Central New Hampshire Public Health Region

Community Health Improvement Plan

2022-2027

CENTRAL NEW HAMPSHIRE
PUBLIC HEALTH ADVISORY COUNCIL

WORKING TO IMPROVE THE HEALTH AND WELL-BEING OF CENTRAL NEW HAMPSHIRE COMMUNITIES

WITH SUPPORT FROM THE

Central New Hampshire Health Partnership

Central
New Hampshire
HEALTH
PARTNERSHIP

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Executive Summary

The Central New Hampshire Public Health Advisory Council (PHAC) is pleased to present the 2022 Community Health Improvement Plan for the Central New Hampshire Public Health Region. This plan builds upon the work of individuals working collectively with support provided by the Central New Hampshire Health Partnership. Our collective vision is to transform public health in our community to an integrated system of seamless, effective collaboration among all healthcare providers, social service agencies and public safety personnel with meaningful engagement of patients, families, and communities. Through this integrated system, all people will have equitable access to timely, comprehensive, cost-effective, high-quality, and compassionate care.

Public health is the practice of preventing disease and promoting good health within groups of people-- from small communities to entire countries. Public Health is YOUR health, the health of your family, and the health and safety of our communities. It embodies everything from clean air to safe food and water, access to healthcare and safer communities.

Through public health planning and prevention initiatives, the public gets sick less frequently, children grow to become healthy adults through adequate resources including health care, and our community reduces the impact of disasters by preparing people for the effects of catastrophes such as hurricanes, floods and terrorism.

In preparing this Plan, the PHAC and its workgroups have reviewed needs assessments, using data from many different sources such as community focus groups, key stakeholder interviews, and surveys. Building on this information, we have identified gaps and priority health needs, and developed action plans to address them. This Community Health Improvement Plan brings into focus the needs, goals, measurable objectives, and strategies to drive our collective work on solutions to priority public health needs facing our community.

We are all responsible for the health of our community. The importance of healthy living and safety in our homes and communities are values that we all share. We look forward to working with the entire community to better understand the health problems confronting our residents and to implement strategies to respond to the public health needs of our community.

We invite you to read through the report, study the objectives and strategies, and consider how you can become involved. The Central New Hampshire PHAC thanks the individuals, agencies, state and local governments who have made this plan possible through their important contributions of time, effort and resources.

Central New Hampshire Health Partnership

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The Central New Hampshire Public Health Advisory Council

The Central New Hampshire Public Health Advisory Council (PHAC) is comprised of board members and staff of Central New Hampshire Health Partnership organizations and other community stakeholders including representatives from local businesses, law enforcement, education, community and family support services.

1. Introduction

The Community Health Improvement Plan (CHIP) for the Central New Hampshire Public Health Region is the result of a participatory, community-driven planning process led by the PHAC, in formal partnership with the Central New Hampshire Health Partnership (CNHHP). The CHIP, together with the Community Health Needs Assessment conducted by the CNHHP, form a long range, systematic effort to address and improve the health of all Central NH residents.

The CHIP is an action-oriented, living document designed to mobilize community partners to work together in ways we can be most impactful to improving the health of all Central NH residents. We work together to improve health in the communities where we live, learn, work and play, particularly for those most vulnerable and people affected by health disparities.

This CHIP is our community's plan for health, a guide for systematic and collective efforts to address high priority health issues in our communities.   The CHIP serves as a comprehensive set of policy and program recommendations for our community, based on the most current information we have regarding the health status and priority health needs of our communities. It recommends goals, objectives and strategies for action to drive collaborative planning and implementation across multiple community sectors including health, behavioral health and substance use care, public health, local government, education, social services, business, faith, and volunteer agencies and organizations. We rely on the CHIP to help guide policy, program and resource allocation decisions that optimize health and well-being.

There are many factors that influence health. Individual behaviors, age, genetics and medical and mental health care all play a role. Social and economic factors including education, health insurance, employment, income, access to healthy foods, living and working conditions, and the physical environment all shape the overall health and vitality of Central NH. The CHIP integrates a socio-environmental approach. We factor in, and aim to address through five priority areas, the full range of influences of all the social determinants of health on individuals and the community. We will improve individual and community health outcomes by applying strategies aimed at improving individuals' experiences of the social determinants of health.

Our goal is to make Central NH a healthier community. We envision a place where everyone has access to health care and preventative services, where we're celebrated for embracing healthy lifestyles and where our communities are strong, connected and vibrant. As partners in the local health system, we recognize we can only achieve this goal through partnerships and positive changes at the individual, school, workplace, and community level. Working together we can reach our shared vision for a healthy community supported by accessible, integrated service delivery systems with focused attention on meeting the needs of underserved populations.

Central New Hampshire Health Partnership and Public Health Network

CNHHP is a collaborative of organizations working to enhance and improve community health and public health-related services throughout the region. The mission of CNHHP is to improve the health and well-being of Central New Hampshire communities by collaborating to optimize prevention, access, and coordination.

The CNHHP hosts the Central New Hampshire Public Health Network, one of 13 regional public health networks in New Hampshire. The mission of the Central New Hampshire Public Health Network is to build a sustainable public health partnership that serves our communities. As a region-wide collaboration of partners to health and well-being, the Central NH Public Health Network works to enhance and improve public health-related services within the region.

As host, CNNHP convenes, coordinates, and facilitates the regional Public Health Network's broad partnership of organizations and individuals who contribute to and share in the health of our region. CNHHP provides leadership through the regional PHAC and supports a variety of services including Public Health Emergency Preparedness and Substance Misuse Prevention.

The Central New Hampshire Public Health Advisory Council

The PHAC is the operational body of the CNHHP, the locus of development and implementation of the CHIP. The role of the PHAC is to advise the Central New Hampshire Public Health Network by identifying regional public health priorities based on assessments of community health; guiding the implementation of evidence-based programs, practices and policies to address identified priorities and improve health outcomes; and advancing the coordination of services among partners. The PHAC works to promote outreach and community engagement to identify and address public health issues.

The PHAC is comprised of community leaders and representatives from a diverse group of community sectors across the domains of health care, public health, emergency planning, mental health, substance misuse prevention and the substance use continuum of care, business, faith, government, education, social services, and citizen representatives. The primary work of the PHAC is to set regional health priorities, provide guidance to regional public health activities, and ensure coordination of health improvement efforts as identified by the CHIP. More information about each of New Hampshire's Public Health Advisory Councils and Networks can be found at nhphn.org/who-we-are/public-health-networks/.

2. Community Profile

The Central New Hampshire Public Health Region includes the towns of Alexandria, Ashland, Bridgewater, Bristol, Campton, Ellsworth, Groton, Hebron, Holderness, Lincoln, Livermore, Plymouth, Rumney, Thornton, Warren, Waterville Valley, Wentworth and Woodstock. CNHHP serves approximately 30,322 people living in these 18 communities.

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey
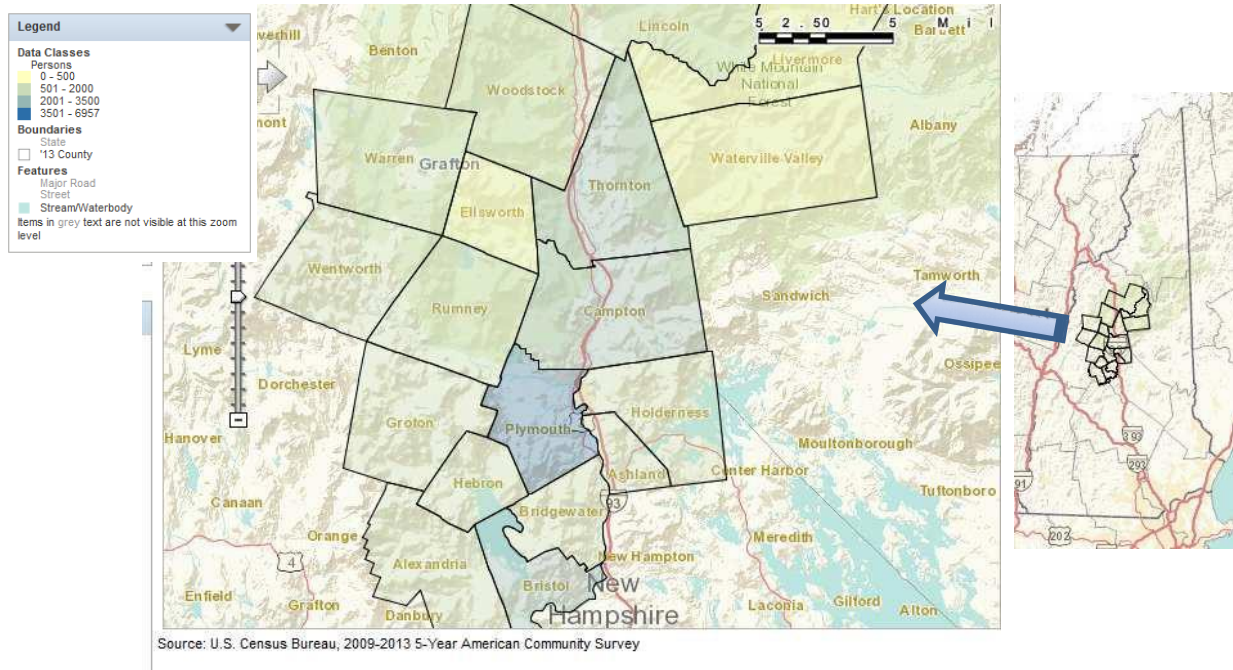
Population Demographics

The Central NH Public Health Region has an older population than the state as a whole: 17.7% of our total population is aged 65 years or older compared to 15.3% for the state overall.[1] Central NH's population is growing, but at a rate slower than New Hampshire overall.

