareness of services available" (Head Start Parent)

   "We need something centralized that "helpers" can use for referral." (Faith Leader)

   "People need more access to jobs" (Head Start Parent)

8. Finally, discussion group participants were provided an opportunity to anonymously write down one service or support that would help them to maintain their own health. The most common responses were:

   - Improved access to physical activity and recreational resources (8 responses)
   - Increased awareness of available resources (3 responses)
   - Improved access to transportation (3 responses)
   - Access to affordable dental care (2 responses)

PRIORITY ISSUES IDENTIFIED BY COMMUNITY DISCUSSION GROUPS

Rank	Issue	Priority Strength*	Head Start Community	Senior Community	Mental Health Community	Educators	Business Leaders	Faith Leaders
1	**Access to Mental Health, Behavioral Health Care Services**	3.00	Access to Mental Health/Behavioral Health Care Services	Chronic Diseases	Access to Dental Care Services	Fragile families, family stress	Physical Activity, recreational opportunities, active living	Education
2	**Physical Activity, recreational opportunities, active living**	2.83	Physical Activity, recreational opportunities, active living	Access to Mental Health/Behavioral Health Care Services	Diet and Nutrition, access to healthy foods	Access to Mental Health/Behavioral Health Care Services	Fragile families, family stress	Physical Activity, recreational opportunities, active living
3	**Fragile families, family stress**	2.83	Generational welfare	Access to Primary Health Care Services	Education	Alcohol and Drug Abuse	Diet and Nutrition, access to healthy foods	Access to Health Insurance
4	**Diet and Nutrition, access to healthy foods**	2.00	Obesity	Access to Dental Care Services	Access to Specialty Care Services	Employment	Access to Health Insurance	Access to Mental Health/Behavioral Health Care Services
5	**Education**	1.83	Transportation	Access to Prescriptions, Medications	Physical Activity, recreational opportunities, active living	Physical Activity, recreational opportunities, active living	Obesity	Diet and Nutrition, access to healthy foods
6	**Access to Health Insurance**	1.67	Fragile families, family stress	Poverty	Fragile families, family stress	Transportation	Income	Poverty
7	**Access to Dental Care Services**	1.67	Income	Transportation	Access to holistic care	Income	Education	Fragile families, family stress
8	**Poverty**	1.17	Employment	Access to Elder Care Services	Access to Health Insurance	Healthy workloads	Poverty	Access to Dental Care Services
9	**Obesity**	1.00	Alcohol and Drug Abuse	Access to Substance Abuse Treatment	Access to Mental Health/Behavioral Health Care Services	Diet and Nutrition, access to healthy foods	Employment	Access to people or place where referrals/resources are available
10	**Transportation**	1.00	Tobacco	Access to Health Insurance		Poverty	Access to Elder Care Services	
11	**Chronic Diseases**	1.00	Screen time/lifestyle choices	Obesity		Abuse & Neglect	Eldercare Facilities	

***Priority Strength is assessed on a scale of 0 to 5 where a score of 0 is equivalent to an issue not being identified by any group and a score of 5 is equivalent to an issue being identified as the highest priority by every group.**

1A -Perspectives on Health and Wellness: What comes to mind when you hear the words "health" or "wellness"?

	Head Start	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
Holistic Perspective, Interconnectedness of Mind, Body, Spirit, Community						
	Wellness of community: winter = isolation = depression		Healthy individuals create healthy communities	Overall wellness: social-emotional, spiritual, physical, nutritional; this means balance	Happiness and mental health	Balance – many factors in balance – need for a total perspective – holistic – need to look at the big picture – wellbeing not just one thing – healthy finances, relationships, community, spiritual, intellectual, physical, political, economic
				If there is something wrong in one area it will affect the other areas of wellness.	Preventive screenings, mind and body awareness both important	Health of individuals AND health of community
				Wellness is in a spectrum – a person is not there in isolation within a group and those in the group can affect the persons		Community is about inter-twining relationships. What the community offers, or doesn't, is connected and vital.
				People don't have access to it or have awareness of what wellness means, and that is tied to the community.		
				Lack of empathy affects the health of the community. But being aware of each other can help.		
				We are all connected and we impact each other. As a collective PSU faculty we meet to look at the needs of students. Also, our moods can affect well-being.		

