Community Health Needs Assessment

Coos County, New Hampshire
Grafton County, New Hampshire

On behalf of:

Androscoggin Valley Hospital
Coos County Family Health
Upper Connecticut Valley Hospital
ACHS
North Country Home Health & Hospice Agency
Littleton Regional Healthcare — Where good health begins
Weeks Medical Center

Community Health Needs Assessment[1]

[1]Response to Schedule h (Form 990) Part V B 4

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Northern New Hampshire Region ("NNHR" or the "Facilities") has performed a Community Health Needs Assessment to determine the health needs of the Greater Northern New Hampshire Region.

Data were gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. Additionally, the group reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The 2019 Significant Health Needs identified for Coos and Grafton Counties are:

1. Drug/Substance Abuse
2. Mental health
3. Obesity/Overweight
4. Accessibility (Transportation, Disability, Access to Care, etc.)
5. Alcohol Abuse
6. Affordability

In the upcoming Implementation Plan the NNHR facilities will develop their implementation strategies for these six needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

The Northern New Hampshire Region ("NNHR" or the "Facilities") joint Community Health Needs Assessment includes four (4) hospitals, two (2) Federally Qualified Health Centers ("FQHCs"), and one (1) home health and hospice agency:

- Ammonoosuc Community Health Services, Inc. ("ACHS")
- Androscoggin Valley Hospital, Berlin, NH ("AVH")
- Coos County Family Health Services ("CCFHS")
- Littleton Regional Healthcare, Littleton, NH ("LRH")
- North Country Home Health & Hospice Agency (NCHHHA")
- Upper Connecticut Valley Hospital, Colebrook, NH ("UCVH")
- Weeks Medical Center, Lancaster, NH ("WMC")

The April 4, 2013 draft regulations state "…every hospital facility must document its CHNA in a separate CHNA report … if a hospital facility collaborates with other hospital facilities in conducting its CHNA, all of the collaborating hospital facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process. In addition, the joint CHNA report must clearly identify each hospital facility to which it applies and an authorized body of each collaborating hospital facility must adopt the joint CHNA report as its own." This requirement guides the development of this report.

A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital/facility identify and respond to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the Facilities.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care
- Billing and collections
- Charges for medical care

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2017 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form

Project Objectives

The Facilities partnered with Quorum Health Resources ("Quorum") to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide NNHR with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for NNHR to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years, and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital/ facility, including those with special knowledge or expertise of public health issues.
- The hospital/facility must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital/facility is required to make the assessment widely available and downloadable from the

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule H (Form 990) V B 6 b

hospital/facility website.

- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*
>
> *(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[6]*
>
> *…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."*

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

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[5] Section 6652

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

To complete a CHNA:

> *"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*
>
> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Facilities followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[8]

The methodology takes a comprehensive approach to the solicitation of written comments. As previously cited, input was obtained from the required three minimum sources and expanded input to include other representative groups. The Facilities asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital

[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources. Response to Schedule H (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) B 3 h

facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs, and that perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. The Facilities rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

Most data used in the analysis is available from public Internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating in this study are displayed in the CHNA report appendix.

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Coos and Grafton Counties compared to all New Hampshire counties	June 12, 2019	2012-2018
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the Facilities' primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an	June 12, 2019	2019

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process. Response to Schedule H (Form 990) V B 3 h

[10] Response to Schedule H (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

	aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics		
http://svi.cdc.gov	To identify the Social Vulnerability Index value	June 12, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	June 12, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	June 12, 2019	2017

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, a standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to the Facilities' Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and NNHR's desire to represent the region's geographically and ethnically diverse population. Community input from 151 Local Expert Advisors was received. Survey responses started July 14, 2019, and ended with the last response on August 25, 2019.
- Information analysis augmented by local opinions showed how Coos and Grafton Counties relate to their peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - The top three priority populations in the area are low-income groups, residents of rural areas and older adults
    - Common pressing needs identified are access to healthcare, affordable healthcare, and transportation

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual,

[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h

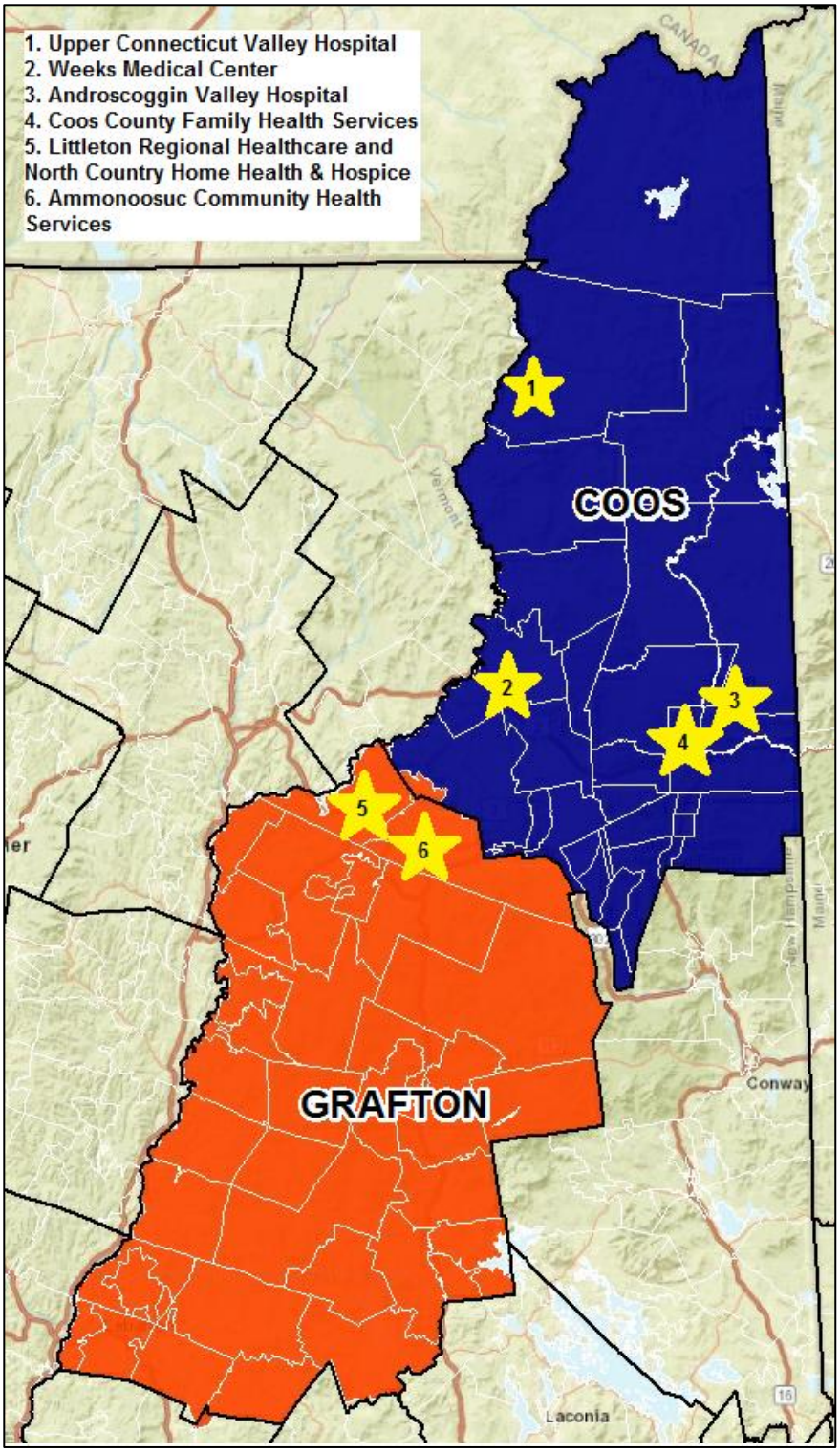
regardless of their professional credentials.[14]

In the NNHR process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then ranked the top five (5) needs they felt were most pressing needs in the NNHR community, including the opportunity to list additional needs that were not identified from the data. The needs that received the top rankings were considered "Significant" and NNHR will look to develop a plan for addressing them.[15]

[14] Response to Schedule H (Form 990) Part V B 5
[15] Response to Schedule H (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by NNHR [16]



For the purposes of this study, Northern New Hampshire Region defines its service area as Coos and Grafton Counties in

[16] Responds to IRS Schedule H (Form 990) Part V B 3 a

New Hampshire, which includes the following ZIP codes:[17]

Coos County:

03575, 03576, 03579, 03581, 03582, 03583, 03584, 03588, 03590, 03592, 03593, 03595, 03598

(Zip codes 03589 and 03597 are included in the above zip codes.)

Grafton County:

03215, 03217, 03222, 03223, 03240, 03241, 03245, 03251, 03262, 03264, 03266, 03279, 03282, 03285, 03561, 03574, 03580, 03585, 03586, 03740, 03741, 03748, 03750, 03755, 03765, 03766, 03768, 03771, 03774, 03777, 03779, 03780, 03784, 03785

(Zip codes 03228, 03293, 03749, 03756 and 03769 are included in the above zip codes.)