Indicator	CNHHP Region[1]	New Hampshire
Total population	30,322	1,343,622
Age 65 and older	17.7%	15.3%
Under age 18	17.0%	19.9%
Change in population from 2017 CHNA	+0.9%	+1.4%

Population Health Indicators

Indicator	CNHHP Region	New Hampshire
Percent of population with a disability overall	15.7%	12.6%
Percent of population with a disability <18	4.2%	4.8%
Percent of population with a disability 18-64	11.9%	10.1%
Percent of population with a disability 65+	38.0%	31.9%
Delayed or avoided health care because of cost	12.2%	9.3%
Adults with a personal health care provider	90.6%	87.5%
Percent with no health insurance coverage	9.6%	6.5%
Percent with Medicare Coverage	22.7%	18.6%
Percent with Medicaid Coverage	17.7%	12.7%
Percent with VA Health Coverage	3.2%	2.7%

Data Source: CHNA, 2021 County Health Rankings (2015-2019 data)

Clinical Care

Access to care requires not only ability to pay and access to insurance, but also access to health care providers. While high concentration of physician specialists has been associated with higher (and perhaps unnecessary) utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care. Population ratio to primary care physicians (PCPs) represents the number of individuals served by one physician in a county, **if the population was equally distributed across physicians**. A lower ratio is better for this indicator, however geographic distribution must be considered in evaluating its impact. While Grafton County ranks at the lowest (most favorable) ratio in the range for New Hampshire, the data belie what we know to be true for our region. There is a misallocation of primary care physicians in Grafton County which translates to a shortage for our Central New Hampshire service area. Because of the concentration of medical resources, including physicians, in the region surrounding Dartmouth Hitchcock Medical Center and other Dartmouth Health affiliates in Grafton County, the population ratio to Primary Care Physicians at the county level is very low. However, Grafton County is large geographically and the residents of our service area are generally located more than an hour from richly resourced medical service hubs, creating a shortage of PCPs and other physicians for our service population.

Area	Population Ratio to Primary Care Physicians
Grafton County	510:1
New Hampshire range	1,570:1 – 510:1
New Hampshire overall	1,110:1
US top performers	1,010:1

Data Source: 2021 County Health Rankings (2015-2019 data)

Social Determinants of Health and Mental Health

Our approach to community health improvement takes a social determinants perspective. Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life risks and outcomes. The impact of social determinants on health status and outcomes are far-reaching and well-documented. Environmental conditions also set the stage for our mental health and emotional well-being. Social and economic inequities in our living conditions can be root causes and contributors to mental illness. Some social determinants are "proximal" – environmental and experiential factors that impact our health and mental health directly. These include adverse childhood experiences (ACEs), social inclusion and access to services. Other social determinants are "distal" – they exert their influence indirectly. Distal social determinants of health and mental health apply pressure to the more proximal determinants to create compound affects. Examples of distal social determinants include employment, food security, educational attainment, income equality, and housing stability.

Poverty and Income Inequality

Poverty and income inequality contributes to every domain individual and community health and well-being. The percentage of individuals in the Central NH Public Health Region living with incomes at or below 100% of the federal poverty level (10.6%) is notably higher than the rate for New Hampshire overall (7.9%).[1] In addition, the percentage of households with children headed by a single parent is higher in the Central NH Public Health Region (33.7%) than in New Hampshire overall (28.7%).[1] The median household income in the Central NH Public Health Region is significantly below that for New Hampshire, at $58,383 compared to $74,057 for the state overall.[1]

Income inequality within a community can have broad health impacts, including increased risk of mortality, poor health, and cardiovascular disease. Inequality can accentuate differences in social class and status and serve as a social stressor to youth, families and individuals. Communities with greater income inequality can experience a loss of social connectedness, as well as a decrease in trust, social support, and a sense of community for all residents. Income inequality is measured by the ratio of household income at the 80th percentile to income at the 20th percentile. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.[2]

Area	80th Percentile Income	20 Percentile Income	Ratio of 80th Percentile to 20th Percentile
Grafton County	$125,292	$26,961	4.6
New Hampshire range			4.0 – 4.6
New Hampshire overall			4.3
US top performers			3.7

Data Source: 2021 County Health Rankings (2015 – 2019 data)

Education

Level of education has a strong influence on health risk and outcomes in every domain. Individuals with a high school diploma are more likely to have longer life expectancy and improved quality of life. Level of education is related to smoking status, exercise habits, and

better physical health including lower rates of diabetes and improved self-reported health. Adults with a high school diploma are more likely to be employed and earn more, on average, than their less educated counterparts. School funding adequacy is a measure of the average gap in dollars between actual and required spending per pupil among public school districts (lower is better). Required spending is an estimate of dollars needed to achieve U.S. average test scores in each district. For Grafton County, our gap in school funding is higher (worse) than NH overall.

Indicator	Grafton County	New Hampshire
Completed high school	93%	93%
Adults with some college	69%	71%
School funding adequacy	$11,291	$9,506

Data Source: 2021 County Health Rankings (2015-2019 data)

3. Methods

Community Health Improvement Plan Development

During 2021-2022, the Central New Hampshire Public Health Advisory Council engaged in a community health improvement planning process. The purpose of this process was to engage community partners to:

- Identify and evaluate health issues
- Provide information to community members
- Help plan effective interventions
- Provide a baseline to monitor changes and trends
- Build partnerships and coalitions
- Identify emerging issues
- Identify current regional public health priorities
- Develop a Community Health Improvement Plan (CHIP)

The community health improvement planning process began with review of several related community health assessments of the region and consideration of priority areas for action that were highlighted by the findings of these assessments.

Community Health Needs Assessment

Assessment of community health needs is an ongoing, integral part of the work done by the CNHHP to improve health and wellbeing in our region. In 2011, the Partnership collaborated for the first time to conduct a comprehensive community needs assessment. With assistance from the New Hampshire Community Health Institute, CNHHP conducted a mixed-methods, multi-domain survey and data gathering process to understand community needs, inform public health decision-making and achieve our mission. CNHHP conducted our most recent Community Health Needs Assessment (CHNA) from February through September 2020. Our purpose is to better understand the health-related issues and concerns impacting Central NH residents; inform community health improvement plans, partnerships and initiatives; and fulfill CHNA requirements in compliance with federal Community Benefit reporting.

We targeted the geographic area encompassing 18 communities that make up the Central New Hampshire Public Health Region, with a total population of 30,332 and served by the member agencies of the CNHHP. The towns we serve include Alexandria, Ashland, Bridgewater, Bristol, Campton, Ellsworth, Groton, Hebron, Holderness, Lincoln, Livermore, Plymouth, Rumney, Thornton, Warren, Waterville Valley, Wentworth, and Woodstock.

Methods of assessment included survey of community residents, community discussion groups, interviews and gathering of secondary data sources.

Surveys of community residents were disseminated through social media, email distribution, website links through multiple channels throughout the region, and partner websites. Paper

survey collection was not utilized for this CHNA cycle due to the COVID-19 pandemic. A direct email survey of key stakeholders and community leaders representing multiple community sectors was administered. A series of community discussion groups were scheduled but convening proved to be challenging due to the pandemic. One discussion group was held, and others were replaced by individual key informant interviews. The purpose of the discussions and interviews was to collect in-depth qualitative information on health issues that matter to the community, and thoughts and perceptions about the health of the community. A review of available secondary data including population demographics and health status indicators framed and supplemented the primary data collected.

The purpose of each of these assessments was to identify community health concerns, priorities and opportunities for community health and health care delivery systems improvement. Priorities and opportunities for improvement were identified by considering factors including:
- Does the health factor or outcome have the potential to result in severe disability, death, or impacts on quality of life?
- Does the health factor or outcome impact a large sub-population?
- Does the health factor or outcome disparately impact a population subgroup?
- Will the health factor or outcome, if not addressed, result in significant healthcare or social costs?
- Is the health factor or outcome feasible for the region to address in terms of cost, resources and community will?
- Will addressing the health factor or outcome build on existing efforts and partnerships?
- Is the health factor or outcome not being adequately addressed by current efforts in the region?

All information gathering activities and analyses sought to focus community health needs assessment on vulnerable and disproportionately served populations including sub-populations that may experience limited access to health-related services or resources due to income, age, disability, and social or geographic isolation.

The following table summarizes the community health needs and issues identified by survey respondents and discussion participants. Full CHNA findings are published at https://www.cnhhp.org/2020-coummunity-health-needs-assessment/.

Table 1. Title	
Affordability of health insurance, and cost of care and prescription drugs	Affordability of health care services including health insurance and prescription drug costs was the highest priority identified by community survey respondents and by community leaders. It was also the most frequently mentioned topic area in an open-ended question about 'one thing you would change'
Availability of mental health services	Availability of mental health care was the second highest priority identified by community respondents and the top priority among community leader survey respondents with 86% considering the issue a 'high priority' or 'very high priority'

Domestic violence and childhood trauma	Child abuse or neglect and domestic violence were identified as a high priority or very high priority by about three quarters of community survey respondents
Cost of living including affordable housing and affordable, high quality child care	Affordable housing was the top issue identified by community leaders as an area for focusing resources that support a healthy community. Affordable housing and child care were also identified as high or very high priorities by about 70% of community survey respondents.
Affordability of and access to healthy foods	Affordability of food and access to enough food was the second highest concern after cost of health care among households with incomes under $50,000.
Availability of primary care and specialty medical services	Availability of primary care services was the 5th highest priority among all community survey respondents and 3rd highest among those age 65 or older. About 11% of all respondents reported difficulty accessing specialty services they needed.
Services and supports for older adults including adult day care and Dementia/Alzheimer's care	Health care for seniors was a top 10 priority identified by community survey respondents and support for older adults was the second most commonly cited area for focusing resources that support a healthy community.
Alcohol and drug use prevention, treatment and recovery	Prevention of substance misuse, addiction and access to substance misuse treatment and recovery services were top issues community leader respondents in particular and by community survey respondents to a lesser extent relative to other priorities for community health improvement.
Planning and Responding to Public Health Emergencies	Planning for Public Health Emergencies was a top 10 priority in the 2020 CHNA, much higher than previous years and most likely a reflection of the ongoing Covid-19 pandemic.