1A -Perspectives on Health and Wellness: What comes to mind when you hear the words "health" or "wellness"?

	Head Start	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
Health Behaviors						
	Diet			Proactive to avoid issues – prevention	Daily lifestyle; nutrition and exercise	Need augmentation to mental health services – drugs are an issue – mental health issues – depression, people feeling "blue", but they don't want to see a psychiatrist/psychologist. They want to talk to their peers.
	Exercise				Keeping employees engaged and aware of nutrition	One participant indicated that when someone comes to them for mental health-type counseling, they will provide three listening sessions, and then refer – there are monetary considerations.
	Activities					
	Adult recreation					
Health Outcomes						
					Employees physically and mentally ready to work	
Services, Programs, Facilities						
	Medical	I don't have the money for that – insurance doesn't cover that	Difficulty communicating what is available		Preventive care	

1A -Perspectives on Health and Wellness: What comes to mind when you hear the words “health” or “wellness”?

	Head Start	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
	Adequate communication from town agencies	In the store a woman said she had to choose between their prescription or food	People don’t know where to get healthy (facilities, classes, programs)			
		Medicare without supplemental insurance may not be enough	Want access to facilities not advertised (PSU facilities, Pemi-Baker facilities)			
		Participants felt that they had great insurance although they have large premiums.				
Physical Environment						
			Need more side walks			
Social and Economic Factors						
			Resources in community are limited	It’s not an individual responsibility but other factors, jobs, family, environment. What is going on the family, and the interconnectedness within the family? How the needs of everyone in the family are being met can affect the overall effectiveness.		

1A -Perspectives on Health and Wellness: What comes to mind when you hear the words “health” or “wellness”?

	Head Start Parents	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
				So many aspects of health and wellness, it can individual but the social factors can affect the accessibility of resources.		
				Culture can be a factor. Poverty is a culture. It can be challenging if there is a language barrier.		
				Work culture is very similar. Is the work culture driving the policy?		

1B - Are people in the community healthy? Contributing factors						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Holistic Perspective, Interconnectedness of Mind, Body, Spirit, Community						
				Education has a lot to do with health.		The local mentality has both a positive and negative impact. We need a more regional view of health.
				Keeping up with a schedule – ball juggling - it is a strain		CNHHP needs to go out and participate within the subgroups to get acquainted with the groups. The groups aren't coalescing at all. "You will learn by being there – by catching the vibes".
				Committee on campus quality vs quantity – doing more with less. Even with young children are doing more with less. – no nap in Kindergarten. This is unhealthy. No downtime. Necessary to renew.		But some sub-communities may be doing something or give off a sense of community, but not sure how they bridge over to other communities. But they seem to take care of each other within the community. "Watch the newspapers and see the gateways and listen to people, talk to people."
				As individuals we need our personal space.		Get to know the community's individuals – "just show up everywhere, know everyone; creates coalescing by virtue of familiarity and being part of the group, to provide the glue and facilitates connections. The community process is the heart of health."
				Technology plays a part of this; there is little downtime, adding to stress.		
				Inspiration is lacking as we check things off a 'to do' list.		

1B - Are people in the community healthy? Contributing factors

	Head Start	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
Health Behaviors						
	Campton elementary school has a required ski/skate program. Very positive element in the elementary school. Jets program is an outdoor ski program through parks and rec for $200 sk every Saturday and Sunday. Motivating kids to do something outside.			Obesity can affect overall health.	Younger people are more aware of nutrition and health	
	There is a role model piece that is missing; of a parent or grandparent doing activities with kids.			Physical health is improving in this area. Technology will help educate. School lunches have changed. Physical activity is integrated in the school. Towns help each other with providing sports/teams.	Some folks making health a priority, most are not	
	"Fituary" in February . . .committing to being active every day.					
Services, Programs, Facilities						
	Transportation is a huge stumbling block. Distance, isolation, rural nature of our communities.	Lack of mental health in this area	Transportation is a barrier to staying or getting healthy	Got lunch – Ashland, Plymouth, Campton Thornton		
	Loneliness. Lack of access.	Commodities food	Access and finances are barriers to using facilities			