Other facilities that offer services outside the service area include:

- Central Vermont Medical Center, Berlin, VT
- Copley Hospital, Morrisville, VT
- Cottage Hospital, Woodsville, NH
- Memorial Hospital, North Conway, NH
- Speare Memorial Hospital, Plymouth, NH
- Northeastern Vermont Regional Hospital, St. Johnsbury, VT
- North Country Hospital and Health Center, Newport, VT

[17] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below

Demographics of the Community[18] [19]

Variable	Coos County			Grafton County			New Hampshire			United States		
	2019	2024	%Change	2019	2024	%Change	2019	2024	%Change	2019	2024	%Change
DEMOGRAPHIC CHARACTERISTICS												
Total Population	32,024	31,884	-0.4%	90,076	91,059	1.1%	1,350,506	1,374,306	1.8%	329,236,175	340,950,067	3.6%
Total Male Population	17,193	17,117	-0.4%	44,464	44,940	1.1%	668,776	680,073	1.7%	162,097,263	167,921,866	3.6%
Total Female Population	14,831	14,767	-0.4%	45,612	46,119	1.1%	681,730	694,233	1.8%	167,138,912	173,028,201	3.5%
Females, Child Bearing Age (15-44)	4,300	4,253	-1.1%	17,156	17,144	-0.1%	243,076	244,921	0.8%	64,251,309	65,231,610	1.5%
Average Household Income	$67,182			$101,864			$103,145			$89,646		
POPULATION DISTRIBUTION												
Age Distribution												
0-14	4,035	3,852	-4.5%	11,998	11,745	-2.1%	206,600	199,457	-3.5%	61,258,096	61,645,382	0.6%
15-17	989	947	-4.2%	2,797	2,741	-2.0%	48,864	47,878	-2.0%	12,813,020	13,319,388	4.0%
18-24	2,388	2,359	-1.2%	11,915	11,744	-1.4%	130,776	131,513	0.6%	31,474,821	32,296,411	2.6%
25-34	3,600	3,576	-0.7%	10,790	10,224	-5.2%	161,464	161,377	-0.1%	44,370,805	43,645,423	-1.6%
35-54	7,844	7,103	-9.4%	19,916	19,584	-1.7%	340,689	321,867	-5.5%	83,304,733	84,255,193	1.1%
55-64	5,481	5,590	2.0%	14,231	14,195	-0.3%	215,190	225,016	4.6%	42,525,512	43,333,585	1.9%
65+	7,687	8,457	10.0%	18,429	20,826	13.0%	246,923	287,198	16.3%	53,489,188	62,454,685	16.8%
HOUSEHOLD INCOME DISTRIBUTION												
Total Households	13,569	13,611	0.3%	37,138	37,820	1.8%	539,935	552,269	2.3%	125,018,838	129,683,911	3.7%
2019 Household Income												
<$15K	1,493			3,330			35,095			13,139,420		
$15-25K	1,706			2,644			35,728			11,333,086		
$25-50K	3,454			7,778			98,474			26,888,001		
$50-75K	2,616			6,333			92,808			21,157,116		
$75-100K	1,703			4,700			76,438			15,409,735		
Over $100K	2,597			12,353			201,392			37,091,480		
EDUCATION LEVEL												
Pop Age 25+	24,612			63,366			964,266			223,690,238		
2019 Adult Education Level Distribution												
Less than High School	796			1,320			21,194			12,173,720		
Some High School	2,167			3,323			48,547			16,245,471		
High School Degree	9,642			17,141			265,528			61,068,735		
Some College/Assoc. Degree	7,637			15,105			280,226			64,945,355		
Bachelor's Degree or Greater	4,370			26,477			348,771			69,256,957		
RACE/ETHNICITY												
2019 Race/Ethnicity Distribution												
White Non-Hispanic	30,176			81,314			1,214,904			197,594,684		
Black Non-Hispanic	337			919			17,589			40,877,627		
Hispanic	706			2,402			52,871			60,675,779		
Asian & Pacific Is. Non-Hispanic	177			3,321			38,157			19,327,168		
All Others	628			2,120			26,985			10,760,917		

[18] Responds to IRS Schedule H (Form 990) Part V B 3 b
[19] Claritas (accessed through IBM Watson Health)

Consumer Health Service Behavior[20]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where the NNHR Service Area varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Coos County:

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	116.9%	35.7%	Cancer Screen: Skin 2 yr	82.7%	8.9%
Vigorous Exercise	96.0%	54.8%	Cancer Screen: Colorectal 2 yr	98.6%	20.3%
Chronic Diabetes	111.0%	17.4%	Cancer Screen: Pap/Cerv Test 2 yr	81.8%	39.4%
Healthy Eating Habits	102.4%	23.9%	Routine Screen: Prostate 2 yr	97.5%	27.7%
Ate Breakfast Yesterday	99.3%	78.5%	**Orthopedic**		
Slept Less Than 6 Hours	113.2%	15.5%	Chronic Lower Back Pain	109.5%	33.8%
Consumed Alcohol in the Past 30 Days	83.2%	44.7%	Chronic Osteoporosis	116.4%	11.8%
Consumed 3+ Drinks Per Session	108.8%	30.6%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.3%	84.1%
Search for Pricing Info	89.4%	24.0%	NP/PA Last 6 Months	109.2%	45.3%
I am Responsible for My Health	100.0%	90.4%	OB/Gyn 1+ Visit	84.0%	32.2%
I Follow Treatment Recommendations	104.3%	80.4%	Medication: Received Prescription	104.6%	63.4%
Pulmonary			**Internet Usage**		
Chronic COPD	140.2%	7.6%	Use Internet to Look for Provider Info	75.0%	29.9%
Chronic Asthma	96.7%	11.4%	Facebook Opinions	76.3%	7.7%
Heart			Looked for Provider Rating	78.3%	18.4%
Chronic High Cholesterol	114.3%	27.9%	**Emergency Services**		
Routine Cholesterol Screening	95.8%	42.5%	Emergency Room Use	100.7%	35.0%
Chronic Heart Failure	172.0%	7.0%	Urgent Care Use	87.2%	28.8%

[20] Claritas (accessed through IBM Watson Health)

Grafton County:

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	100.6%	30.7%	Cancer Screen: Skin 2 yr	109.5%	11.8%
Vigorous Exercise	99.9%	57.0%	Cancer Screen: Colorectal 2 yr	106.8%	21.9%
Chronic Diabetes	88.2%	13.8%	Cancer Screen: Pap/Cerv Test 2 yr	96.9%	46.7%
Healthy Eating Habits	105.8%	24.7%	Routine Screen: Prostate 2 yr	98.1%	27.8%
Ate Breakfast Yesterday	101.5%	80.3%	**Orthopedic**		
Slept Less Than 6 Hours	89.9%	12.3%	Chronic Lower Back Pain	89.3%	27.5%
Consumed Alcohol in the Past 30 Days	100.6%	54.0%	Chronic Osteoporosis	98.9%	10.0%
Consumed 3+ Drinks Per Session	94.0%	26.5%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	102.8%	83.5%
Search for Pricing Info	84.5%	22.7%	NP/PA Last 6 Months	112.6%	46.7%
I am Responsible for My Health	102.6%	92.7%	OB/Gyn 1+ Visit	100.2%	38.5%
I Follow Treatment Recommendations	101.9%	78.5%	Medication: Received Prescription	103.5%	62.7%
Pulmonary			**Internet Usage**		
Chronic COPD	97.7%	5.3%	Use Internet to Look for Provider Info	90.8%	36.3%
Chronic Asthma	92.0%	10.8%	Facebook Opinions	95.1%	9.6%
Heart			Looked for Provider Rating	88.5%	20.8%
Chronic High Cholesterol	98.1%	24.0%	**Emergency Services**		
Routine Cholesterol Screening	95.9%	42.5%	Emergency Room Use	89.0%	30.9%
Chronic Heart Failure	108.5%	4.4%	Urgent Care Use	91.9%	30.3%

Conclusions from Demographic Analysis Compared to National Averages

Coos County:

The following areas were identified from a comparison of Coos County to national averages. **Adverse** metrics ***impacting more than 30%*** of the population and statistically significantly different from the national average include:

- 16.9% more likely to have a **BMI of Morbid/Obese**, affecting 35.7%
- 8.8% more likely to have **Consumed 3+ Drinks Per Session**, affecting 30.6%
- 18.2% less likely to receive **Cancer Screen: Pap/Cerv Test every 2 Years**, affecting 39.4%
- 9.5% more likely to have **Chronic Lower Back Pain**, affecting 33.8%
- 16.0% less likely to receive **OB/Gyn Routine Visit**, affecting 32.2%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 16.8% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 44.7%

- 9.2% more likely to have had a **Routine Visit with an NP/PA in the last 6 months**, affecting 45.3%

Grafton County:

The following areas were identified from a comparison of Grafton County to national averages. **Adverse** metrics ***impacting more than 30%*** of the population and statistically significantly different from the national average include:

- **None**

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 12.6% more likely to have had a **Routine Visit with an NP/PA in the last 6 months**, affecting 46.7%
- 11.0% less likely to visit **Emergency Room (for non-emergent visits)**, affecting 30.9%

Leading Causes of Death[21]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. New Hampshire's Top 15 Leading Causes of Death are listed in the tables below in Coos and Grafton County's rank order. Coos and Grafton Counties were compared to all other New Hampshire counties, New Hampshire state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in NH	Rate of Death per 100,000 age adjusted		Observation (Coos County Compared to U.S.)
NH Rank	Coos County Rank	Condition	(#1 rank = worst in state)	NH	Coos County	
2	1	Heart Disease	1 of 10	149.6	220.2	Higher than expected
1	2	Cancer	3 of 10	153.4	188.7	Higher than expected
3	3	Accidents	1 of 10	62.9	58.4	Higher than expected
4	4	Lung Disease	1 of 10	42.9	53.4	Higher than expected
5	5	Stroke	7 of 10	28.8	35.2	As expected
6	6	Alzheimer's	1 of 10	24.7	31.8	As expected
7	7	Diabetes	3 of 10	19.1	24.0	As expected
9	8	Flu-Pneumonia	1 of 10	13.1	18.6	As expected
8	9	Suicide	2 of 10	18.9	18.3	As expected
10	10	Nephritis/Kidney	4 of 10	9.4	11.3	As expected
12	11	Liver Disease	1 of 10	9.1	9.8	As expected
13	12	Blood Poisoning	4 of 10	8.1	7.2	As expected
11	13	Parkinson's	8 of 10	10.0	6.6	As expected
14	14	Hypertension/Renal	7 of 10	5.5	5.1	As expected
15	15	Homicide	1 of 10	N/A	3.3	As expected

[21] www.worldlifeexpectancy.com/usa-health-rankings

Cause of Death			Rank among all counties in NH (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Grafton County Compared to U.S.)
NH Rank	Grafton County Rank	Condition		NH	Grafton County	
2	1	Heat Disease	9 of 10	149.6	165.7	As expected
1	2	Cancer	10 of 10	153.4	163.6	Higher than expected
4	3	Lung Disease	10 of 10	42.9	38.9	As expected
3	4	Accidents	8 of 10	62.9	37.7	Lower than expected
5	5	Stroke	10 of 10	28.8	32.7	As expected
6	6	Alzheimer's	4 of 10	24.7	27.3	As expected
7	7	Diabetes	7 of 10	19.1	18.1	As expected
9	8	Flu-Pneumonia	8 of 10	13.1	14.1	As expected
8	9	Suicide	8 of 10	18.9	12.0	As expected
10	10	Nephritis/Kidney	8 of 10	9.4	9.1	As expected
11	11	Parkinson's	1 of 10	10.0	8.9	As expected
12	12	Liver Disease	9 of 10	9.1	7.6	As expected
13	13	Blood Poisoning	10 of 10	8.1	4.9	Lower than expected
14	14	Hypertension/Renal	8 of 10	5.5	4.6	As expected
15	15	Homicide	2 of 10	N/A	1.8	As expected

Priority Populations[22]

Earlier in the document, a description was provided for Priority Populations, which is one of the groups whose needs are to be considered during the CHNA process. It can be difficult to obtain information about Priority Populations in a hospital's community. The objective is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

Begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of the Facilities and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **Access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy (NQS)**. The complete report is provided in Appendix C.