Planning Process

The PHAC used the results of the 2020 CHNA and the NH State Health Improvement Plan as the basis to identify community priorities. The 2020 CHNA process included community feedback from focus groups to rank identified priorities to determine focus areas for the CHIP.

The PHAC continues to meet regularly to gain information about current public health issues from regional partners, to understand community public health trends and associated community response, and to inform and advise the CNHHP on priorities and plans. Because the individuals who serve on the PHAC include representatives from a broad cross-section of towns, community sectors and stakeholders, their feedback is vital to planning for community health. As a result, the CNHHP relies on the input of the PHAC in developing public health plans, as well as to inform plan implementation and evaluation.

In some cases, the strategies included in this plan are building on the efforts of existing partnerships and workgroups, while in other cases new workgroups will be formed. In all cases, these efforts are moving forward in collaboration with multiple local organizations and individuals representing a broad cross-section of regional assets and strengths.

4. Community Health Improvement Priorities and Plans

Community health improvement priorities are guided by findings of the CNHHP 2020 CHNA. The top public health priority areas chosen by the PHAC and CNHHP for focused community health improvement efforts over the next five years are shown below. These pressing unmet needs, each requiring integrated approaches and solutions, prevent our community from reaching its full potential for health and quality of life.

1. **Affordable Health Insurance, and Cost of Care and Prescription Medications**

2. **Access to Mental Health Care**

3. **Domestic Violence and Childhood Trauma**

4. **Affordability of and Access to Healthy Foods**

5. **Substance Misuse Prevention, Treatment and Recovery**

6. **Social Determinants of Health**

In the remainder of this CHIP, each priority area is described, along with goals, objectives and strategies that will work to close the gap on unmet needs. In chapter 10, we describe strategies for embedding promotion of the social determinants of health throughout our health and social service systems.

7. Priority Area 1: Affordability of Health Insurance, and Cost of Care and Prescription Medications

Background and Importance

Affordability has been called the most serious health care problem faced by most Americans, and was the number one priority identified by our CHNA. The majority of respondents (89%) identified affordable health insurance, cost of care and prescription drugs as our highest priority community health need.

Affordability means different things to different people: residents, patients, employers, the government, providers and insurers may define it differently. What we mean by promoting affordability is working collaboratively to implement strategies to lower costs, improve quality and enhance patient access to care. First and foremost, consumers must be able to get through the door to receive the care and the medications they need, and affordability removes barriers to access. While the rate of uninsurance has declined in recent years, 8% of our residents still lack health insurance, higher than NH overall (figure 1). As partners to providing the care our residents need, we focus our attention on what we can do locally to help more people enroll in insurance they can afford, and access the prescription medications they need, to improve and maintain their health as affordably as possible.

Figure 1
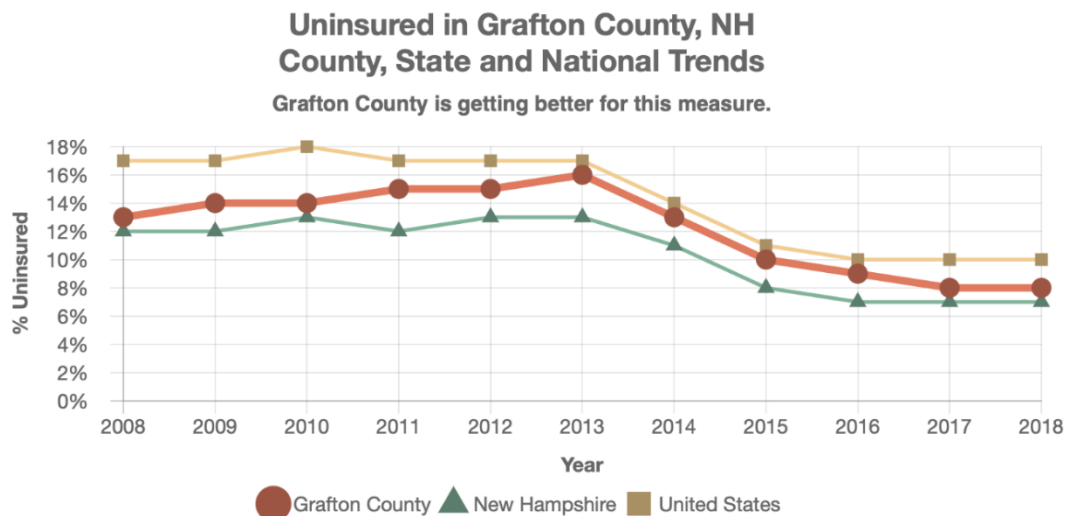
2021 County Health Rankings (2018 data)

Regional Initiatives and Opportunities

- Low-cost or sliding scale clinics providing health and mental health services accessible to residents include Mid-State Health Center in Plymouth and Bristol; Speare Primary Care, Plymouth Pediatrics and Adolescent Medicine, and Plymouth OB/GYN in Plymouth; Lakes Region Mental Health Center in Plymouth; and Ammonoosuc Community Health Services in Warren.

- CNHHP provider sites operate financial assistance programs to assist eligible residents with access to sliding scale and charity care for health and mental health care.

- The New Hampshire Medication Bridge Program assists eligible uninsured and underinsured patients to receive prescription medications at free or reduced cost. Access to Medication Bridge is available through Speare Memorial Hospital, Mid-State Health Center, Rural Health Clinics, physician offices, senior housing, ServiceLink and other partners.

- New Hampshire Medicaid and CHIP (Children Health Insurance Program) has increased enrollment by 72.8% since Marketplace opening and related Medicaid program changes in October 2013. CNHHP partners provide Certified Application Counselors to assist residents with application and enrollment.

- Health Market Connect (HMC) operates a federally funded program to provide no-cost, unbiased Marketplace health insurance assistance to New Hampshire residents, and is funded through 2024. HMC has a staff of 10 Navigators located throughout New Hampshire to help residents of NH access affordable health insurance (help@hmcnh.com or 603.309.2021). Navigators closest to, but not in, the Central NH region are located in Lancaster, North Conway, Tilton and Concord.

Goals, Objectives and Strategic Approach

Goals: Affordability of Health Insurance, and Cost of Care and Prescription Medications

Goal 1	Provide assistance to community members to promote access to health insurance
Objective 1	Increase number of individuals served by Certified Application Counselors.
Objective 2	Increase number of individuals served by Financial Assistance.
Goal 2	Provide resources and supports to promote access to prescription medication assistance programs
Objective 1	Increase number of individuals served by prescription medication assistance programs.

Strategic approach

STRATEGY 1: Increase number of Certified Application Counselors available through regional provider sites, to assist community members to access health insurance.

STRATEGY 2: Coordinate Certified Application Counselor office hours across CNHHP partner sites to enhance access and availability of counselors during enrollment period.

STRATEGY 3: Provide financial assistance counseling to assist community members with enrollment in Medicaid and Financial Assistance including charity care and sliding fee scale.

STRATEGY 4: Provide education to providers and staff on programs that provide free and reduced cost access to prescription medications.

STRATEGY 5: Provide education to consumers on programs and resources for free and reduced cost access to high-cost drugs.

STRATEGY 6: Engage Community Health Workers to refer consumers to Certified Application Counselors, Financial Assistance or prescription medication assistance programs.

8. Priority Area 2: Access to Mental Health Care

Background and Importance

Mental health, including emotional, psychological and social well-being, is an integral part of health throughout the lifecycle. Mental health is measured and experienced as a health outcome, but is also a determinant of physical health and well-being. Mental health contributes to how we respond to and experience stress, and how we cope and whether we are resilient to life's challenges. Health behaviors and the health choices we make are affected by our mental health, and it impacts our ability to access health care and services. Optimal mental health is essential to youth and adults for personal well-being, positive family and interpersonal relationships, and contributes to one's ability to contribute to the community.

Availability of mental health care was the second highest priority community health need identified by CHNA survey respondents among the general community: 80% rated it as a "high" or "very high" priority. Among community leaders, it was the highest rated priority, with 86% rating the issue a "high" or "very high" priority. More than a third of community survey respondents (35%) said they had difficulty accessing mental health care. Community discussion groups underscored the need for community health improvement in availability and access to mental health services.

A shortage of behavioral health professionals creates a significant barrier to access and poorer health outcomes. In the Central New Hampshire Public Health Region, the ratio of residents per behavioral health care provider is higher than for Grafton County and for New Hampshire overall and the entire service area is designated a Mental Health Professional Shortage Area.

Area	Population Ratio to Mental Health Providers
Grafton County	290:1
New Hampshire range	500:1 – 180:1
New Hampshire overall	290:1
US top performers	250:1

Behavioral health care services include approaches to promoting well-being, recovery and resilience; preventing a mental illness; intervening to treat a mental illness such as depression or anxiety; and preventing, intervening to treat, and promoting recovery from substance misus or an addiction. To promote access to needed mental health services, we focus on mitigating the range of factors that individuals experience as barriers to care. Central NH residents cite a number of reasons for difficulty accessing mental health care including unavailability of care (59%), long wait times (39%), could not afford to pay (26%), lack of insurance (26%), and service was not accepting new clients/patients (26%).