1B - Are people in the community healthy? Contributing factors						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
		Lucky to live in a community where there is easy access to things- Walmart, Hannaford's.				
		Some reported using the local farmers markets too.				
Physical environment						
	NO! Do not believe majority of people are as healthy as they could be due to area of country we live in, and lack of motivation to be active. I have children in Colorado and Seattle where there is much more public transportation and walking communities.			Health of the community is big picture. Access to walkway and clean rivers.	Winter and darkness are a problem	
	No sidewalks!			Access to the physical environment		
Social and Economic Factors						
		Socializing	Plymouth is healthier than outlying rural towns.	Professionals have a voice. But what about the other segments of the community. Regular folks are not necessary connected to the community and have a voice.	Plymouth healthier than most due to university	No. There are economic barriers that lead to behaviors that affect health – drinking, smoking, abuse of substances comes partly from economic pressures, which affects family and community.
			Skewed look at health because of there being university and hospital	Not a lot that happens in the weekends or night. A lot of folks work 2 and 3 jobs.	Have and have-nots: no in-between	There is no consistent community cohesion.

1B - Are people in the community healthy? Contributing factors						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educator**	**Business Leaders**	**Faith Leaders**
			Limited amount of jobs creates limited finances (using facilities, taking classes, etc.)	Cooking and nutrition class: The experience of the participants is positive. But when done at home the quality of the food is not the same as it is in the class.		There is no consistent community cohesion. There are sub-communities that are healthy. Different health in different towns.
				We may offer Educational programs but can the participants follow thru at home? Is there the support away from the class to implement? There is a gap between knowing and implementing.		Relative to social and mental health within the faith-based communities, subsets of congregation can impact or be catalysts of health.
				The social economic/financial barriers. Kids aren't bringing quality food to school.		

2A - Community strengths and resources that promote health (When you think of people, places or events in your community that promote health what comes to mind?)						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Health/Human Service Organizations						
	Hospital health fair	Foot clinic and BP clinic at Senior Center	Speare Memorial Hospital	Shop N Save does a lot of outreach with food and nutrition along with the Newfound Area Nursing		
	Pool at Boulder Point and other for profit.	Speare Health Fair	Whole Village Family Resource Center	Whole Village is great resource even for Bristol.		
			Parenting classes			
Schools, University						
		Would be nice to see a health day at PSU – open to the public		Rely on the school (Thornton) school is the key. And does things for Seniors		Churches, the Grange, University, schools, downtown. They are all positive regarding health.
				Bristol – there are many resources but within the community, the school is the central location. Xmas gift, baskets, fuel, healthy snack 3 days a week thru the school. Shop N Save does a lot of outreach with food and nutrition along with the Newfound Area Nursing. And this works in collaboration with the school. School is the hub of the many things. Court stuff, back pack filling, etc.		
Faith Community						
				Local churches are a good connection		Churches, the Grange, University, schools, downtown. They are all positive regarding health.

2A-Community strengths and resources that promote health (When you think of people, places or events in your community that promote health what comes to mind?)						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Community Service Organizations, Coalitions, Businesses, Charities						
	Jazzercise	People can come to senior center and for $3.00 have a healthy		PYC received frozen corn dogs. Taste of NH – raising money for food access but is providing substandard food to	Gyms in businesses	Churches, the Grange, University, schools, downtown. They are all positive regarding health.
				Shop N Save does a lot of outreach with food and nutrition along with the Newfound Area Nursing.	Promotions of exercise by individual in company	4H; Scouts;
Municipalities						
				Ashland has pride and will take care of their own. Really knowing who's doing what when. Coordinating in area is good but knowing who coordinate what. Ashland is looking at a Community garden. Change comes when you experience it. And education should come with Got Lunch program to help with planning.		
Physical Environment, Recreational Assets, Events, Programs						
	Races		Organizations that host 5k races (ex: circle program)		Events encourage health and community; example: Speare's Shamrock Shuffle	Mountains, paths, outdoor pursuits, getting people out.
	Ecogardens		Parks & Recreation			Clean air, clean water, and organic produce.
	Skateboard park in Plymouth					