A specific question was asked to NNHR's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, NNHR places a great reliance on the commentary received from NNHR's Local Expert Advisors to identify unique population needs to which NNHR should respond. Specific opinions from the Local Expert Advisors are summarized below:[23]

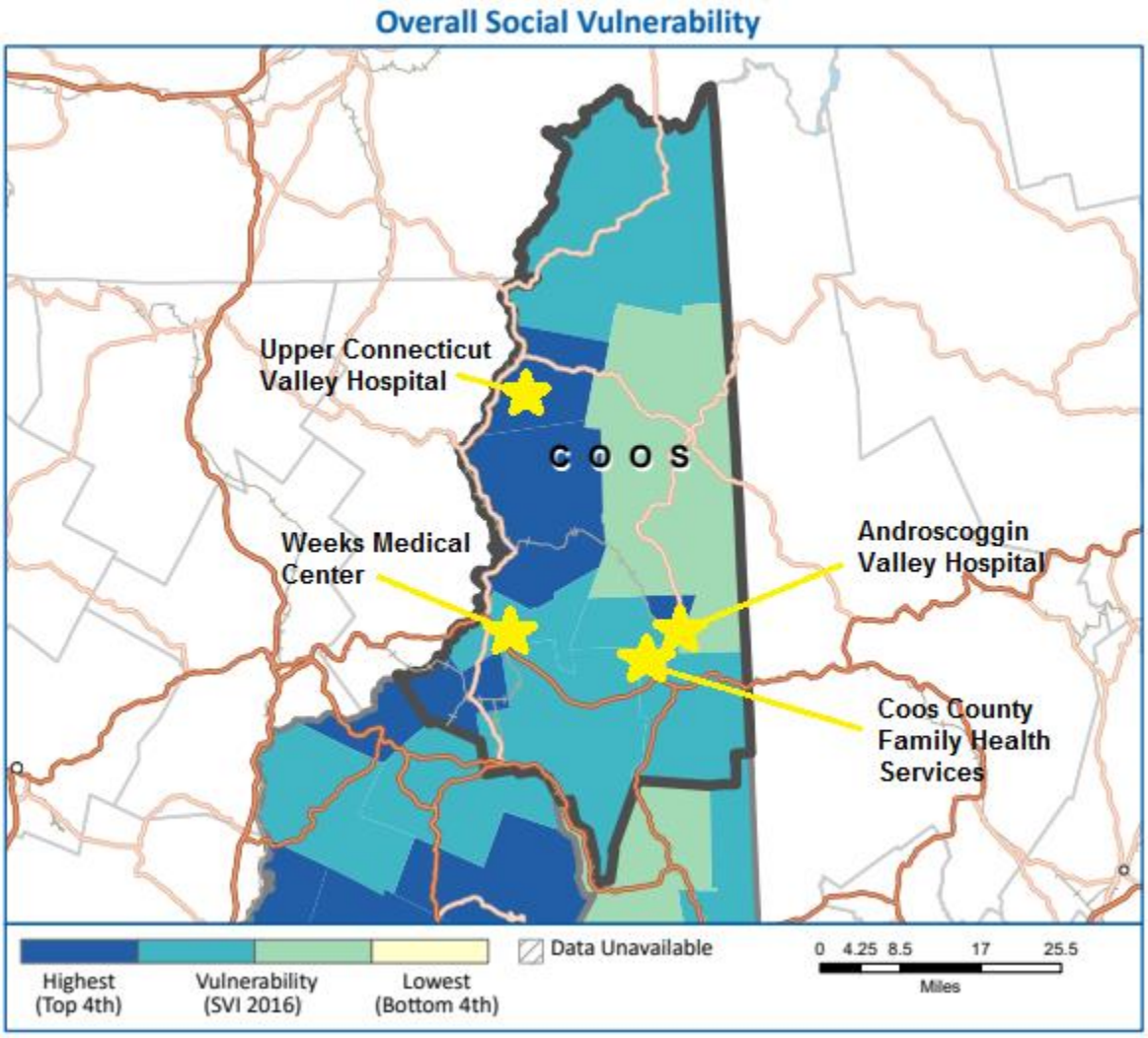
- The top three priority populations in the area are low-income groups, residents of rural areas and older adults
- Common pressing needs identified are access to healthcare, affordable healthcare, and transportation

[22] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[23] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[24]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks.

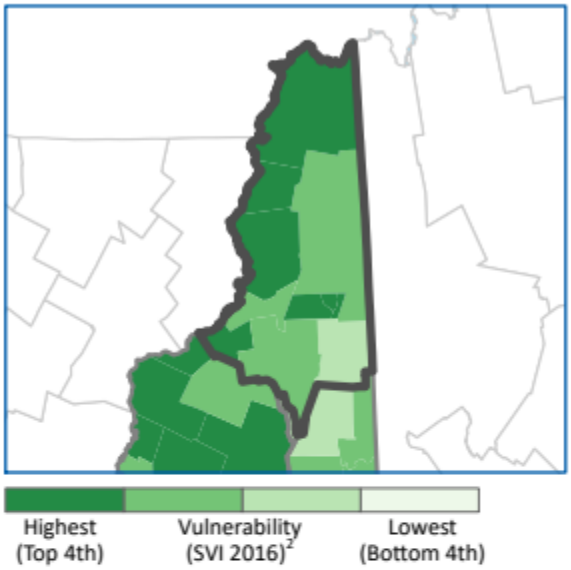
Coos County falls into the top three quartiles of social vulnerability. The areas in dark blue are the areas with the highest vulnerability. The light blue areas are considered to be the second highest social vulnerability, while the light green is the third:



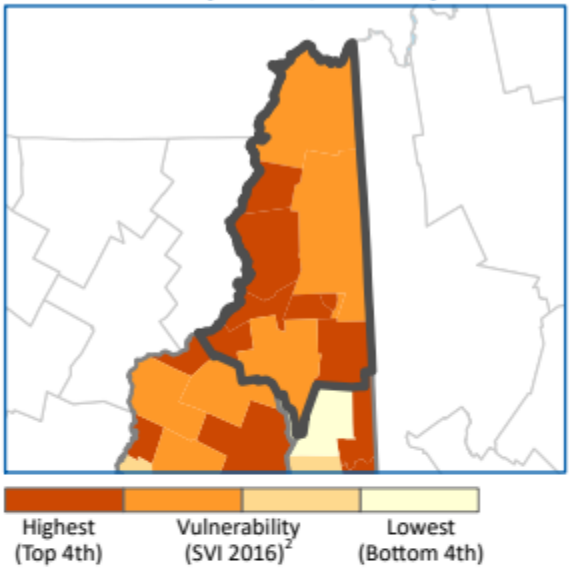
[24] http://svi.cdc.gov

SVI Themes

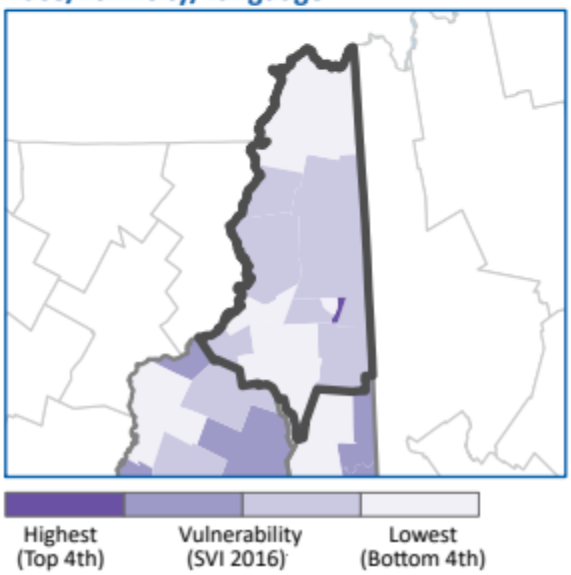
Socioeconomic Status



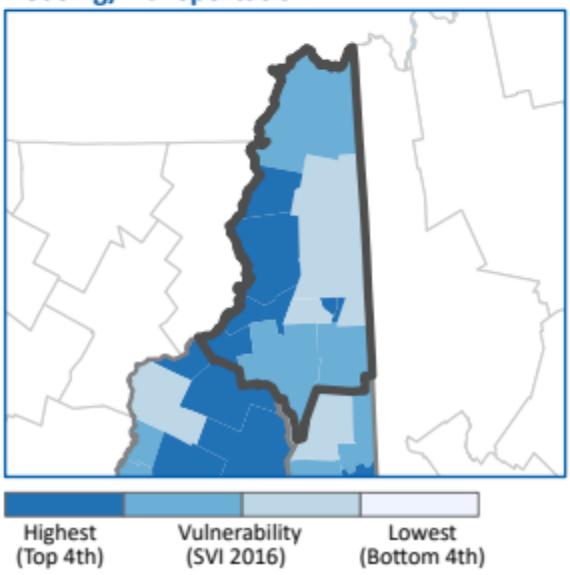
Household Composition/Disability



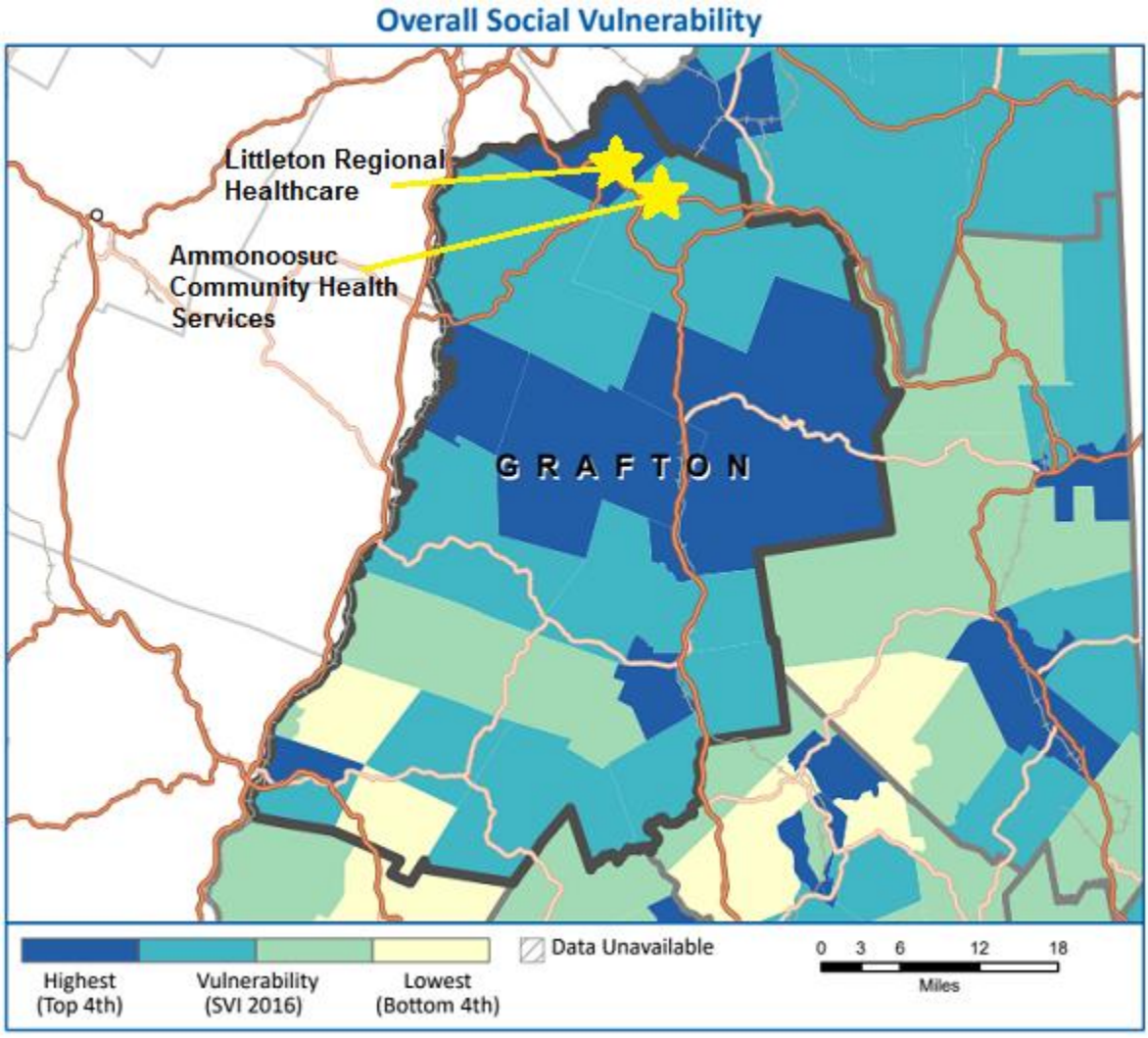
Race/Ethnicity/Language[7]



Housing/Transportation[8]

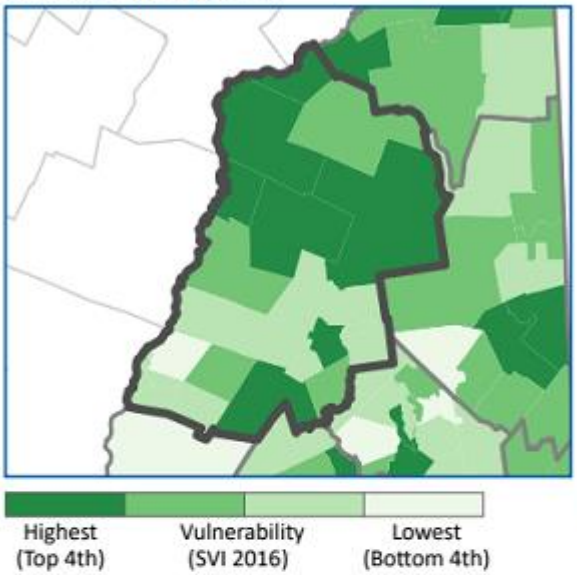


Grafton County falls into all four quartiles of social vulnerability. Dark blue areas have the highest social vulnerability, light blue has the second highest, light green is the third and yellow is the lowest:

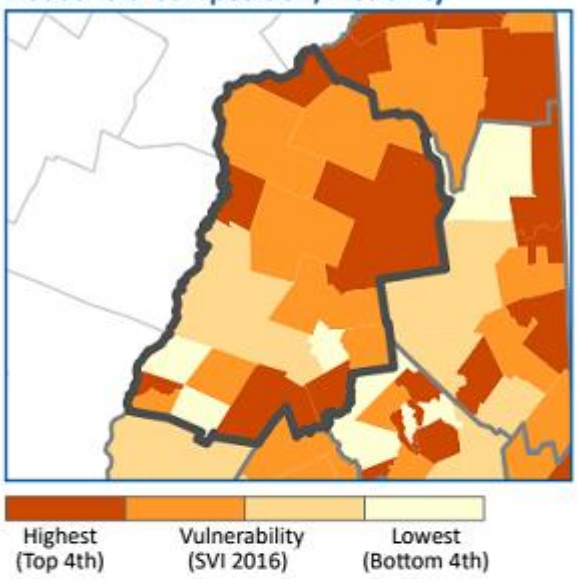


SVI Themes

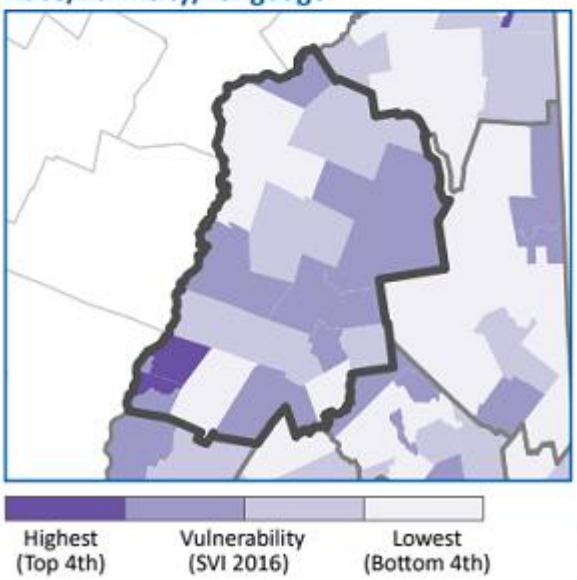
Socioeconomic Status



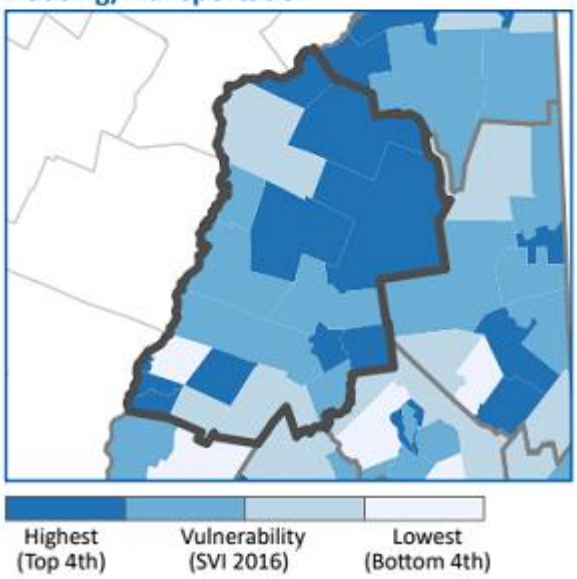
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to New Hampshire[25]

To better understand the community, Coos and Grafton Counties have been compared to all 10 counties in the state of New Hampshire across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

In the chart below, the county's rank compared to all counties is listed along with measures in each area compared to the state average and U.S. Median.

	Coos County	Grafton County	New Hampshire	U.S. Median
Length of Life				
Overall Rank *(best being #1)*	10/10	1/10		
- Premature Death*	8,400	5,400	6,500	8,100
Quality of Life				
Overall Rank *(best being #1)*	10/10	3/10		
- Poor or Fair Health	14%	12%	14%	17%
- Poor Physical Health Reported in 30 Days	3.6	3.5	3.7	3.9
- Poor Mental Health Reported in 30 Days	4.1	3.8	4.2	3.9
Health Behaviors				
Overall Rank *(best being #1)*	10/10	2/10		
- Adult Smoking	17%	14%	18%	17%
- Adult Obesity	32%	23%	28%	32%
- Physical Inactivity	26%	19%	20%	26%
- Access to Exercise Opportunities	67%	89%	87%	66%
- Excessive Drinking	17%	19%	20%	17%
- Alcohol-Impaired Driving Deaths	29%	24%	31%	28%
- Drug Overdose Deaths* *(not included in overall ranking)*	35	19	34	19
Clinical Care				
Overall Rank *(best being #1)*	10/10	3/10		
- Uninsured	9%	9%	7%	10%
- Population to Primary Care Provider Ratio	940:1	520:1	1,100:1	2,050:1
- Population to Dentist Ratio	1,760:1	1,240:1	1,370:1	2,450:1
- Population to Mental Health Provider Ratio	610:1	240:1	350:1	970:1
- Preventable Hospital Stays	3,978	3,202	3,947	4,648
- Mammography Screening	41%	46%	49%	40%
- Flu Vaccinations	31%	39%	48%	42%
Social & Economic Factors				
Overall Rank *(best being #1)*	10/10	2/10		
- Unemployment	3.4%	2.2%	2.7%	4.4%
- Children in Poverty	19%	12%	10%	21%
- Children in Single-Parent Households	39%	29%	28%	32%
- Violent Crime*	159	167	197	205
- Injury Deaths*	114	75	80	82
Physical Environment				
Overall Rank *(best being #1)*	2/10	1/10		
- Severe Housing Problems	16%	15%	16%	14%

Per 100,000 Population

[25] www.countyhealthrankings.org

Conclusions from Other Statistical Data[26]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Coos and Grafton Counties' statistics to the U.S. average, as well as the trend in each measure over a 34-year span.