BARRIERS to ACCESS to NEEDED MENTAL HEALTH SERVICES

- **Stigma.** Stigma associated with mental illness, and co-occurring substance use where present, creates a barrier to seeking or receiving needed mental health care services.

- **Capacity for behavioral health care services.** Regionally, statewide and nationally, there is a shortage of mental health and substance use service providers. While integration of physical and mental health care and substance use services is an ongoing goal, there are still pockets where services are not well connected to other parts of the health care system.

- **Screening and referral to treatment:** People with both acute and chronic mental health conditions are often under-diagnosed and under-treated, leaving them with significantly poorer health and social outcomes including shortened life spans, lower rates of steady employment, and higher rates of homelessness.

Regional Initiatives and Opportunities

- Lakes Region Mental Health Center (LRMHC) offers 24/7 emergency response, psychiatric services, children and family services, adult and elder services, substance use disorder and recovery services, peer support, housing, employment support, in-house behavioral health pharmacy, promotion of healthy lifestyles, onsite care at local schools and nursing homes, and trauma-informed care.

- Screenings and referral for mental health and substance misuse are implemented at multiple points of service across CNHHP partner sites, including Speare Memorial Hospital, Mid-Sate Health Center, PARC, CADY and other agencies. Conditions screened for include depression, anxiety, substance misuse (general and substance-specific), and insomnia severity, among others.

- New Hampshire Rapid Response Access Point is available 24 hours a day, 365 days a year, offering telephone support and problem solving for any person experiencing a mental health or substance use crisis. The Access Point offers referrals to outpatient services and deployment of a Mobile Crisis Response Team. The Rapid Response Access Point provides timely access to services and avoids use of hospital Emergency Departments for individuals with mental health and substance use treatment needs.

- Plymouth State University Counseling Center offers counseling services to students within its scope of practice, and referrals to outside counseling and psychiatric care. In matters of psychological crisis and emergency, the Counseling Center provides services in response to on-campus suicide attempts or threats, sexual assault, or other trauma, dangerous, erratic or psychiatric behavior, volatile behavior in proximity to a weapon, by calling Campus Police at (603) 535-2330 or 911 (on campus) or the Counseling Center at (603) 535-2461 (on or off campus during business hours).

- Plymouth State University (PSU) students have free access the WellTrack app, an interactive self-help therapy app. WellTrack includes self-help tools, education, and referral information to PSU and community resources. Students may download and register for the WellTrack app with their Plymouth State University email address.

- Peer Support Agencies (PSAs) are private, not-for-profit agencies that are part of New Hampshire's mental health system. They provide hope, education, and ongoing support to individuals with mental illness. Services may include face-to-face and telephone peer support; outreach; monthly educational events; activities that promote self-advocacy; wellness training; after hours warm line; and crisis respite, a 24-hour, short-term, non-medical crisis program. Programs vary from region to region, some offering transitional housing, crisis respite, computer skills training, trauma recovery groups, and one-on-one community outreach, and other services. In Plymouth, Pemi Valley Peer Support & Outreach may be accessed by calling the Coordinator at (603) 412-7050 during business hours.

- Referral Education Assistance & Prevention Program (REAP) provides free preventative home and community-based counseling and education services to people over the age of 60, who have problems with alcohol, drugs, mental health or other life changes. Staff also work with caregivers of "at risk" elders to educate them on how to intervene if an elder becomes unable or unwilling to accept help.

Goals, Objectives and Strategic Approach

Goals: Access to Mental Health Care

Goal 1	Increase mental health provider capacity within CNHHP
Objective 1	Increase number of full-time equivalents (FTE) of mental health provider resources.
Goal 2	Increase access to mental health screening across CNHHP partners.
Objective 1	Increase number of patients screened.
Goal 3	Improve integration of mental health treatment across CNHHP partners.
Objective 1	Increase occurrence of closed loop referrals across treatment providers in the region.
Goal 4	Promote access to mental health services
Objective 1	Provide community education and outreach to reduce stigma and build awareness of need and access to mental health services

Strategic approach

STRATEGY 1: Implement recruiting, incentive and retention strategies to increase the number of full-time equivalents (FTEs) of mental health service providers among CNHHP partner sites.

STRATEGY 2: Develop and distribute a resource and referral tool to promote referral of residents to mental health services.

STRATEGY 3: Engage Community Health Workers to refer residents to needed mental health resources.

STRATEGY 4: Conduct public health outreach and education to decrease stigma, informing community members about mental health risk and impact of social determinants on mental health, to promote prevention and increase access to treatment including 24/7 rapid response services.

STRATEGY 5: Collaborate among CNHHP members to strengthen integrated models of care and referral systems.

STRATEGY 6: Collaborate with CNHHP members to evaluate options and resources for expanding service sites and hours of operation for mental health services to increase access.

STRATEGY 7: Collaborate with justice system, courts, schools, youth and family services, community-based services and other regional partners to raise awareness and engage individuals in screening and referral to services.

9. Priority Area 3: Domestic Violence and Childhood Trauma

Background and Importance

Domestic Violence
Domestic violence (DV) and intimate partner violence is a serious public health problem that can have a profound impact on lifelong health, opportunity, and well-being. Domestic violence can occur between a parent and child, siblings and other family relationships. Intimate partner violence occurs between people who have an intimate or sexual relationship, who may or may not be living together in the same household. Both forms of violence may include physical, sexual, or emotional abuse, or sexual coercion and stalking by a current or former intimate partner. Domestic and intimate partner violence affects millions of women each year in the United States.[3] While women are statistically more likely to be victims of domestic violence, domestic violence can and does affect anyone, regardless of age or gender identity.

Domestic and intimate partner violence can range from one episode that could have long-term impacts to repeated episodes over multiple years. Ultimately, DV is not "incident focused", but a pattern of perpetrator behaviors intended to gain and maintain power and control over their victim. Threats of or actual physical violence is connected to, and may co-occur with, other forms of violence such as financial abuse and human trafficking.

Violence in the home and between partners is related to serious health and economic outcomes that affect the victim and children in the home who are witnesses and victims. People who are exposed to domestic and interpersonal violence experience visible and hidden physical and emotional injuries, trouble sleeping, mental health impacts such as depression, anxiety and post-traumatic stress disorder, economic impacts, and other serious effects.[4] Domestic and intimate partner violence is linked to many long-term health problems, including arthritis, asthma, chronic pain, gastrointestinal problems, heart problems, migraine headaches and immune system problems.[5]

It is important to remember that when a victim/survivor asserts their independence, such as by filing for divorce or separation, the perpetrator is losing their power and control. The perpetrator will go to extreme lengths to maintain control in the relationship. Women are 70 times more likely to be killed in the weeks after leaving their abusive partner than at any other time during the relationship.[4]

According to the Violence Against Women in New Hampshire Report, 33.4% of NH women have experienced intimate partner violence, and 81% of perpetrators were married or related to the victim. One in four men in the US report being physically assaulted by an intimate partner.[6]

Sexual Assault
Sexual assault is about power and control and is often used to intimidate, control, and demean victims of domestic violence. Perpetrators of child sexual abuse are most often people known by the victim, which increases the victim's confusion and self-blame, and hinders disclosures.

Sexual assault by an intimate partner is often not seen by the victim as a crime or predictor of danger. However, 40-45% of women in abusive relationships will be sexually assaulted by their partner. When someone is sexually assaulted by an intimate partner, they are seven times more likely to be murdered by that partner.[4]

Stalking

Current or former intimate partners are the most common type of stalkers. The majority of female (60.8%) and 43.5% of male stalking victims report being stalked by a current or former intimate partner, with more than half of intimate partner stalking initiated during the relationship.[3] A perpetrator may use many tools to maintain control of their partner, such as family location sharing apps and home security systems, which will not be recognized as stalking. Abusive litigation, or stalking by way of the courts, is often used by perpetrators when the court system becomes the only avenue to maintain contact and continue to abuse their victim. Continuous motions to amend parenting plans uses the children as pawns and instills fear and anxiety in the victim.[3] Approximately 90% of actual or attempted femicide victims who experienced physical assault in the preceding year were also stalked by the violent partner.[3]

Trafficking

Homelessness is the largest risk factor for sex trafficking of minors, with nearly one-fifth of homeless youth identified as victims of human trafficking.[7] In fact that is a low estimate: research suggests that trafficking rates among youth experiencing homeless range from 19% to 40%.[7] Homelessness and trafficking occurs in every American community, whether urban, rural, suburban or American Indian Reservations.[7] The pathways to sex and labor trafficking are similar to the pathways to homelessness for youth: trauma, being in vulnerable situations, child maltreatment, and sexual abuse.[7] The vast majority of youth who were sex trafficked (95%) reported a history of child maltreatment and 49% of those indicated a history of childhood sexual abuse.[8] Grooming tactics, such as gaining trust, fulfilling needs, and isolation, reinforce an unequal power dynamic between a vulnerable youth and the perpetrator, creating a pathway to victimization.

Childhood Trauma

Violence in the home where children are present is a significant source of childhood trauma and adverse childhood experiences (ACEs). Trauma is a public health problem with a range of costly and harmful impacts on children, families and communities.[9] ACEs are events that occur before the age of 18 that cause emotional or physical harm, undermine a child's sense of safety and create trauma for the developing child. ACEs include experiencing emotional or physical violence; abuse or neglect; housing instability or food insecurity; witnessing violence at home or in the community; living in a household affected by substance use, mental illness or suicide; and parental separation or incarceration.[10]

ACEs have consequences to brain and physical development that may leave the child with lifelong effects in every facet of their life. ACEs generate toxic stress that changes the developing brain, creating physical and emotional responses that affect how the child behaves, relates to family, school and the community, and develops.[9,11] Everything the child experiences is filtered through the effect of ACEs, including learning, friendships, play, and medical and behavioral health services.