2A - Community strengths and resources that promote health (When you think of people, places or events in your community that promote health what comes to mind?)						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Social Groups, Informal Connections						
				Enhancing what is being done. There is a very strong link between youth and adults with getting your hands dirty. Gardens are very important. They nurture food and soul.	Yoga group in Hebron – informal	Just getting together
					Groups of friends	People need connection with one another to be healthy. There is a group that doesn't access people, places, and events, which causes or results in poor health; people in the margins who aren't connected; people who are isolated, outliers. Yankee individualism – not wanting connection is sometimes a choice. Are they healthy? Yes, sometimes; sometimes not. How can Yankee individualists be healthy? Can you be healthy and be alone? A lot of people think so.
					Plymouth and Campton: running group	
					Hiking group at Café Monte Alto	
					Need a promoter/driver to keep it going	
					Social media supports	

Other Assets, Strategies, Initiatives						
	In Campton, condo complex has pool and tennis courts should be open to public. Overlook condos wants to shut them down as residents don't use.			Fear that there is something that we are not aware of in terms of resources available.		

2B - Barriers in the community to promoting good health (What is happening in your community that gets in the way of or undermines good health?)						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Organizational/Service Barriers and Needs						
	PSU doesn't advertise the community membership options	Transportation	Transportation (Programs reaching people without transportation are: Headstart, schools, Voices Against Violence, Homevisit NH, CASA, Family Resource Center)	Parents. From a nutrition standpoint – Programming doesn't always get well received by the parents when the youth solely are involved in the program. This is in all programs like Head Start youth, Nutrition Connections. There is a resistance to change by the parents		
	Fear of liability	Not everyone knows of the things they can access	It's not getting worse, but less resources are available and access is limited making it difficult and in turn getting in the way of creating healthy communities.	Transportation		
	(Access to) Dental care	Worry about cost and access	Resources stretched so thin and being cut.			
	Cost of prescriptions	Many can't afford home health aides	Child care being cut			
	Transportation. Example: kid has a cold, not yet an ear infection, but tomorrow it is, and means another trip	Some don't know where services are or how to access them	Access: Can't get good care close to where you live and you should be able to; Limited provider resources; May need certain health care and can't get it			
Health Issues, Behaviors, Attitudes						
	People's attitude. Okay to do that, but not in my backyard.	Depression	Mental Health of individual, don't want to reach out because of stigmas attached to needing help/assistance.	Human Nature to resist – lack of awareness.	Mental health: folks need life coach	Poverty, addiction, lack of education, people are not well- educated.
	Cigarettes are the thing. Can hospital relook at offering smoke cessation?	Worry about becoming incapacitated		Perception of Risk – low perception of risk affects youth behaviors		School budgets – people don't want to spend money on education

2B - **Barriers in the community to promoting good health** (What is happening in your community that gets in the way of or undermines good health?)						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
	Fast food restaurants			Thornton – extra sports – if I make my child's life busy then they will avoid risky behavior		People are conservative, anti-tax viewpoint.
				Worried about mental wellness of the youth growing up – Feeling safe!		
				Technology is so fast paced and changing and parents don't know what to do. And opens the world to danger. Imagination is lacking in youth. And being removed from contact – conflict resolution is going away! What does that do to self-development?		
				Parents are on their devices. No conversation coming from the parents.		
Physical environment						
		Concerned about water supply (radon)				
Social and Economic Factors						
	Economy		Catastrophic illness; with healthcare so expensive and providers restricting access families are 1-2 paychecks away from losing homes.	Parents don't have the money to access the sports	Cost: of food, particularly in events or gym	Poverty, addiction, lack of education, people are not well- educated.