Coos, New Hampshire	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Coos County measures that are WORSE than the U.S. average and had an UNFAVORABLE change		
- Female Tracheal, Bronchus, and Lung Cancer*	50.6	47.5%
- Female Skin Cancer*	2.4	9.2%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	56.2	39.6%
- Male Self-Harm and Interpersonal Violence Related Deaths*	36.6	14.2%
- Male Mental and Substance Use Related Deaths*	34.1	433.2%
- Female Liver Disease Related Deaths*	14.2	16.2%
UNFAVORABLE Coos County measures that are WORSE than the U.S. average and had a FAVORABLE change		
- Female Life Expectancy	80.6	3.5%
- Female Heart Disease*	141.3	-35.4%
- Male Heart Disease*	215.3	-55.0%
- Female Transport Injuries Related Deaths*	10.2	-38.1%
- Male Transport Injuries Related Deaths*	22.2	-47.2%
DESIRABLE Coos County measures that are BETTER than the US average and had a FAVORABLE change		
- Female Stroke*	33.6	-52.5%
- Male Stroke*	40.4	-56.0%
- Female Breast Cancer*	22.6	-42.6%
- Male Liver Disease Related Deaths*	19.6	-33.1%
DESIRABLE Coos County measures that are BETTER than the US average and had an UNFAVORABLE change		
N/A		
AVERAGE Coos County measures that are EQUAL to the US average and had a FAVORABLE change		
- Male Life Expectancy	76.0	8.5%
- Male Tracheal, Bronchus, and Lung Cancer*	67.9	-48.5%
- Male Breast Cancer*	0.3	-8.8%
AVERAGE Coos County measures that are EQUAL to the US average and had an UNFAVORABLE change		
- Male Skin Cancer*	4.4	20.0%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	63.7	22.7%
- Female Self-Harm and Interpersonal Violence Related Deaths*	9.4	18.2%
- Female Mental and Substance Use Related Deaths*	8.9	430.3%

**rate per 100,000 population, age-standardized*

[26] http://www.healthdata.org/us-county-profiles

Grafton, New Hampshire	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Grafton County measures that are WORSE than the U.S. average and had an UNFAVORABLE change		
N/A		
UNFAVORABLE Grafton County measures that are WORSE than the U.S. average and had a FAVORABLE change		
N/A		
DESIRABLE Grafton County measures that are BETTER than the US average and had a FAVORABLE change		
- Female Life Expectancy	82.7	5.7%
- Male Life Expectancy	79.0	10.1%
- Female Heart Disease*	95.8	-51.8%
- Male Heart Disease*	162.9	-63.4%
- Female Stroke*	38.6	-41.5%
- Male Stroke*	34.0	-58.0%
- Male Tracheal, Bronchus, and Lung Cancer*	50.7	-52.4%
- Female Breast Cancer*	22.4	-46.9%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	48.2	-7.1%
- Male Self-Harm and Interpersonal Violence Related Deaths*	23.9	-8.4%
- Female Transport Injuries Related Deaths*	6.9	-45.3%
- Male Transport Injuries Related Deaths*	13.2	-56.7%
- Female Liver Disease Related Deaths*	9.8	-19.1%
- Male Liver Disease Related Deaths*	17.2	-28.4%
DESIRABLE Grafton County measures that are BETTER than the US average and had an UNFAVORABLE change		
- Female Tracheal, Bronchus, and Lung Cancer*	41.3	19.8%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	43.2	5.4%
- Female Mental and Substance Use Related Deaths*	6.7	353.3%
AVERAGE Grafton County measures that are EQUAL to the US average and had a FAVORABLE change		
- Male Breast Cancer*	0.3	-19.2%
AVERAGE Grafton County measures that are EQUAL to the US average and had an UNFAVORABLE change		
- Female Skin Cancer*	2.1	4.4%
- Male Skin Cancer*	4.2	7.0%
- Female Self-Harm and Interpersonal Violence Related Deaths*	8.4	10.7%
- Male Mental and Substance Use Related Deaths*	18.2	326.0%

**rate per 100,000 population, age-standardized*

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

NNHR solicited written comments about the 2016 North Country Region CHNA.[27] 151 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by NNHR. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	40	53	93
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	41	52	93
3) **Priority Populations**	42	48	90
4) Representative/Member of **Chronic Disease Group** or Organization	23	62	85
5) Represents the **Broad Interest of the Community**	99	14	113
Other			0
Answered Question			128
Skipped Question			23

Congress defines "Priority Populations" to include:

- Racial and ethnic minority groups
- Low-income groups
- Women
- Children
- Older Adults
- Residents of rural areas
- Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care
- Lesbian Gay Bisexual Transsexual (LGBT)
- People with major comorbidity and complications

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *transportation, addiction treatment, dental care*
- *Access, affordability, education.*
- *Access to primary and dental care. Access to mental health services.*

[27] Responds to IRS Schedule H (Form 990) Part V B 5

- *chronic serious mental health; comorbid substance use disorder; alcohol use disorder*
- *Health Education/Awareness, Patient empowerment for self-reliance and making wise choices. Recognizing that mental health is impacted by chronic disease and socio-economic issues.*
- *more investment in preventative care and health education. Access to these services*
- *I believe that we are a well-rounded facility, and try to serve the community at whole.*
- *Transportation and cost of services*
- *lack of public transportation - need of transitional housing - lack of affordable housing - lack of education of services available for the elderly - need of medical services for elderly.*
- *Mental Health services, transportation for medical appts*
- *transportation to medical services, availability of home health, availability for proper nutrition, availability of help in the home for ADL's, availability of medications, dressing supplies and assistive devices to ambulate.*
- *Lots of overlap among certain of those groups, but the ones with the most pressing needs tend to be the lowest income groups. The needs include smoking cessation, opioid/alcohol/other drug misuse, poor diet.*
- *patients with substance use and mental health disorders*
- *Affordable health care is the most pressing need for all of these groups. Access is also problematic in our very small rural community.*
- *Polypharmacy.*
- *Public transportation options*
- *transportation, housing, care coordination, medication assistance, selected specialty care (if not available locally)*
- *Transportation, housing assistance, health care maintenance needs education*
- *Access to affordable healthcare, as well as affordable DENTAL*
- *Lack of quick access to local specialty care. Inability to pay for care and medicine. Low health literacy.*
- *Primary Care Physicians - we currently are in desperate need of PCP's*
- *The rural nature of the north country makes it difficult to provide and attract all the services needed. We live here because there is "not much" but medical assistance needs to be a priority for the people here. Older and you*
- *Population is highly dependent upon state and federal aid. Need education and job assistance.*
- *Transportation to and from medical appointments, health literacy concerns, limited food access- financially/food deserts.*
- *Children with special needs. Very little resources or knowledge regarding special needs children. Not just at Weeks but entire northern portion of Maine, NH and VT.*
- *Many of these populations are prevalent and in need - a lot by way of health care that isn't covered through the normal structures - such as dental and eye care, people who don't take care of themselves, aren't well educated*

in the importance of well care checkups, etc. Beyond that issues with pain management that leads to problems with opioids, lots of problems just being in an area that has more winter months than not, in need of things to do that are low cost for residents to keep people moving.

- *Community resources--some are limited such as transportation, housing, etc.*
- *transportation to and proximity of active living opportunities, healthy affordable food, health education*
- *affordable care and food*
- *Affordable Housing (Can't stress this one enough). For a small community homelessness is something we see frequently in the clinic setting, and have limited options especially for those who are not disabled or elderly. Transitional housing for those in recovery would be another pressing need.*
- *Easier access to translation services for non-English speaking ethnic populations, and more psychiatric services for all others checked.*
- *Fixed income and or low/no income are major issues for aging and very young in our region*
- *My experience leads me to believe that all of these categories are met as individual needs present. Those I have identified are personally identified by me.*
- *Northern Coos County, the Colebrook area, has an older and sicker population by all recent measures.*
- *Transportation barriers, economic barriers to labs, radiology*
- *I am impressed with the awareness and treating of the groups I have checked. This is and has been a prime goal of ACHS.*
- *We have several residents locally who are in need of food, shelter, access to transportation and accessible, quality healthcare.*
- *Access to care.*
- *Mainly financial limitations*
- *affordable, easy to access healthcare*

In the 2016 CHNA, there were seven health needs identified as "significant" or most important:

1. **Substance Misuse**
2. **Obesity/Overweight**
3. **Alcohol Abuse**
4. **Smoking and Tobacco Use**
5. **Mental Health Problems**

3. Should NNHR continue to consider and allocate resources to help improve the needs identified in the 2016 CHNA?

	Yes	No	Response Count
Substance Misuse	123	1	124
Obesity/Overweight	108	10	118

Alcohol Abuse	111	5	116
Smoking and Tobacco Use	101	12	113
Mental Health Problems	124	0	124

Comments:

- *There is a severe deficit in the country for mental health help and facilities for treatment. I would love to see this improved.*
- *Addressing Social Determinants of Health will help in decreasing all of the above.*
- *These areas are all significantly underfunded (although substance abuse is being addressed.)*
- *Affordable oral hygiene is needed in rural areas also*
- *Addressing mental health, in my opinion, needs to begin with deconstructing the myth "weak people need help in mental health."*
- *Needs associated with taking care of the elderly*
- *All of these areas are important. However, for "obesity/overweight" the funding needs to be going towards preventative measures OR be encouraging healthy habits for people of all weights. Focusing on simply weight loss is ineffective and damaging to one's health.*
- *The amount of money being spent substance abuse, obesity and alcohol use far outweighs the benefits. Further, most of those issues are really mental health issues.*
- *All of these things continue to be issues in our community and some of them are not well funded or well understood.*
- *Heath needs, although they may change in time, are not "fixed" in a 2 or 3 year period of time. Continue developing programs/resources and add areas of need as deemed necessary.*
- *There is no finish line in the pursuit of success in all these needs. There are always young people who take the same position as the adults of yesterday. Never ending needs!*
- *Shortage of providers, especially dental and mental health.*

6. Please share comments or observations about the actions NNHR has taken to address <u>SUBSTANCE MISUSE/ALCOHOL ABUSE/MENTAL HEALTH PROBLEMS</u>.