ACEs are linked to a long list of health problems and mental illnesses, and substance misuse.[11] ACEs can shorten lives, and have been associated with at least five of the leading causes of death including cancer, diabetes, heart disease and suicide.[12-15]

Adverse childhood experiences (ACEs) are highly prevalent: more than 60% of the adult population is thought to have experienced one ACE and 15.6% experienced four or more.[12,16] More than half of families are likely affected by ACEs in one or more ways, and ACEs tend to cluster in families.[9,12,17-19] Children who experience one ACE are highly likely to experience one or more additional sources of childhood trauma.[17]

Child abuse or neglect, and domestic violence, were the third and fourth highest community health improvement priorities identified by CHNA survey respondents, respectively. More than 70% of community respondents rated both priorities "high" or "very high".

Regional Initiatives and Opportunities

- Voices Against Violence is a crisis services agency located in Plymouth, providing information and support to victims and survivors, their family and friends, community members, and professionals around domestic violence, children who witness domestic violence, sexual violence and harassment, stalking, human trafficking and bullying. Voices Against Violence operates a 24 hour crisis line at (877) 221-6176. Their offices may be reached at (603) 536-5999.

- Speare Memorial Hospital provides Sexual Assault Nurse Examiner (SANE) registered nurses who complete additional education and specialty training to provide comprehensive health care to survivors of sexual assault. SANE nurses are accessed by visiting the Speare Memorial Hospital Emergency Department.

- The New Hampshire Rapid Response Mobile Crisis Response Team operates 24 hours a day, every day of the year to respond to individuals experiencing mental health crisis due to trauma or violence.

- CNHHP partners provide multiple points of screening and referral for individuals experiencing domestic violence and trauma, including CADY, Inc., Mid-State Health Center, Speare Memorial Hospital, Lakes Region Mental Health Center and others?

- New Hampshire Coalition Against Domestic and Sexual Violence offers a 24-hour helpline and crisis resource locator, advocacy services, information and education, prevention and empowerment of anyone affected by sexual violence, domestic violence, stalking and human trafficking.

- Law enforcement: The NH Attorney General has established a protocol for law enforcement agencies to respond to victim reports of domestic violence.

- Grafton County Attorney is connected through the New Hampshire Attorney General's Office, Office of Victim/Witness Assistance program, to provide information, services and supports through New Hampshire's Sexual Assault Resource Team (SART) Program (www.doj.nh.gov/criminal/victim-assistance/sart.htm).

Goals: Domestic Violence and Childhood Trauma

Goal 1	**Build capacity in Central NH to respond to domestic and sexual violence, trauma and ACEs.**
Objective 1	Assess landscape of resources, services and access across 18 towns in eastern Grafton Count to respond to sexual assault, domestic violence, stalking and childhood trauma.
Objective 2	Identify gaps in access to services and resources for domestic violence, sexual assault and trauma.
Objective 3	Develop a collaborative plan to improve available service and access.
Goal 2	**Build capacity among CNHHP partners to identify violence, trauma and/or ACEs in the population.**
Objective 1	Increase number of CNHHP members screening for violence, trauma and/or ACEs.
Goal 3	**Increase access to services for residents exposed to violence, trauma and/or ACEs.**
Objective 1	Provide education and outreach to raise awareness of services and promote access.
Objective 2	Increase number of referrals of individuals to services for violence, trauma and/or ACEs.

Strategic approach

STRATEGY 1: Develop and implement a standardized violence, trauma and/or ACEs screening tool for adoption by CNHHP partners.

STRATEGY 2: Provide education and outreach to promote adoption of increased standardized screening for trauma and/or ACEs by CNHHP partners.

STRATEGY 3: Develop and distribute a resource list and tool for referrals to services for children and adults exposed to violence, trauma and/or ACEs.

STRATEGY 4: Engage Community Health Workers to adopt standardized screening and refer adults and children to identified services for people exposed to violence, trauma and/or ACEs.

STRATEGY 5: Implement public health outreach and education to increase public awareness of resources and promote access to services for children and adults exposed to violence, trauma and/or ACEs.

STRATEGY 6: Implement public health outreach and education to increase awareness of strategies to prevent violence, trauma and/or ACEs.

10.   Priority Area 4: Affordability and Access to Healthy Foods

Background and Importance

Nutrition Security

A household is food secure if all members, at all times, can access enough food for an active, healthy life. Food security is access to readily available, nutritionally adequate, safe foods, and the ability to acquire those foods without resorting to emergency food supplies, scavenging, stealing or other coping strategies.[20,21] Nutrition security is consistent access, availability and affordability of foods and beverages that promote well-being, prevent disease, and when necessary, treat disease.[22] Poor nutrition is widespread in the US and is a leading cause of illness, responsible for more than 600,000 deaths per year.[23] Many if not most adults have diet-related conditions: more than 40% of adults have obesity, and half have diabetes or prediabetes.[24] Diet-related conditions such as obesity and diabetes among children are on the rise, and estimates suggest that most American children will have obesity by the time they are 35 years old.[25-27]

Food insecurity co-occurs with diet-related diseases and health disparities,[20] and other issues such as housing instability or unaffordability, social or rural isolation, high medical costs, health and mental health problems, and low wages. Food insecurity is often the result of a necessary trade-off in the face of competing financial demands that de-prioritizes access to healthy foods. Effective policy and program measures to address food insecurity take a social determinants approach because of these overlapping challenges of co-occurring issues affecting health and well-being.

Our CHNA found that among respondents 18 to 44 years old, access to affordable and adequate food was among their top five community health improvement priorities. Among all respondents, affordability of and access to enough food was the fifth highest priority community health issue with 68% rating it "high" or "very high" in importance. For residents with income less than $50,000, access to food was their second highest priority after affordability of health care and prescription medications.

Pre-pandemic population estimates of food insecurity at some point during the year were 9.7% for Grafton County (8,760 people) and 9.3% for NH overall.[28] Covid-19 has increased economic pressures through gaps in employment, supply-side shortages and increase in prices, increasing food insecurity in NH.[29] Recent survey data suggest that 17% of NH households are food insecure, almost 2-1/2 times the rate at the beginning of 2020 before the Covid-19 pandemic.[30] Most of these households have children. It is estimated that northern and western counties of NH, and rural areas, such as the Central NH Region, have even higher rates of food insecurity than the state overall.[29] While SNAP (Supplemental Nutrition Assistance Program or "food stamps") benefits are available to some people experiencing food insecurity, there are large gaps due to benefit level and eligibility constraints. In Grafton County the average cost per meal is $3.79, compared to a maximum NH SNAP benefit of $1.98 per person per meal.[29] SNAP and other nutrition programs in NH have an eligibility threshold of 185% of the federal poverty level, and it's estimated that nearly half (44%) of food insecure households in Grafton County are not eligible for benefits.[28] While SNAP and other programs are available and essential toward

closing the gap in access to healthy foods for Central NH residents, Grafton County overall still experiences an annual food budget shortfall of $5,620,000 to feed food-insecure individuals.[28] This translates to a food budget shortfall of $1,893,940 to feed the approximately 3,000 people in Central NH experiencing food insecurity.

NH is low in participation in federal food programs, standing 47th among states in school breakfast, 39th in SNAP, 32nd in Child and Adult Care Food Program, 25th in summer meals programs, and WIC serves only 37% of those eligible.[31] Promoting public awareness of available food and nutrition programs, and supporting applications for those eligible and in need of services, are important strategies to address food and nutrition insecurity in our region.

Regional Initiatives and Opportunities

- Community Action Program Belknap-Merrimack Counties (CAP) provides access to federally-funded food and nutrition programs serving Central NH. Belknap-Merrimack CAP may be accessed at www.? (800) 578-2050 or (603) 225-2050.

- NH Hunger Solutions is a statewide advocacy organization established to connect more New Hampshire residents to the food and nutrition supports they need, and to end food insecurity and hunger in NH. NH Hunger Solutions engages in policy advocacy to close the gap between those eligible for and those enrolled in federal nutrition programs (SNAP, School Meals, Summer Meals, WIC). NH Hunger Solutions works with schools and communities to increase participation in school meals, increases public awareness of the causes of and solutions to hunger in New Hampshire, and builds coalition among existing and emerging food access councils and groups.

- USDA Commodity Supplemental Food Program (CSFP) provides eligible low-income persons at least 60 years of age with supplemental nutrition and USDA Foods through prepacked boxes containing nutritious foods and healthy recipes. Deliveries include foods like low sodium canned vegetables, low sugar fruits, low fat dry milk and cheese, shelf stable milk, whole grain cereal, pasta or rice, canned meat, poultry or fish, juice, peanut butter, dry beans, and fresh produce during the summer months. CSFT delivers throughout Central NH to convenient locations like churches, senior housing, community centers, and other sites. CSFP is accessible to those who qualify through Belknap-Merrimack CAP at (800) 578-2050.

- Senior's Farmers Market Nutrition Program (SFMNP) provides fresh produce to people 60 and older enrolled in the Commodity Supplemental Food Program (CSFP). From July-September, participants receive a bundle of produce that includes both fruits and vegetables at their CSFP appointment. The program supports New Hampshire farmers and all produce is locally grown. Seniors receive nutrition education, information about storing and cooking their produce, and information on local farmer's markets

- The Emergency Food Assistance Program (TEFAP) provides cost-free food assistance to families and individuals in need. TEFAP is coordinated by local NH Community Action Agencies and distributes donated items to local community organizations such as food pantries, soup kitchens, and homeless shelters. Families and individuals in need of food can access TEFAP through the Coordinator at (603) 225-3295.