2B - Barriers in the community to promoting good health (What is happening in your community that gets in the way of or undermines good health?)						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
	Worry about the cost of food.		The people in the middle; the haves, have-nots, and in between. Haves: access to community resources and transportation to get to resources Have- nots: linked to services because of court/legal issues, children, DCYF but don't use resources because they don't want to. Inbetweens: falling through cracks, don't have resources linked to them (because not linked with agency) and can't access them either (transportation/financial barriers)	Worried about mental wellness of the youth growing up – Feeling safe!	Lack of personal encouragement	
				Emotional Safety – families are just surviving. And the emotional well-being is a secondary concern. This comes back to awareness.	Lack of personal relationships	

2C - Awareness of programs or activities that have focused on recent priority areas						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Improving access to health insurance; access to care						
	ObamaCare		No. So many restrictions and provider limitations. No local specialty care facilities, restrictions on number of visits, etc.	ACA –affordable health care	Insurance availability	Obamacare
				Midstate Health Center has been helping people gain access to ACA		Not aware of Mid-State Health Center's sliding fee scale to ensure access to health care.
				Mental Health care – there is a need to access that health care in a timely manner. Hospital and Genesis.		Psychological care – "It's too complicated, too expensive. People want to talk to someone they know. Familiarity is a good system for small communities."
				Mental Health Court		
				Dental care in the schools.		
				Laconia eye doctor in the Bristol school		
Availability of transportation						
	Transport Central	The group didn't not feel that there were any improvements	Yes. Transport Central started and gives access to community members, local agencies getting busses, senior center providing transportation.	Transport Central has helped disabled residents and seniors that have medical issues	Transportation	Group had no awareness of transportation initiatives.
		Only 2 of 5 participants had heard of transportation central				

2C - Awareness of programs or activities that have focused on recent priority areas						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Healthy eating and physical activity						
	UNH Cooperative Extension Nutrition Programs		Yes. Healthy Choices/Healthy Eating (Genesis Behavioral Health Program),	Federal Government has pushed a healthier option in the schools. – new guidelines. Some principals push back on these federal guidelines. Leadership issue	Healthy eating and physical activity	D'Acres
	More Eat local/ farm stands					Nutrition/fitness – group not aware of any programs. "It's getting worse."
Substance abuse prevention						
	Increase in Heroin use		Yes. CADY doing restorative justice program, lots of AA/NA programs in area happening daily and sometimes twice-a- day. Proportionally seeing more substance abuse than parenting issues. Drug court happening (also mental- health court starting)	ADAPT is just a summer program now. This program has been reduced	Substance abuse prevention	12-step programs in the community
	CADY			CADY		Not aware of prescription drug take- back program.
				Youth center is a support system		
				Wellness Center at PSU		
				DARE in Bristol		
				PSU / CADY collaboration		
				Counties have expanded the drug court		

2C - Awareness of programs or activities that have focused on recent priority areas						
	Head Start Parents	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
Other issues and priorities						
	See more investment by people in cable/phones than three years ago					No connection between programs and community. How can people know about these things?
	Failure to address stress at work and its impact on overall health					The average person wants simplicity. Sliding scale, Community Care, etc. – it's all too complicated
						"Go to where people are for health."

3A - Most important issues for the community to address to improve health (supplemental comments to priority/ranking list)						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Access, Availability, Affordability; Health Care Reform						
	Access to mental and behavioral health care services		1. Dental Care: No dentist that takes Healthy Kids (Medicaid) locally and then transportation is issue.		Affordable Care Act has helped with insurance availability	1. Access to health insurance – "needs to be simple and comprehensive"
			2. Specialty Care: No local places to go to; have to go to Dartmouth or Concord for care.		Possible age discrimination due to health costs	2. Access to mental health/behavioral health care services
			3. Holistic Care: No holistic care options		Shift from employer insurance to the exchange	3. Access to dental care
			4. Major Illness: If you need to see someone in Boston that may not be covered.		Navigators important to transitioning folks	4. Access to people or place where referrals/resources are available
			5. Visit Limitations: Especially for mental health, number of visits limited and in turn creating major issue for people who need services.		Lack of understanding of what insurance is and how plans work	
Health Promotion, Disease Prevention; Health Behaviors						
	Drugs and alcohol		1. Diet/Nutrition: Food stamps and donation locations generally carrying unhealthy food. Healthy food spoils faster.		Substance abuse: correlates with mental health issues	1. Physical activity, recreational opportunities, active living
	Tobacco use		2. No farmers market coupons anymore.			2. Access to healthy food
	Screen time		3. Got Lunch program: Expanding this program even more to help support children in summer getting healthy meals at home.			