- *IDN is helpful. Friendship House renovation helpful--needs continued work on efficient, effective program management.*
- *ACHS is adding counselors and treatment protocols for substance abuse. Working with other agencies who influence vulnerable populations.*
- *Narcan, MAT, outpatient counseling housing for recovery, integrated care, care management*
- *Outreach, education, expanded service provision.*
- *increased availability of MAT*

- *Many are not linked to care; due to stigma and lack of meeting patients and families where they are at.*
- *Improvements at The Friendship House for starters. The Doorway... ACHS' Behavioral Health in the schools program. Lots of good progress here.*
- *Now that there are providers who prescribe MAT- how do we get these patients IN to the clinic?*
- *free programs to identify at risk individuals, mental health awareness programs, removing stigma*
- *Education of staff, additional counselors, new programs*
- *kudos in taking BH to the schools and taking the stigma away from counseling*
- *Friendship house. Behavior health integration. Educating the Providers.*
- *We have hired more staff in these areas. That is very encouraging and being utilized to the fullest*
- *Legalization of marijuana appears to be HUGELY increasing use amongst teens as they now feel it's " safe"*
- *The Doorway at LRH is part of a statewide initiative to address the growing opioid crisis. Littleton Regional healthcare (LRH) serves as a hub for Northern New Hampshire.*
- *The Hub and Spoke model is a good start, but more information needs to be shared with the public and other agencies including about how to access naloxone after being trained in its administration. More energy and money needs to be committed to Prevention, ACE information, behavioral health for families and children.*
- *behavioral health services at ISHC and new Pain Management at UCVH*
- *I've heard a program with Dr. Nielsen has come online recently - I hope that is sustained and expanded.*
- *Does not appear to be any substance abuse actions by NHC in UCVH catchment area!*
- *I was disappointed that North Country Healthcare did not take a more prominent leadership role in the development of the Friendship House*
- *unaware of any specifics*
- *Creation and implementation of educational sessions to make sure the patient is aware of the problem and avenues available to improve or resolve it.*
- *Much more money and energy are spent on these problems then in the past*
- *While Substance abuse has grabbed headlines and therefore new funding, Alcohol and Mental Health issues remain under the radar and underfunded in our region. They also contribute to the Substance misuse issue.*
- *Increased MAT, increased care coordination and mental health care coordination.*
- *There are programs to help with these problems*
- *WMC's MAT program has had a high success rate in keeping those addicted to opioids from using. It would be great to begin a similar program for alcohol abuse beyond providing facilities for AA.*
- *The doorway programs and hiring more Licensed Counselors*
- *We have recently been designated one of the hubs for the "Doorway" program*

- *Much greater public awareness with human interest stories, educational opportunities, lessening/removing stigma associated with this issue.*
- *The gateway and doorway programs*
- *Timely and lack thereof mental health issues 24/7.*
- *rising problem; need better coordination of care, housing options (transitional), transportation, input facility in north country*
- *I believe clinics have occurred in this area*
- *More training is available. Mental health is currently being reviewed and some help may be forthcoming.*
- *Our facility recognizes substance abuse as a local issue and has taken action to address the issue. Better coordination with other services would improve services. Mental Health problems continue to persist in the community, but there is a lack of providers for the population*
- *opened The Doorway center*
- *New drug abuse programs opening up but have not been given any information yet. Not aware of any Alcohol abuse programs; possibly included in the substance misuse program. Not aware of mental health services if NCH. Major problem is that Weeks Behavioral Health will only accept patients that have a Weeks PCP so that shuts everyone else out.*
- *Mental health is undeserved*
- *No actions are evident. More resources do not appear to be more available since 2016 although the need is greater.*
- *We now have a drug/alcohol counselor on staff at Weeks. Too often we see patients "stuck" in our inpatient facility for these types of issues, and the process of being placed in a facility that deals with these issues is time-consuming, as there are often not enough beds.*
- *Don't separate the issues. All of it falls under Mental Health. Also, the drug clinics are not helping but instead keeping the drug problems going.*
- *Reviewed at visits with PCP. Addition of staff to provide mental health counseling. Availability of local meetings for alcohol abuse and drug abuse clients.*
- *MAT programs in the area. Increased BH/MH services at CCFHS*
- *Pleased to see a drug takeback box at UCVH and have UCVH participate in local efforts to combat substance misuse*
- *there is a close relationship between all three and must be taken into account when treating any one of them*
- *we see a lot of issue alcohol in the community maybe bring more awareness of the help available*
- *Opioid treatment (MAT); increasing access to MH treatment for youth; community-based recovery support*
- *Substance abuse should be our focus.*
- *I would like to see the health care community work/continue to work closely with peer support networks and*

White Mountain Mental Health

- *Better access to tx but still hard to jump through all the hoops when people are ready.*
- *Improved coordination of effort in caring for the BH population, while waiting for additional resources (transitional housing)*
- *Coos County Family Health and AVH both have MAT programs to address the opioid crisis. CCFHS has expanded its behavioral health team by adding two licensed mental health counselors*
- *Unaware of any - there is a severe shortage of psychiatric care*
- *Not enough inpatient facilities*
- *A New facility has opened called Open Door*
- *They have some but i think we need more*
- *I know the hospital and other providers are involved in IDN 7 and offering additional support for substance misuse. I do feel there is more support needed for mental health problems*
- *I think these have been priorities and efforts to improve mental health substance abuse have been focus for NCHC*
- *More providers; additional groups, i.e. NA; community educational/interest*
- *The opioid crisis was created by licensed professionals in Colebrook. This, the alcohol and poverty are a deadly mix needed public and private funds to work on solving the problem.*
- *I do not see significant action*
- *I'm not aware of programs available through UCVH to address any of the above issues*
- *Unknown*
- *A small but great staff which treats and counsels those patients who need help.*
- *CCFHS has a Controlled substance committee and reviews all patients currently prescribed narcotics. Access to suboxone has improved with the doorway program. There is improved access to pain care providers.*
- *MAT clinics in Lancaster, Whitefield, Littleton and Berlin. Weeks also has a robust behavioral health team*
- *weeks leader in substance abuse in the north country*
- *Working with state on spoke and wheel approach to substance abuse treatment; working with state on increase of mental health hospitalization/facilities. Also, for both, focusing on establishing hospital based treatment separate from medical beds.*
- *This is a huge issue. In particular mental health problems, which has few resources in the area*
- *Emergency Dept*
- *Substance misuse has been a priority.*
- *Offering AA groups, a place to meet, supporting a local mental health support group, hiring 24/7security in the*

hospital to help protect the patients and the staff when needed when patients with substance abuse present in the ER.

- *Substance use continues to be an issue in the North Country. We have recently been designated as a hub for the "doorway" program.*
- *There seems to be plenty of materials available at facilities, I'm not sure how to integrate this with local law enforcement and the judicial system*

7. Please share comments or observations about the actions NNHR has taken to address <u>OBESITY/OVERWEIGHT</u>.

- *Education and treatment*
- *monitoring area obesity rate, promote 5,2,1 cooking and nutrition classes*
- *Outreach, education, expanded service provision.*
- *gratis nutritional counseling at ACHS*
- *Culturally accepted high carb diet; lack of affordable exercise programs; i.e.: local outreach such as rec centers; yearlong pools that are affordable; gym memberships that are affordable and embraced by the community*
- *ACHS has provided nutritional outreach to the community in the form of Diabetes workshops and Cooking Demonstrations at the Littleton Coop and senior center which focus on healthy, low cost meals*
- *Supervised afterschool programs help with obesity. There are so many barriers to impoverished families getting their kids into sports: transportation, parent needs to stay at the practice, parent needs to volunteer, equipment costs, etc. Get kids on sports teams!*
- *support groups, shopping/meal planning classes*
- *Encouragement between provider and patient. Community activities such as walks/runs and how to prepare healthy foods*
- *nutritional counseling, cookbooks and cooking classes*
- *This is nationwide epidemic and yes, I am witness to this daily.*
- *not enough :(very little access to gyms in low income populations & weather in North Country makes exercise difficult in winter*
- *Not sure.*
- *needs help*
- *Unsure*
- *UCVH works with obese patients*
- *unaware of any specifics*
- *Creation and implementation of educational sessions to make sure the patient is aware of the problem and avenues available to improve or resolve it.*

- *lots of diabetes programs*
- *We have partnered with local Health Care Providers supporting healthier eating in our community. We have also made gains with SNAP recipients via a FINI grant.*
- *Weeks has added bariatric beds and ambulatory aids;*
- *Not sure.*
- *Not aware of any. This is an important area to try to get out in front of - that is, start educating the whole population of our catchment area in better choices of food, learning how to prepare whole foods, and the dangers of processed food so people who are not overweight don't head in that direction.*
- *Medicare program that provided nutrition counseling*
- *I have not seen much progress here*
- *Unfamiliar with actions taken.*
- *Classes on the effects of diabetes, Good nutrition*
- *Stronger nutritional programs and education.*
- *aware of none in particular*
- *This area seems to be overlooked at NCH.*
- *I believe clinics have occurred in this area*
- *Education and special assistance for those in need of help.*
- *Very limited*
- *I am not aware of any*
- *Not aware of anything other than dieticians at the hospitals. No affordable exercise programs other than the Rec Ctr, but not everyone likes swimming.*
- *Help in this area is only evident for someone who actively seeks it.*
- *At one point in time Weeks was running an IBT program. I am glad to see that this is no longer the case, as research is showing these programs to be ineffective at improving health outcomes- I hope to see more preventative efforts.*
- *It is unlikely that you are going to change people's eating habits unless they want to change.*
- *Promotion of weight programs and exercise.*
- *Added a nutritionist at CCFHS RN in training to become a CDE*
- *Dietary department has worked to address this issue with patients; the food prescription program is promising*
- *While there may be a genetic relationship there needs to be more promotion of diet and exercise in changing this disorder*
- *maybe more nutritional help*