- The Women, Infants and Children Nutrition Program (WIC) provides nutrition education, breastfeeding support, health screenings, and nutritious foods to pregnant women, new mothers, breastfeeding mothers up to 12 months after the baby is born, infants, and preschool children up to age five. The goal of the program is to promote healthy living, and all participants are seen regularly by a nutritionist. Food benefits include whole grains, fruits, vegetables, and other healthy options. WIC may be accessed through Belknap-Merrimack CAP by calling (800) 578-2050 or (603) 225-2050 and WIC clinic services are available at sites throughout NH including Ashland, Bristol, Lincoln and Plymouth.

- The Elder Services' Meals on Wheels program provides home-delivered meal services to older adults and adults with disabilities. Their mission is to assist frail and older adults and adults with disabilities to remain in their homes for as long as possible in an independent and dignified manner. Meals on Wheels provides nutritious meals delivered by trained drivers, daily safety checks, resource information, and peace of mind for participants and their loved ones. Program goals are to reduce or prevent malnutrition, ensure safety, reduce isolation and to keep seniors and people with disabilities at home where they prefer to be. For access call (603) 225-3295**.**

- Senior Centers located throughout the region provide health and wellness programming and daily community dining. There is no cost for attendance for individuals 60 and older. Meals meet 1/3 of the USDA recommended daily requirements and are donation-based; suggested donation is $2 per meal. Senior Centers are located in Bristol, Danbury, Lincoln and Plymouth.

- SNAP (Supplemental Nutrition Assistance Program), sometimes called the Food Stamp Program, serves approximately 70,000 NH residents. SNAP is the largest nutritional aid program in the US. SNAP may be access through the online NH EASY application process. Help is available by calling at 603-669-9725 ext. 1147 or emailing snap@nhfoodbank.org.

- SNAP maximum benefit amounts are updated in June of each year based on the cost of the Thrifty Food Plan. New benefit levels take effect annually on October 1. The Thrifty Food Plan is the cost of groceries needed to provide a healthy, budget-conscious diet for a family of four (www.fns.usda.gov/snap/thriftyfoodplan).

- USDA National School Lunch Program (NSLP) and School Breakfast Program (SBP) provide nutritionally-balanced free or low-cost meals every day in public and nonprofit private schools and residential child care settings. NSLP and SBP meals are a vital

source of nutrition for children experiencing food insecurity. Nearly 25% of NH children are eligible.[29] Enrollment information for school meal programs is available through the Pemi-Baker, Newfound, and Lin-Wood school district offices and through NH Hunger Solutions.

- The Summer Food Service Program (SFSP) provides nutritious meals for children during the summer months when school lunch programs are closed. This USDA nutrition program partners with local rec departments, schools, and Boys and Girls Clubs, offering breakfast and lunch to children in need. CAP sponsors Summer Food meal service sites within Belknap, Merrimack, and Grafton Counties. To access SFSP call (603) 225-3295.

- The WIC Farmers' Market Nutrition Program (FMNP) is available to WIC participants who are issued FMNP coupons in addition to their regular WIC benefits. These coupons can be used to buy eligible foods from farmers, farmers' markets or roadside stands that have been approved by the state agency to accept FMNP coupons.

- The New Hampshire Food Bank distributes food to more than 400 partner agencies across New Hampshire including food pantries, homeless shelters, soup kitchens, children's programs, senior centers and other sites. Assistance is available to help individuals with SNAP enrollment and make referrals to local food pantries. NH Food Bank also coordinates mobile drive-up food pantries in various locations throughout the state. A variety of food and nutrition supports, and listings of resources and food pantries across NH, are available on their website at nhfoodbank.org.

- Churches and faith-based organizations provide food and nutrition security programs, such as the Plymouth Congregational Church which operates "Feeding Our Children Together and a 24/7 access "take what you need" pantry.

- Food Pantries in Central NH include Helping Hands Food Pantry- Restoration Church (Plymouth); Plymouth Area Community Closet (Plymouth); Campton Area Resource Center (Campton); and Warren/Wentworth Food Pantry (Warren).

Goals: Affordability and Access to Healthy Foods

Goal 1	**Build capacity among CNHHP partners to identify food and nutrition insecurity in the population**
Objective 1	Increase number of CNHHP members screening for food and nutrition insecurity.
Goal 2	**Increase access to healthy food for residents experiencing food insecurity.**
Objective 1	Increase number of referrals of individuals to food and nutritional supports.

Strategic approach

STRATEGY 1: Implement and adopt across CNHHP partners, a standardized screening tool to assess food insecurity as part of screening for social determinants of health.

STRATEGY 2: Provide education and outreach to promote adoption of increased standardized screening for food insecurity by CNHHP partners.

STRATEGY 3: Develop and implement across CNHHP partners, a resource list and tool for referrals to aids and resources for people with food insecurity.

STRATEGY 4: Engage Community Health Workers to adopt standardized screening and refer people to identified aids and services for people with food insecurity.

STRATEGY 5: Participate in and promote state and national WIC outreach and engagement initiatives to increase early intervention during pregnancy through post-partum, promotion of breastfeeding and retention in the WIC program until children reach their fifth birthday.

STRATEGY 6: Promote participation in National School Lunch and School Breakfast programs.

STRATEGY 7: Promote participation by seniors in USDA Commodity Supplemental Food Program (CSFP) (federal) & Senior Farmers Market (CAP) and SNAP

STRATEGY 8: Implement public health outreach and education to increase public awareness of resources and promote access to affordable, healthy food.

11.   Priority Area 5: Substance Misuse Prevention, Treatment and Recovery

Background and Importance

The Surgeon General of the United States has deemed substance misuse one of the most pressing public health crises of our time. Many more people die from alcohol and drug overdoses each year than are killed in automobile accidents.[32] The impact of substance misuse as a public and individual health issue is growing. The United States exceeded 100,000 overdose deaths in the year ending April 2021, an historic high.[33,34] The list of longer-term health and societal effects of substance misuse pervades every aspect of community life.

Substance misuse, including misuse of alcohol, tobacco and other drugs, can have a wide range of health, mental health, safety and other effects. Effects can be immediate and direct, by means of automobile accidents, alcohol or drug overdose, psychotic episodes, suicide and death. Indirect effects include consequences that increase risk behaviors, resulting in driving under the influence, unprotected sex, needle/syringe sharing, interpersonal violence, and other outcomes that can ultimately lead to disease, injury or death, or socio-emotional effects.[32,35]

Over time, substance misuse has serious adverse impact on individual health and quality of life. Heavy drinking can lead to hypertension, liver disease, and cancer. Regular marijuana use is associated with chronic bronchitis[32] and will affect the developing adolescent brain.[36] Use of stimulants such as methamphetamine and cocaine can lead to heart disease.[32] Substance misuse during pregnancy can result in long lasting health effects for the baby including fetal alcohol spectrum disorders (FASDs), which are estimated to affect as many as 2 to 5 percent of the population.[32] The opioid crisis has caused a five-fold increase in the number of babies born with Neonatal abstinence syndrome (NAS), dependent on opioids at birth.[32,37] Intravenous drug use can result in outbreaks of HIV and hepatitis that spread through needle sharing; these infectious disease outbreaks can then spread to people who do not use drugs.

The fallout from widespread, increasing rates of substance misuse has broad societal and socio-economic consequences. Substance misuse can result in reduced productivity, higher health care costs, drug-related crime, unintended pregnancy, stress and separation within families, adverse childhood experiences (ACEs), and many other direct and indirect individual, family and community effects. Many of these effects are generational, handed down from parent to child, and handed back to grandparents who care for grandchildren whose parents are lost to a growing opioid epidemic and other drug problems.

Community Health Needs Assessment
Alcohol and drug use prevention, treatment and recovery was identified as a top community health priority by CHNA discussion group participants. Among community leaders, access to substance misuse treatment and recovery services was the 4th highest priority overall, with 77% rating the need a "high" or "very high" priority. Prevention of substance misuse and addiction was rated "high" or "very high" priority by 70% of community leaders. Overall, 10% of CHNA

respondents indicated they had difficulty accessing drug and alcohol treatment and recovery services.

Substance Use Disorder

A substance use disorder can be diagnosed as mild, moderate, or severe depending on the extent of a person's symptoms. Addiction is a severe substance use disorder associated with a chronic brain disease that causes compulsive or uncontrolled use of one or more substances.[32] The majority of individuals who misuse substances do not develop a substance use disorder. Addiction and substance use disorder can be prevented, and recovery is possible with medical, mental health, emotional, life skills and social determinants supports.

Area	Substance Use Disorder 12 and older, past year
Grafton County	14%
United States	12%

Data Source: National Surveys on Drug Use and Health, 2019-2020.[38]

Marijuana Use

Marijuana is the most commonly used illicit drug, and youth accessibility is increasing in states opting to legalize recreational use. Among people 12 and older 17.9% (49.6 million people) report using marijuana in the past 12 months.[38] Among people aged 12 or older in 2020, an estimated 5.1% (14.2 million people) had a marijuana use disorder in the past 12 months.[38] NH youth and young adults use marijuana at rates significantly higher than the rest of the US.[38] Marijuana use is risky for youth, not only through effects on the developing brain, but as a contributing factor to the use of other drugs.

Youth Marijuana Use

In Central NH, past 30-day use of marijuana among youth is 22.2% higher than NH average.

Area	Past 30-day use of marijuana among youth
CNHHP Service Area	31.9%
New Hampshire	26.1%

Data Source: Central NH High School Survey YRBS 2019.[39]

In our region, youth's perception of risk of marijuana use is below state average.

Area	Youth risk perception of marijuana use (great risk)
CNHHP Service Area	9.1%
New Hampshire	10.3%

Data Source: Central NH High School Survey YRBS 2019.[39]

Fewer Central NH youth (70.2%) report their parents disapprove of them using marijuana compared to NH overall (78.5%).

Area	Parental disapproval of youth marijuana use (wrong or very wrong)
CNHHP Service Area	70.2%
New Hampshire	78.5%

Data Source: Central NH High School Survey YRBS 2019.[39]

Alcohol Use

Alcohol continues to be the most commonly misused substance in the US and in NH. Underage drinking, binge drinking, regular heavy drinking and drinking during pregnancy are among the highest risk forms of alcohol misuse. Emerging research suggests a new measure of alcohol use and risk: high-intensity drinking at levels two or more times binge levels, particularly common in college or college-influenced settings among young adults who attend 4-year colleges and do not live with their parents.[40] High-intensity drinking has much more dangerous short- and long-term consequences than other patterns.[40] About 15% of youth 12th grade through 20 years old are high-intensity drinkers.[40]

Excessive Drinking

Excessive drinking is either heavy drinking (more than two drinks per day for men, and more than one drink per day for women) or binge drinking (five or more drinks on an occasion for men or four or more drinks on an occasion for women). Excessive drinking can lead to increased risk of adverse health effects and unintentional injuries.

Area	Excessive drinking among adults, past 30 days
Grafton County	22%
New Hampshire	20%

Data Source: Behavioral Risk Factor Surveillance System accessed via County Health Rankings, 2021.[2]

Youth Alcohol Use

Central NH youth's past 30-day alcohol use is 20% higher than NH youth overall. Binge drinking is more prevalent among our youth also.

Area	Past 30-day binge drinking among youth
CNHHP Service Area	15.7%
New Hampshire	14.1%

Data Source: Central NH High School Survey YRBS 2019.[39]

Area	Past 30-day alcohol use among youth
CNHHP Service Area	32.2%
New Hampshire	26.8%

*Data Source: Central NH High School Survey YRBS 2019.[39]*

In Central NH, youth's perception of parental disapproval of their alcohol use is below state average.

Area	Parental disapproval of youth alcohol use (wrong or very wrong)
CNHHP Service Area	88.6%
New Hampshire	90.9%

Data Source: Central NH High School Survey YRBS 2019.[39]

Underage Past-30 day Ten Year Trend

While youth substance use declined regionally in the period 2011-2015, the ten-year trend shows youth substance use is again on the rise. Representative 10-year trend data available for the Pemi-Baker Region, combined with decreasing risk perceptions overall among Central NH youth, suggest the need for increased emphasis on youth substance use prevention.
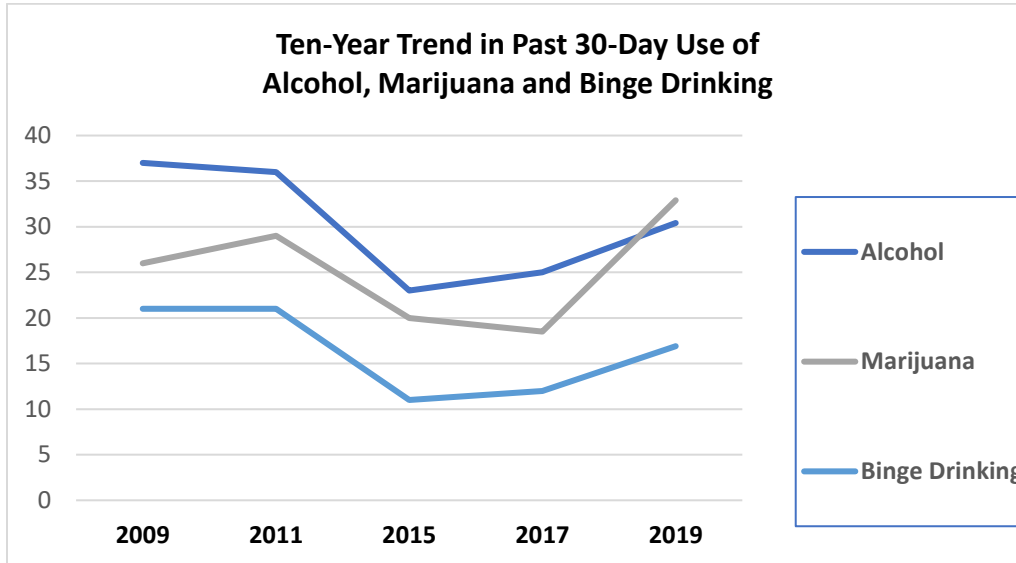
Data Source: Pemi-Baker Regional High School TAP and YRBS, 2009-2019

Youth Vaping

Vaping, or using E-cigarettes is dangerous for youth and adults, and is a growing health risk. E-cigarettes produce an aerosol by heating a liquid that usually contains nicotine, flavorings, and other chemicals, which is harmful when inhaled by the user or bystanders. In addition, nicotine is highly addictive and can harm adolescent brain development. Youth who engage in vaping are more likely to smoke cigarettes in the future.[41] In our Central NH region, 14.3% of youth use a vapor product every day. [39]

Area	Every used an electronic vapor product	Past 30-day use of a vapor product
CNHHP Service Area	58.5%	43.2%
New Hampshire	49.8%	33.8%

Data Source: Central NH High School Survey YRBS 2019.[39]

Adult Smoking

Tobacco use contributes to leading causes of death including lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease, and smoking during pregnancy is risky to the health of the unborn child through low birthweight and other outcomes. While smoking in

the Central NH region has decreased over time, the prevalence of current smokers in our region is higher than NH overall.

Area	Percent of Adults who are Current Smokers[1]	Smoked During Pregnancy, per 100 births[2]
CNHHP Service Area	16.8%	14.4
New Hampshire	15.7%	11.0

1. Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2017
2. Data Source: New Hampshire Vital Records Birth Certifiates, NHDHHS Office of Health Statistics 2015-2018

Regional Initiatives and Opportunities

- CADY Inc., with main offices in Plymouth, offers a full spectrum of youth empowerment, parent engagement, school-based prevention and education programs throughout the Central NH region. CADY also offers Naloxone education and distribution, community education on ACEs and trauma, and a court-approved, prevention-based youth restorative justice and mentoring program accepting referrals of high-risk youth from courts, law enforcement, schools, providers and social service agencies.

- Newfound Drug Response Task Force is a federally-funded coalition of health care, prevention, treatment, recovery, law enforcement, community members and others, established to respond to opioid and other drug problems, on the ground in the Newfound region.

- New Hampshire Rapid Response Access Point is available 24 hours a day, 365 days a year, offering telephone support and problem solving for any person experiencing a mental health or substance use crisis. The Access Point offers referrals to outpatient services and deployment of a Mobile Crisis Response Team. The Rapid Response Access Point provides timely access to services and avoids use of hospital Emergency Departments for individuals with mental health and substance use treatment needs.

- The Doorway is a statewide program providing a single point of entry to substance use treatment and recovery services, for individuals and families seeking help and supports. Community members may access the Doorway by calling 211 from anywhere in NH.

- FindWellNH.org is an online substance misuse prevention, treatment and recovery locator that offers reliable resources to help individuals, families and communities in Central NH respond to, find resources, and learn more about substance misuse and addiction, and take action. Access is available at www.FindWellNH.org or call (603) 236-1873 for more information.

- Central NH Community Opioid Response (CNHCOR) is a federally-funded consortium of health and mental health care, prevention, treatment, recovery, law enforcement,

community members and others, established to respond to and build capacity to address opioid and other drug problems in Central NH.

- Stand Up Newfound (SUN) is a grassroots collaborative of community members working together to eliminate substance misuse through raising awareness, prevention, intervention, treatment, and recovery.

- RISE is a Recovery Team at Mid-State Health Center committed to helping individuals improve quality of life by offering evidence-based, recognized treatment and recovery options proven to provide the best opportunity for success. RISE Recovery offers a variety of treatment options including Medication Assisted Treatment, Intensive Outpatient Program, and Recovery Support Services, regardless of ability to pay.

- Plymouth Area Recovery Connection (PARC) is a Recovery Community Organization (RCO) providing a caring and supportive environment for anyone working to recover from addiction. PARC communicates a message of hope; links individuals with recovery-related treatment services and peer support services; and facilitates the development of healthy and sustainable lifestyles.

- Lakes Region Mental Health Center provides comprehensive, integrated mental health treatment for people living with and recovering from mental illness and substance use disorders. LRMHC provides a diverse range of mental health, psychiatric, counseling and support services that are designed to improve health outcomes and support each individual's path to recovery.

- Naloxone (Narcan) distribution and education is available throughout Central NH at nearly 20 locations, with the number of sites of service growing all the time. Some access points for naloxone include CADY, Inc., Speare Memorial Hospital, Mid-State Health Center, Lakes Region Mental Health Center, PARC, SUN, Newfound Area School District, Plymouth State University, Fire Departments and EMS services in Bristol and Plymouth, and Police Departments of Alexandria, Campton, Danbury, Thornton, and Wentworth.

Goals, Objectives and Strategic Approach

Goals: Substance Misuse Prevention, Treatment and Recovery

Goal 1	Build capacity for youth marijuana prevention
Objective 1	Increase youth's perception of harm of use of marijuana, as measured by youth who think people are at great risk of harming themselves (physically or in other ways) if they use marijuana one or twice a week.
Objective 2	Increase youth's perception that parents think it is wrong or very wrong if they use marijuana.

Goal 2	Build capacity for youth alcohol prevention
Objective 1	Increase youth's perception of harm of use of alcohol, as measured by youth who think people are at great risk of harming themselves (physically or in other ways) if they have five or more drinks of alcohol once or twice a week.
Objective 2	Increase youth's perception that parents think it is wrong or very wrong for youth to have one or two drinks of alcohol nearly every day.
Goal 3	Build capacity to address substance misuse and addiction across the Central NH Region
Objective 1	Increase number of CNHHP member sites screening for substance misuse.
Goal 4	Improve access to treatment and recovery services
Objective 1	Increase number of referrals of individuals to needed substance misuse treatment and recovery services.

Strategic approach

STRATEGY 1: Implement public health outreach and education to increase the perception of alcohol and marijuana-related risk among parents, youth and the general community.

STRATEGY 2: Promote adoption of universal screening for substance misuse by CNHHP partners, to increase opportunities for early intervention and engagement of individuals to prevention, treatment and recovery.

STRATEGY 3: Adopt tools and systems to enhance efficiency and effectiveness of referrals to needed prevention, treatment and recovery services, and optimize closed loop referrals.

STRATEGY 4: Provide training and education to partners, staff and the community in ACEs and trauma-informed approaches to prevention, treatment and recovery services.

STRATEGY 5: Provide stigma-reduction education, outreach and training to partners, staff and the community.

STRATEGY 6: Build capacity to provide trauma-informed early intervention and mentoring to youth, young adults and families at high risk of substance misuse, substance use disorder and/or opioid use disorder, and negative consequences including family separation and justice involvement.

12. Social Determinants of Health

Background and Importance

Our approach to community health improvement takes a social determinants perspective. To improve the health of our residents, we aim to identify and address distal and proximal social determinants of health, starting before birth and extending throughout the lifespan. We can start at the individual level by better recognizing and addressing the basic needs of health consumers, such as employment, housing, food, and income. At the multi-system level, we can improve the service array so that all residents can access the services and supports they need, regardless of where they live, how much money they make, or their health condition. We address services and supports with goals and objectives throughout our community health improvement priority areas. In this section we establish goals that directly address the social determinants that impact our population's potential for optimal health and well-being.

The Centers for Medicare and Medicaid Services identified core health-related social needs that, if addressed, can help reverse their damaging health effects.[42] These core social needs are **housing instability and quality; food insecurity; utility needs; interpersonal violence; and transportation**. These needs have been consistently identified as priority health issues for our community through our CHNA process. Two priority social determinants of health, food insecurity and interpersonal violence, are addressed directly in chapters 7 and 8, respectively.

In this chapter we take a broader look at methods and mechanisms for improving health by addressing the social determinants through a systematic, coordinated regional approach.

Regional Initiatives and Opportunities

- Health care and social service providers throughout the region conduct regular, universal screening for health-related social needs, including Speare Memorial Hospital, Mid-State Health Center, Whole Village Family Resource Center and others.

- Community Health Workers (CHWs) and Navigators are located at service sites throughout the region to refer and navigate individuals to address unmet social determinants needs. Service sites that provide CHWs and/or Navigators include Mid-State Health Center, Speare Memorial Hospital, Speare Primary Care, PARC, Whole Village Family Resource Center, and others.

Goals: Social Determinants of Health

Goal 1	**Build capacity to coordinate referral and navigation to resources to address social determinants of health**
Objective 1	Increase number of sites of service providing CHW and navigation services.
Objective 2	Increase coordination among CHWs, Navigators and others providing referral and navigation services.
Goal 2	**Build capacity to identify and address health-related social needs**
Objective 1	Increase number of sites of service in Central NH conducting universal screening for social determinants of health.
Objective 2	Increase number of residents screened for social determinants of health.
Objective 3	Increase awareness of screening, referral and navigation services to improve access to resources to address unmet social needs.
Objective 4	Increase number of referrals of individuals to address unmet social needs.
Goal 3	**Build capacity to identify and address need for childhood early intervention services**
Objective 1	Increase number of sites of screening for early childhood developmental service needs.
Objective 2	Increase number screened for early childhood development needs.
Objective 3	Increase referral to early childhood intervention services.

Strategic approach

STRATEGY 1: Promote adoption of universal screening for social determinants by CNHHP partners, to increase opportunities to identify and address unmet social needs to improve our community's health, well-being and quality of life.

STRATEGY 2: Adopt tools and systems to enhance efficiency and effectiveness of referrals and coordination of resources, and optimize closed loop referrals.

STRATEGY 3: Implement outreach and education to increase awareness of importance of social determinants, and availability of navigation and referral services in Central NH.

STRATEGY 4: Convene and connect CHWs, Navigators and others providing screening and referral services, to enhance collaboration, coordination, and outcomes for individuals with unmet social needs.

13. Moving Forward

CHIP Implementation

The CNHHP and Central NH PHAC will work collaboratively to implement, monitor and improve the strategies defined in this Community Health Improvement Plan. The CNHHP and PHAC will continue to meet bi-monthly and create workgroups to meet more often as necessary to achieve identified goals.

Measurement and Monitoring

The first step in implementation is to identify, and/or establish, measurement systems by which we will monitor and evaluate our progress toward the objectives of the CHIP. Once measurement systems are in place, we will measure baselines for each objective, select the percentages by which we will improve, and establish the target outcomes we aim to achieve. This table summarizes our six priority improvement areas, and the goals and SMART objectives we will achieve within each area.

Central NH Community Health Improvement Plan 2022 - 2027 Goals and SMART Objectives	
Goal	**Objective**
Priority Area 1: Affordability of Health Insurance, Cost of Care and Prescription Medications	
Promote access to affordable health insurance	Increase number served by Certified Application Counselors
	Increase number served by financial assistance
Promote access to prescription medication assistance	Increase number served by prescription medication assistance programs
Priority Area 2: Access to Mental Health Care	
Increase mental health provider capacity	Increase number of FTEs of mental health provider resources
Increase access to mental health screening	Increase number screened.
Improve integration of mental health treatment	Increase occurrence of closed loop referrals across treatment providers
Promote access to mental health services	Provide community education and outreach to increase awareness and access, and reduce stigma
Priority Area 3: Domestic Violence and Childhood Trauma	
Build capacity to respond to domestic and sexual violence, trauma and ACEs	Identify and create directory of resources and services to respond to sexual assault, domestic violence, stalking and childhood trauma
	Identify gaps in access to services and resources for domestic violence, sexual assault and trauma
	Develop a collaborative plan to fill gaps and services and access
Build capacity to identify violence, trauma and ACEs in the population	Increase sites of screening for violence, trauma and ACEs
Increase access to services to respond to violence, trauma and ACEs	Provide community education and outreach to raise awareness and promote access
	Increase referrals to services for violence, trauma and ACEs

Priority Area 4: Affordability and Access to Healthy Foods	
Build capacity to identify food and nutrition insecurity in the population	Increase sites of screening for food and nutrition insecurity
Increase access to healthy food	Increase number of referrals to food and nutritional supports
Priority Area 5: Substance Misuse Prevention, Treatment and Recovery	
Build capacity for youth marijuana prevention	Increase youth's perception of harm of marijuana
	Increase youth's perception of parents' disapproval of youth marijuana use
Build capacity for youth alcohol prevention	Increase youth's perception of harm of alcohol
	Increase youth's perception of parents' disapproval of youth alcohol use
Build capacity to address substance misuse and addiction across the region	Increase number of sites of screening for substance misuse
Improve access to treatment and recovery services	Increase number of referrals of individuals to needed substance misuse treatment and recovery services
Priority Area 6: Social Determinants of Health	
Build capacity to coordinate referral and navigation to address social determinants of health	Increase number of sites providing CHW and navigation services
	Increase coordination among CHWs, Navigators and other providing referral and navigation services
Build capacity to identify and address health-related social needs	Increase number of sites screening for social determinants
	Increase number of residents screened for social determinants
	Increase awareness of screening, referral and navigation services to improve ability to address social determinants
	Increase number of referrals to address social determinants
Build capacity to identify and address need for childhood early intervention services	Increase sites of screening for early childhood developmental service needs
	Increase number screened for early childhood developmental needs
	Increase referral to early childhood intervention services

Collective Impact

The CNHHP and Central NH PHAC have defined an ambitious plan for improvement of the health of the Central NH community. This plan, like all work of the CNHHP and PHAC, is founded in and propelled forward by strong partnerships and collaboration. It is not possible for a single organization or individual to achieve the far-reaching community impact necessary to implement this plan and achieve our goals and objectives. The success of this endeavor turns on the ability of all stakeholders to embrace our shared vision and common agenda, and to leverage our resources and opportunities to create collective impact. Collective impact occurs when organizations from across all sectors agree to solve specific health and social problems using a common agenda, aligning their efforts, and using common measures of success.[43]

The Five Conditions of Collective Impact

Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the spectrum of players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a coordinating organization with staff and a specific skillset to serve as the infrastructure for the initiative.

Source: Kania, J., Kramer, M., Collective Impact. 2011: Stanford Social Innovation Review.

The CNHHP and the PHAC use the collective impact model to ensure inclusive and effective implementation. We continue to engage a wide array of stakeholders including the general public to identify priority areas and collaborate to meet the goals and objectives of the Community Health Improvement Plan. We invite all stakeholders and community members to find a way to participate, and utilize your personal and organizational strengths to support the implementation of this Community Health Improvement Plan. We all share in the responsibility for caring for, and improving, our community's health and well-being. The future growth and vitality of the Central New Hampshire Region depends on us all.

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