3A - Most important issues for the community to address to improve health (supplemental comments to priority/ranking list)						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
	Obesity		4. Recreation/Physical Activity: Making recreational facilities more affordable and increasing the number of them. Making natural resources (hiking trails/parks) more family friendly and known about			
Social and Economic Factors						
	Income	Access to groups who might provide free or minimal cost home care improvements	1. All of items on (this part of the) list are connected. (ex: better education>better employment>less poverty>less family stress)			"Education is No. 1"
	Transportation		2. Fragile Families/Family Stress: Major concern. System is not supporting long term. People in the middle are falling in cracks. People with persistent mental health have unlimited resources, but hard to get resources if you have other mental health issues.			1. Education 2. Poverty 3. Fragile families, family stress

3B - Who should be responsible for working on these issues that could improve health?						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Community, Collective Responsibility						
	Everyone as individuals and community			All of us are responsible – regular folks should be coming to a community conversation. It is a collective responsibility. It takes a village to raise a child.		Everybody
				There are great resources but it's the collaboration – how can we combine everyone who's working in silos?		
Government/Government agencies						
						Go to government representatives to sell your point. It is a political matter. Who can shake things? Who can move things?
Schools. University						
				On Campus – all people are doing positive things but they are in isolation. – Duplication of effort. There needs to be more communication. And those resources could be used differently.		
Community Leaders						
		A representative from each community – or committee to make sure the community needs are being meet				

3B - Who should be responsible for working on these issues that could improve health?						
	Head Start	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Non-profits; Health/Human Service Organizations						
						Non-profit organizations, but they should enlist the help of other groups
Communication, Coordination, Trust Building and Other Issues						
				And the resources change all the time making it difficult to know and coordinate.		Need a resource guide? "People" are where people seek information and resources. Resource people?

3C - What health and human service organizations could be doing to better support or help improve health in the priority areas						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Increase, Enhance Education in schools						
			Getting into the schools more. Providing educational programs about healthy living and wellness (mental, physical, and emotional) to create a stronger and healthier community.	Having health education in schools more than just once a month. Integrated across the curriculum in the lower grades		
				Reality – school boards are seeing the limited time with these programs – there is only so much time		
				In Ashland health class is strong – sex ed. It's well screened.		
				Does the school have time to fit in the nutrition workshops? How do we reach youth? After school?		
				Education Requirements for health and wellness should be increased		
Improve Communication and Coordination						
			Improve communication and co-collaboration between agencies. We often are doing a lot of the same work for the same clients that we don't realize.	Enhanced collaboration		
				Enhance collaboration and communication to build assets and resources		

3C - What health and human service organizations could be doing to better support or help improve health in the priority areas						
Head Start Parents		**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Increase Health Promotion and Disease Prevention Efforts						
				More prevention		Address the highlighted areas in the list.
Increase Awareness of Available Resources						
	More awareness of services available			Increased awareness of programs and resources. Mapping them and knowing what can and can't be done. Like a 211 but should be regional.		We need something centralized that "helpers" can use for referral. My job is to connect people to resources
						Health and Wellness Hotline
						Some centralized resource. Some expect us to know everything about what there is, and we don't."
Improve Services and Supports						
		Help to have someone avoid duplication of efforts	Improve wrap-around services	Nonprofits are competing with high property taxes.		
Individuals, Families						
		Make sure that folks are giving back and stocking the food pantry				

3C - What health and human service organizations could be doing to better support or help improve health in the priority areas						
Head Start Parents		**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Social, Cultural, Economic Changes						
	Pay people more			We need to slow down as a society		Get to know people as individuals in the sub-communities.
	People need more access to jobs			We are lacking creativity to enhance and collaborate		
	Sense of entitlement needs to go away					
	Why work for $10 hour, and give up my benefits from system? (generational welfare)					

4 - What is one service or support that would make a difference for you to help or maintain your health?						
	Head Start Parents	**Seniors**	**Mental Health Community**	**Educators**	**Business Leaders**	**Faith Leaders**
Physical Activity, Recreational Opportunities						
	Access to recreational opportunities		Community adult recreational opportunities.			
	Knowing what and when exercise program are (advertising/challenges)		Physical Activity			
	Open Campton pool and tennis courts to public – talk to condo and give them motivation on why it would be good for the community		More recreational facilities that are affordable			
	More places close to home that promote activity – parks, centers, and rec programs. I live in Wentworth and would have to drive to get my children to the town "park" or school playgrounds. No sidewalks – dangerous roads		More options for gyms in the winter months			
Health Services						
	Affordable dental care	Telephone reminders of appointments	More substance abuse and eating disorder help/services.			
			Holistic health center			
			Teen clinic			
			Dental services			

4 - What is one service or support that would make a difference for you to help or maintain your health?						
	Head Start Parents	Seniors	Mental Health Community	Educators	Business Leaders	Faith Leaders
Increased awareness, coordination of resources and services						
			Knowledge of available resources in community			
			Easier access to information/resources			
			Education on what resources are available on all levels.			
Transportation						
			Access to transportation			
			Transportation services			
			Transportation within the town as well as an outreach.			
Housing, Housekeeping						
			Housing			
			Access to someone to assist with housekeeping etc.			
			The ability to sell your own home and live in an assisted living or senior housing - -not as much of it as folks would like to have			

Central New Hampshire Community Health Discussion Group

Facilitator Guide

Hello and welcome to our discussion group today. Thank you for taking the time to participate. The purpose of our discussion is to get your input on health issues that matter most to you *{from your perspective as _____},* as well as your thoughts and perceptions about the health of your community. This is part of an effort by the members of the Central New Hampshire Health Partnership to understand the health-related needs of the community and to plan programs and services that address those needs.

My name is _____, and I will serve as the facilitator of today's discussion. My role is to introduce our topics and ask questions. I will try to make sure all the issues are touched on as fully as possible within our time frame and that everyone gets a chance to participate and express their opinion.

Discussion Guidelines

1. I will ask general questions, and ask for your opinions and ideas. Please remember that there are no right or wrong answers. Everything you tell us is valuable. I know you will have a lot of information and experiences to offer, so on occasion I may have to change the direction of the discussion so we can cover everything in the time we have together.

2. I want to emphasize that the discussion today will remain absolutely confidential. It's possible that some people will share personal stories or opinions. We ask all of you to refrain from sharing information from our discussion with others outside of the group. Any reports that come out of this discussion will focus on themes and ideas. Your name will not be shared or linked with anything that you say in today's focus group.

3. Today's session will go from *(time of session)* and we will be sure to end on time. You should also feel free to get up and stretch, go to the bathroom, or help yourself to refreshments.

Are there any questions before we begin?

Central New Hampshire Community Health Discussion Group

Draft Discussion Questions:

1) Our first set of questions explores how people think about health and wellness. Some of the questions refer to the "community" which can mean something different for everyone- it could mean your town or region, your friends, your ethnic group, people you work with, or however you think of your "community". *{about 10-15 minutes for this section}*

   a) What comes to mind when you hear the words "health" or "wellness"?

   Prompt: Do you see a relationship between the health of individuals and the health of a community?

   b) Do you think people in your community are healthy? Why? Why not?

   Prompt: What thoughts or issues came to mind as you answered this question?

   Prompt: What do you think affects the health of people in your community the most?

2) Our next few questions ask for your thoughts on the strengths or resources in your community that help support or enhance individual, family, and community "health." We are also going to ask your opinions about what some of the barriers to good health are. *{about 25 minutes for this section}*

a) When you think of people, places or events in your community that promote health what comes to mind?

Prompt: What else comes to mind?

Prompt: Are there any strengths or resources that contribute to good health in your community that people may not typically think of?

b) What is happening in your community that gets in the way of or undermines good health?

Prompt: What do the people you know worry about most when it comes to their health and their family's health?

Prompt: How has this changed in recent years? If so, what has changed?

c) About 3 years ago, a similar round of community conversations identified some high priority health issues for this region of New Hampshire. Some of these priorities were:

- improving access to health insurance;
- availability of transportation;
- healthy eating and physical activity; and
- substance abuse prevention.

Are you aware of any programs or activities that have focused on any of these areas? *(Describe, elaborate)*

Have you noticed any improvements in these areas? *(Describe, elaborate)*

3) A number of people in this region of New Hampshire have been involved in other meetings and efforts to improve community health similar to this one. I would like to show you a list of issues that some people have identified as important to their health and the health of their family and larger community. We have already touched on some of these issues *(we may have added some new ones*) and there may be some issues on this list that haven't been mentioned so far. *{about 30 minutes for this section}*

{At this point, facilitator puts up 3 sheets of poster paper prepopulated with issues on next page; plus a fourth or more sheet of blank poster paper on which additional issues/concepts are written}

a) Please take a moment to look over this list. Which of these issues do you believe are the most important for your community to address for improving health now?

Prompt: There are a lot of issues here. Perhaps you can start by thinking of the most important 2 or 3 issues in your mind? Why are these most important?

Prompt: Are there other important health issues in your community that you would add to this list?

b) Who do you feel should be responsible for working on these issues?

Prompt: What other people or organizations come to mind?

c) What do you think the health and human service organizations in this community could be doing to better support or help improve health in these areas?

(Display list as handout or poster; preferably a poster on which other issues that are brought up in the conversation can be added)

{Access/availability/affordability issues}

A. Access to Primary Health Care Services
B. Access to Specialty Care Services
C. Access to Mental Health/Behavioral Health Care Services
D. Access to Dental Care Services
E. Access to Elder Care Services
F. Access to Health Insurance
G. Access to Prescriptions/Medications

{*Diseases and Behaviors}*

H. Obesity
I. Cancer
J. Chronic Diseases such as Heart Disease, Diabetes, Arthritis, Asthma and COPD
K. Infectious Disease and Vaccines
L. Unintended Injury
M. Physical Activity, recreational opportunities, active living
N. Diet and Nutrition, access to healthy foods
O. Tobacco
P. Alcohol and Drug Abuse

*{Socioeconomic factors; Note: **if** the discussion focuses substantially on these root causes, it is OK to direct people to also consider the above issues by explaining that health-related organizations involved in this effort may be less capable of addressing these socioeconomic factors and more capable of addressing access and disease-specific issues. So while these issues are clearly important and we want to hear your ideas about these, we **also** would like to hear some ideas about some of the access and disease-specific issues.}*

Q. Public Safety, crime, domestic violence
R. Income
S. Poverty
T. Employment
U. Education
V. Fragile families, family stress
W. Healthy environment, air and water quality
X. Transportation

DOT EXERCISE (about 10 minutes): After participants have had an opportunity to describe which issues they feel are most important and why, provide each participant with 5 sticky dots. Explain that "Everyone will now have an opportunity to place 5 stickers next to the issues that they feel most strongly about on the papers at the front of the room. You can put your stickers next to five different issues, or if you feel very strongly about one topic, you can put all your stickers next to that topic. If you feel strongly about two different topics, you can put two stickers next to one and three next to the other. This will help us with the final prioritization of the topics that are most important for the health of your community"

DEMOGRAPHIC QUESTIONNAIRE AND OPTIONAL QUESTION: As you wrap up, distribute the one page question asking for age and gender information. Explain that the information will help us to summarize the discussion findings. Also point out that there is an optional question asking about one service or support that would help them with their own health.

SIGN-UP TO RECEIVE RESULTS: Finally, offer participants an opportunity to sign up to receive the results of the assessment and explain that later on we will be looking for people who may want to stay involved in efforts to improve community health.

Central New Hampshire Community Health Discussion Group

Thank you very much for participating in our discussion group today.

We have just a few more questions to help us summarize the results from this and other similar discussion groups we are holding. Your responses to these questions are not required and you do not need to write your name on this form.

1. **Please tell us your gender:**

   - ☐ Male
   - ☐ Female

2. **Please tell us your age:**

   - ☐ Under 20 years of age
   - ☐ 20 – 34
   - ☐ 35 – 49
   - ☐ 50 – 64
   - ☐ Over 65

3. **Please share one type of service or support that you or your family would like to help maintain or improve your own health.** *(Optional)*

   _____

   _____

   _____

THANK YOU FOR YOUR PARTICIPATION!

WOULD YOU LIKE TO KNOW THE FINDINGS OF THE 2014 COMMUNITY HEALTH ASSESSMENT?

If you would like to receive a summary of the findings of the 2014 Community Health Assessment from the Central New Hampshire Health Partnership, please provide your contact information here. Thank You.

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