- *Programs designed to increase awareness around healthy eating and proper nutrition.*
- *Great to see advertisements about support groups for weight management.*
- *Patients are unwilling to do their part*
- *Unaware of any*
- *Need more services that go into homes*
- *Not sure what they have for this but it is needed*
- *I know they have held forums at the hospital which I think are a great resource for our community*
- *Unaware of any programs*
- *Very little.*
- *Nutrition counseling*
- *They have dietary sessions available*
- *Unknown*
- *I know this has been important to the staff. Not sure how it is handled. (special staff or family doctor)*
- *More patients have been able to access bariatric care, counseling and surgery. Greater access to dietitian and nutrition counseling is needed. It is recommended that all patients with BMI >30 should receive dietary counseling.*
- *primary care deals with this w/ support from nutritionists. More BH interventions would be helpful as well as easier access to bariatric surgery*
- *I know UCVH has a nutritionist on staff and the local FQHC refers patients to her.*
- *support of groups involved in weight loss and education*
- *LRH established community/hospital based treatment programs for many physical disorders, including obesity, which work to combat diabetes and/or development of diabetes. Such programs include focus on exercise, food and lifestyle changes.*
- *Our population in a rural area has a disproportionate number of obese residents. Obesity causes numerous health issues which we as a society pay for.*
- *Do not know*
- *Unknown.*
- *Offer over eater anonymous and weight watchers space in the hospital for meetings. The dietician and diabetic education nurse often offer classes on healthy cooking and eating.*
- *The contribution of obesity to overall health has been well established. Reducing the obesity rates will help both individuals and the financial burden in society. We have programs for diabetes, but I think more could be done for obesity in general.*

- *There seems to be plenty of materials available at facilities, as an obese person myself, I would like to see some sort of program, covered by insurance, that could help on a more personal training type basis.*

8. Please share comments or observations about the actions NNHR has taken to address <u>SMOKING AND TOBACCO USE</u>.

- *Education and quitting aids*
- *monitor rates tobacco and nicotine use, education, smoking cessation*
- *Outreach, education, expanded service provision.*
- *culturally acceptable; vaping education to youth*
- *ACHS has worked with health care providers to deliver educational messages on the dangers of vaping to teens etc.*
- *free programs for smoking cessation, Quit aids such as patches, gum, etc.*
- *I am not aware of any new programs or promotions*
- *everyone is on board-all can speak to the advantages of quitting and offer encouragement*
- *I will say that compared to other neighboring states. Our state of NH does not seem as bad in this area.*
- *vaping has exploded in younger population- (even in teens too young to purchase) & especially among those who previously didn't use tobacco products*
- *Not aware of any.*
- *smoking cessation counseling by providers at ISHC and smoking cessation classes*
- *Unsure*
- *Unknown*
- *unaware of any specifics*
- *Same*
- *not as big an issue as in the past*
- *I am out of the loop as far as progress on these issues go. Vaping should be part of this conversation.*
- *All this money goes into people to stop smoking but nothing for people with weight or other problems.*
- *unsure*
- *there have been classes for smoking and tobacco use.*
- *Regular smoking cessation programs are held; not sure how heavily marketed they are or the extent to which PCPs push patients to enroll.*
- *Smoking cessation classes.*

- *Tobacco use continues to be a problem in our area- I have not seen much progress here either*
- *Wonderful to see smoking cessation programs offered regularly in local communities.*
- *Not sure*
- *aware of none in particular*
- *As there are so few places anyone can smoke, I can't imagine what else could be done.*
- *I believe clinics have occurred in this area*
- *Continue to offer cessation programs*
- *Moderately addressed*
- *I haven't noticed any program in particular*
- *Not aware of anything*
- *Although smoking and tobacco usage appears to be declining, unaware of smoking cessation classes or programs available.*
- *We offer community cessation programs for staff & the community- I am unsure of the outcomes of this program*
- *not sure.*
- *I believe they offer smoking cessation classes*
- *not familiar with their programs with this issue*
- *smoking may be the hardest habit to kick because it is not immediately life threatening But it is deadly and ends the same way drugs and alcohol does*
- *nicotine prevention programs; youth vaping focus*
- *Not familiar with efforts on this issue.*
- *Patients are unwilling to do their part*
- *Refer patients to the State Quitworks program.*
- *Unaware of any*
- *I like that the hospital is tobacco free*
- *I know they have held forums at the hospital which I think are a great resource for our community*
- *I think programs are in place to address this chronic is due*
- *Actually a lot. There quite a few smoking cessation programs*
- *I am not aware of significant action*
- *They have made the facility campus smoke free*
- *Unknown*

- *Such a change from a few years ago. Such a large reduction of smokers which seems to be in all areas, not just through the clinics...*
- *There is an active DARE program in the elementary grades. All public areas are nonsmoking areas. Local providers are comfortable providing smoking cessation counseling and medication. Vaping and Juuling has increased in the adolescent population. Studies suggest that many of these will transition to smoking. More education about the risk of this activity is needed.*
- *auricular acupuncture will soon be available*
- *Unfortunately, I am not personally knowledgeable of what has been set up for smoking cessation.*
- *teen and adult smoking session programs*
- *Programs are available. Good signage for LRH as non-smoking campus*
- *I do not consider this that serious issue anymore and resources should not be expended. It should be obvious that smoking will shorten your life*
- *Do not know*
- *Unknown.*
- *Offering courses or patches to help staff and community quit smoking*
- *Smoking rates continue to be high. We need to do more to address this.*
- *There seems to be plenty of materials available at facilities, I'm not sure how well they work with students and young adults regarding prevention and not starting to begin with.*

Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey Results)

Need Topic	Number of Local Experts Voting for Needs	Need Determination
Drug/Substance Abuse	63	Significant Needs
Mental Health	61	
Obesity/Overweight	45	
Accessibility (Transportation, Disability, Access to Care, etc.)	38	
Alcohol Abuse	31	
Affordability	25	
Education/Prevention	23	Other Identified Needs
Diabetes	19	
Smoke/Tobacco Use	19	
Cancer	18	
Dental	16	
Chronic Pain Management	16	
Physical Inactivity	14	
Heart Disease	11	
Alzheimer's	9	
Women's Health	8	
Hypertension	6	
Suicide	6	
Stroke	5	
Accidents	2	
Respiratory Infections	1	
Women recovery housing with and without children	1	
Lung Disease	1	
Birth	1	

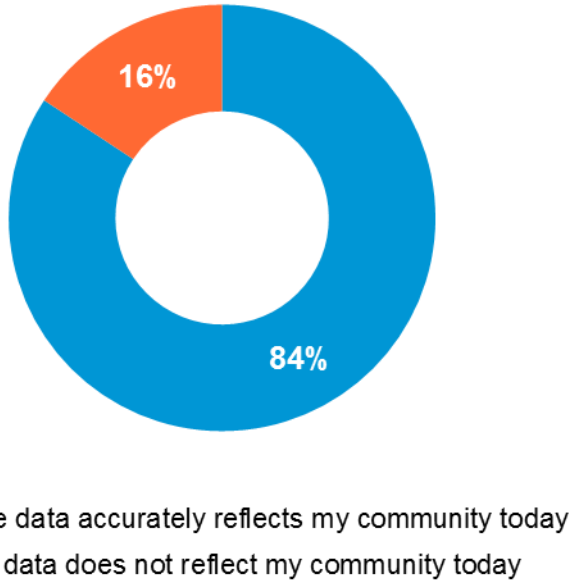
Individuals Participating as Local Expert Advisors[28]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	40	53	93
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	41	52	93
3) **Priority Populations**	42	48	90
4) Representative/Member of **Chronic Disease Group** or Organization	23	62	85
5) Represents the **Broad Interest of the Community**	99	14	113
Other			0
Answered Question			128
Skipped Question			23

[28] Responds to IRS Schedule H (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

Question: Do you agree with the comparison of Coos and Grafton Counties to all other New Hampshire counties?



Comments:

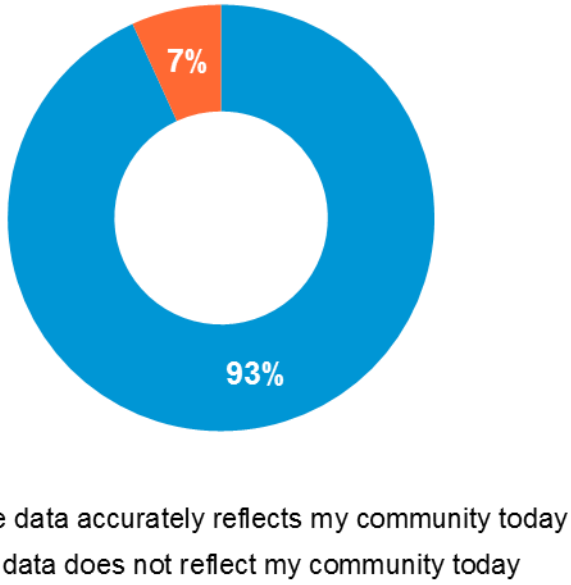
- *Grafton statistics likely swayed by more affluent areas near Hanover. Our area likely to have stats closer to Coos county stats.*
- *suspect Grafton County data skewed by Hanover-Lebanon economic bubble*
- *shortage of affordable housing; lack of mental health care is higher; In 2017 NH was 3rd highest for fatal overdose. Lack of meeting patients caught in cycle of addiction where they are at; lack of needle exchange centers, linking patients to care; shaming patients on MAT; lack of education regarding evidence based practice. Increasing rates of Hep C; increased risk of sepsis and other blood borne infections, many are unidentified. Homophobic culture of unacceptance and shame, stigma; lack of progression*
- *People are reporting that they are healthier than they really are. Self-assessment lacking.*
- *Unfortunately, it does reflect Coos County*
- *Grafton county is always skewed by Hanover/Lebanon*
- *Numbers seem low.*
- *My community is becoming a retirement community. Those that come here to retire are in much better health, discipline for exercise, and financially strong. Those that were raised here are moving out which changes the whole dimension of our county. I believe over the next 10 years we'll see a huge transition of retirees Moving in and locals leaving the area.*

- *We need to get people back to work and not encourage them to do nothing. Our society has gotten to the point to forcing people to not work instead of encouraging them to work.*
- *I believe the Grafton data do not accurately depict northern Grafton, and are skewed by the Hanover/Lebanon area, especially. While Littleton and northern Grafton no doubt are slightly healthier than Coos, I believe the numbers are likely much closer to one another.*
- *There are few housing options in Coos county and there are very few resources or transportation to these resources.*
- *We are trying to address these areas but have not received much financial support*
- *My answer is based on speculation*
- *I'm not sure I understand the above data*
- *People in this area are proud to be who they are and too proud to ask for education or assistance. "I can do it myself and don't need help" I feel bad today but it will go away "*
- *Obviously Coos County is in worse shape than Grafton County. How do you change something so widespread as rural obesity problems? Are there early education programs in place in schools to help resist smoking, drinking and other destructive health behaviors?*
- *Mammograms numbers would improve if UCVH radiology would call patients that we refer to schedule their mammogram.*
- *I was surprised by our excellent doctor to patient ratio! It is now more confusing, however, as to why it takes so long to schedule appointments with specialists. Often people within my catchment area drive to Concord or Dartmouth to see specialists.*
- *I believe that quality of life isn't the worst of any county in NH.*
- *The economic state of our community I feel is the biggest influencer on the health status of our community.*
- *I feel our community has improved.*
- *The only exception I would make would be the unemployment data - I believe it is underreported due to people timing out of the system.*
- *I do not feel qualified to answer this as I do not have the status on many of the questions.*
- *Deadly data! I agree with it all. Coos county has a lot of old, sick, poor folks and the worst ratio of physicians to citizens. A lot to do.*
- *For the most part, data seems to reflect population. I think poverty and financial burden is more significant than 3.4%.*
- *I am surprised by the numbers for access for exercise, also the food news for Mental Health ratio. I know the dentistry figures are still changing with the history of the setting up and hiring of staff in the last few years. So*

many children helped and more to come! Mammogram figures needed and shocking amounts of Preventable Hospital stays!

- *Patients should be called by the radiology department to schedule mammograms in order to increase routine screening numbers. Currently patients have to call to schedule which is a barrier to treatment. Employing frequent travelers in multiple departments has caused decreased quality which will result in decreased patient care.*
- *We currently have only one dentist serving the local community within approx. 50 miles. We currently have minimal psychiatrist coverage.*
- *I believe the upper valley population (Dartmouth College, DHMC) drastically skews the Northern Grafton County towns in your service area, as I would associate the Health of Northern Grafton much more comparable to that of Coos County than to that of the Upper Valley and the rest of the County.*

Question: Do you agree with the demographics and common health behaviors of Coos and Grafton Counties?

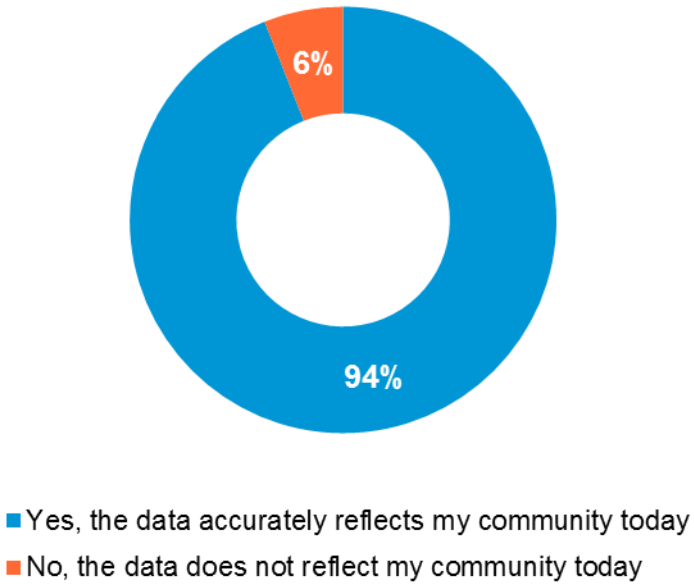


Comments:

- *suspect lower median income for our area of Grafton*
- *question income data for Grafton county*
- *see previous re: influence of Hanover-Lebanon area*
- *unclear new provider to this community;*
- *self-reporting for etoh use is under reporting. There is way more chronic back pain than 5%. I believe that state insured pts visits the ER more than 5% more than others for non-emergent issues because of the hours*
- *I think the median household income seems higher than reality*
- *cervical cancer screenings likely inaccurate and ? if calculated on current recommendations*
- *Again, the portion of Grafton that is served by the hospital is skewed by the southern portions of the county*
- *not sure what to base it on*
- *I'm doubtful that Coos County population will drop by approximately 2,200 in the next five years.*
- *unknown*
- *I work for ACHS (although have been asked to answer this survey as the President of the LRH medical staff.) We have instituted policies to screen for and address the problems above. I believe we do an excellent job but the statistics for our area are still grim.*

- *Not sure.*
- *Answer based on speculation*
- *Please note; the Frequency of Pap smears is now recommended less often with HPV testing.*
- *Again, I believe substance abuse, weight, access to medical attention is all reflective of the economic status- Coos has a significant lower medium household income.*
- *Although this data may be accurate for each county, I believe the data from lower Grafton county is different than for upper Grafton county. Incomes are higher in lower Grafton county and upper Grafton county may be more like Coos county in many ways.*
- *Unsure*
- *However, I am surprised with the population estimate for 2024, and also surprised and pleased at the median Household Income for Grafton. This means to me that we are really doing something right and making a big difference in a lot of lives...*
- *Some of the above numbers are eye opening.*
- *Will greatly help now that Littleton Urgent Care is open!*

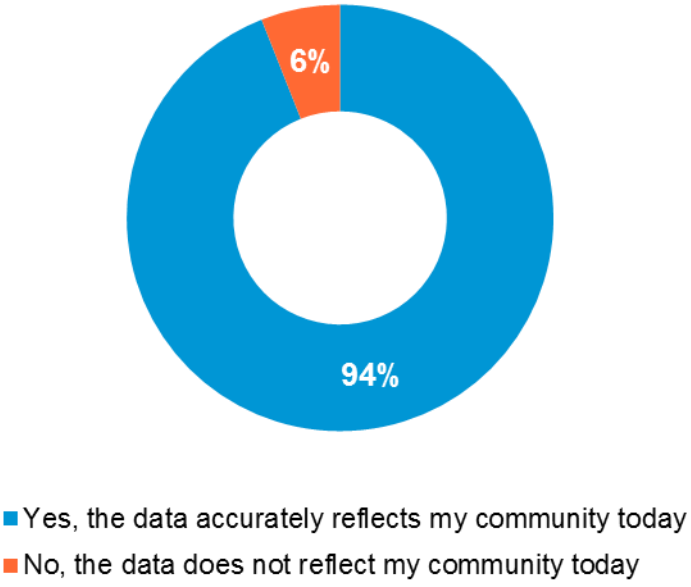
Question: Do you agree with the overall social vulnerability index for Coos and Grafton Counties?



Comments:

- *I would have guessed Woodsville area more vulnerable than Ltn*
- *unclear new provider to this community*
- *How could I doubt the data?*
- *Seems like more populated areas have more issues. Somehow this data doesn't look like it's based on a percentage of population.*
- *transportation is a huge issue in Coos County*
- *I have no idea*
- *No surprises here. A lot of poverty.*
- *But only because I am putting my faith in accuracy and hard work of the folks who have been working on this whole project! I am admiring and thanking them for all this! Yes, there have certainly been many changes in the last few years and most of them have been for the better! Congrats to the folk who designed and compiled this huge job!*
- *WEEKS area is higher*

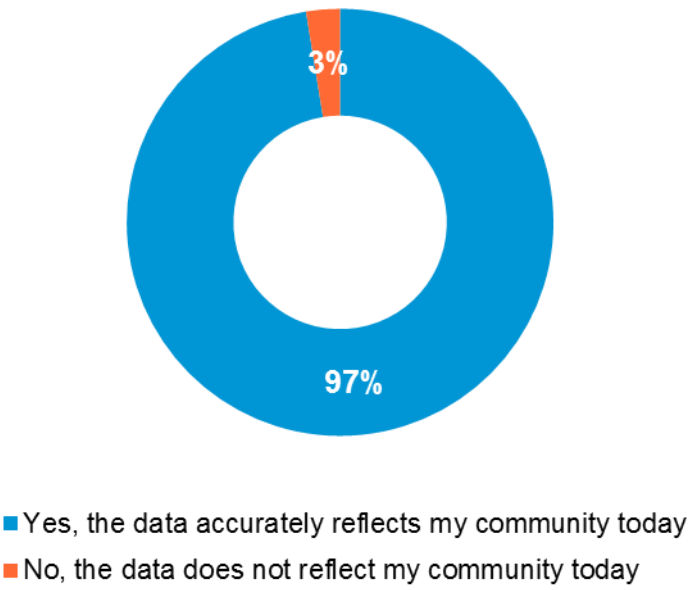
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *recent data reports fatal overdose is greatest risk of death to millennials,*
- *Alzheimer's is higher than 1/10. I believe there are more undiagnosed cases in Coos County*
- *And would have expected Alzheimer's to be higher*
- *Though it's a little hard to understand how Coos County could be the worst county in the state for accidents, yet have an average death rate lower than the state average.*
- *It does not include substance use deaths.*
- *Were long term care facilities included in gathering data?*
- *I wasn't aware Grafton County was highest in Parkinson's?*
- *I am curious if there is a correlation between Grafton/Coos cancer rates and the solid waste facility in Bethlehem.*
- *Not sure why accidental deaths in Coos is higher than expected when it's lower than the state rate?*
- *I am surprised with the cancer figures, sad about the Parkinson's and Alzheimer's figures and hopeful that the future will have an effect on those numbers one day...*
- *MENTAL HEALTH NOT INCLUDED*

Question: Do you agree with the health trends in Coos and Grafton Counties?



Comments:

- *Our area of Grafton likely has worse outcomes than Grafton average*
- *lack of progression*
- *I believe there are some changes from the 2014 data to today. For example, life expectancy is lower due to effects of substance misuse.*
- *Again, there is no way that I can with any sort of accuracy say if this data is a true reflection of the population in Grafton that the hospital serves.*
- *not sure*
- *unknown*
- *Unknown*
- *I have to assume the data is accurate as I don't have enough insight to dispute it*
- *I do not know the answer to many of these questions*
- *Sad...*
- *Interesting and Sad comparison with Coos.*
- *unsure*

- *I would assume the numbers reflect my community today, but I have never seen numbers publicly displayed on which to a definitive yes or no.*
- *Don't know*
- *Upper Valley greatly skews results for Northern Grafton County*

Appendix C – National Healthcare Quality and Disparities Report[29]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsured, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

Key Findings

Access: An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

[29] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

Quality: Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

Disparities: Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[30] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[30] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

Link to the full report:

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf