Community Health Needs Assessment

September 2013

Presented by

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CONSULTING GROUP, LLC

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Executive Summary

Background

Since 1903, Cottage Hospital has served resident of the Upper Connecticut Valley of New Hampshire and Vermont by providing high-quality care and by being a leader in projects that bring strength and vitality to the service area.

Currently, the 25-bed hospital includes core services designed to meet the divergent health needs of the community. In addition to those noted above, Cottage Hospital provides the following services:

- Cardiac Rehabilitation & Cardiology
- Cosmetic & Medical Laser Center
- Counseling
- Day Surgery
- Diabetes Education
- Emergency Services
- Family & Pediatric Medicine
- Gastroenterology
- Hospice & Palliative Care
- Inpatient Services & Therapy
- Inpatient Rehabilitative Services
- Intensive Care & PACU
- Internal Medicine
- Mental Health
- Neurology
- Nutrition Management
- Obstetrics
- Occupational Therapy
- Oncology
- Orthopedics
- Pain Management Services
- Pathology Services
- Physical Therapy
- Podiatry
- Radiology & Imaging
- Social Services
- Speech Therapy
- Urology

Community outreach and leadership are also important pieces of Cottage Hospital's role in the area. Involvement in broad-based community initiatives helps define Cottage Hospital. In order to better serve their community and meet State of New Hampshire and federal guidelines, Cottage

Hospital conducted a Community Health Needs Assessment (CHNA) in 2013. The Affordable Care Act of 2010 requires not-for-profit hospitals to conduct a CHNA every three years. In addition, the State of New Hampshire requires one to be done every five years. Crescendo Consulting Group, LLC, provided support and guidance to Cottage Hospital in order to conduct the required research and complete the CHNA.

During the course of the CHNA, key healthcare and public service stakeholders representing a breadth of community perspectives participated in the research as key leaders and sources of information. Crescendo supplemented the stakeholder research with an in-depth review of demographic and epidemiological data in order to identify underlying health trends in the service area. The research results in this report are based on the most currently available data from the community resources, the State of New Hampshire, the State of Vermont, and other regional sources.

This document addresses Federal and State of New Hampshire research requirements and can be used as a guide for further community outreach.

As per the requirements of the Affordable Care Act, this assessment includes the following:

- List of prioritized community needs
- Definition of the community served
- Description of the methodology to identify needs in the community
- Description of the approach used to prioritize community needs
- A list of area healthcare resources

Throughout the CHNA process, Cottage Hospital leadership stayed true to the mission and vision of the organization.

… Reaching out to include a broad range of perspectives

… Listening to healthcare consumers – the people served

… Including the professional insights of healthcare providers

… Reviewing the data the profiles community health, envisioning the impact shifting demographics

Cottage Hospital continues to work to provide accessible, compassion, quality care and be seen as the area's healthcare organization of choice.

Summary of Prioritized Community Needs

As shown in the following narrative, several methodologies were combined to develop a comprehensive and prioritized list of community needs. A summary table is shown below with methodological details and processes following.

Prioritized Community Needs

Rank	**Health Need**
1 tie	Access to primary care providers (including the availability of providers, affordability of care, and transportation)
1 tie	Access to behavioral health service providers (including the availability of providers and affordability of care)
3	Drug and alcohol abuse; Drug and alcohol education and early intervention
4	Screening for heart disease, cancer, and other chronic illnesses
5	Chronic disease treatment and co-morbid conditions such as mental health and other disease management initiatives
6	Dental services / availability of providers
7	Obesity / exercise / nutrition programs for adults and children
8	Preventive health services (e.g., flu shots, mammograms, and other screenings)

CHNA Community Participants

Cottage Hospital is pleased to have had a community-driven leadership team that provided project oversight, feedback regarding perceptions of area health needs, data evaluation, and other guidance throughout the CHNA process. These individuals had the diverse breadth of community health vision, knowledge, and power to impact the well being of the service area.

The Leadership Group included the following members:

- Nancy Lusby, 3 Rivers Business Association President
- Ed Shanshala, ACHS Executive Director
- Richard Pike, Blue Mountain Union Superintendant
- Sheriff Doug Dutile, Cohase Lions Club
- Teresa Puffer, Cottage Hospital Board
- Rev. Dwight White, Cottage Hospital Board & Rotary Club
- Craig Labore, Grafton County Nursing Home
- Chief Smith, Haverhill Police Department
- Glenn English, Haverhill Town Manager
- Liz Shelton, Local Business Owner
- Gail Auclair, LRHC Executive Director
- Roderick "Rick" Ladd, NH State Legislature
- Jeannie Forrester, NH State Senator
- Nancy Frank, North Country Health Consortium
- Kent Brooks, North Country Hospice
- Ray Burton, State of New Hampshire Executive Committee
- Steve Robbins, Woodsville EMS
- Frank Tilghman, WRSB CEO
- Bruce Labbs, Haverhill Superintendent

Description of the Community Served

Cottage Hosptial Primary Service Area (PSA) includes a roughly 535 square mile area split between New Hampshire and Vermont. With an approximate population of 20,163, Cottage Hospital's PSA includes 13 towns plus some additional affilitated regions (see map below). In addition to New Hampshire residents, several bording towns in Vermont rely upon Cottage Hospital's programs and services.

The Cottage Hospital service area includes the following towns in addition to other regions included in the map below

Bath, NH

Benton, NH

Haverhill, NH

Lisbon, NH

Monroe, NH

Piermont, NH

Barnet, VT

Bradford, VT

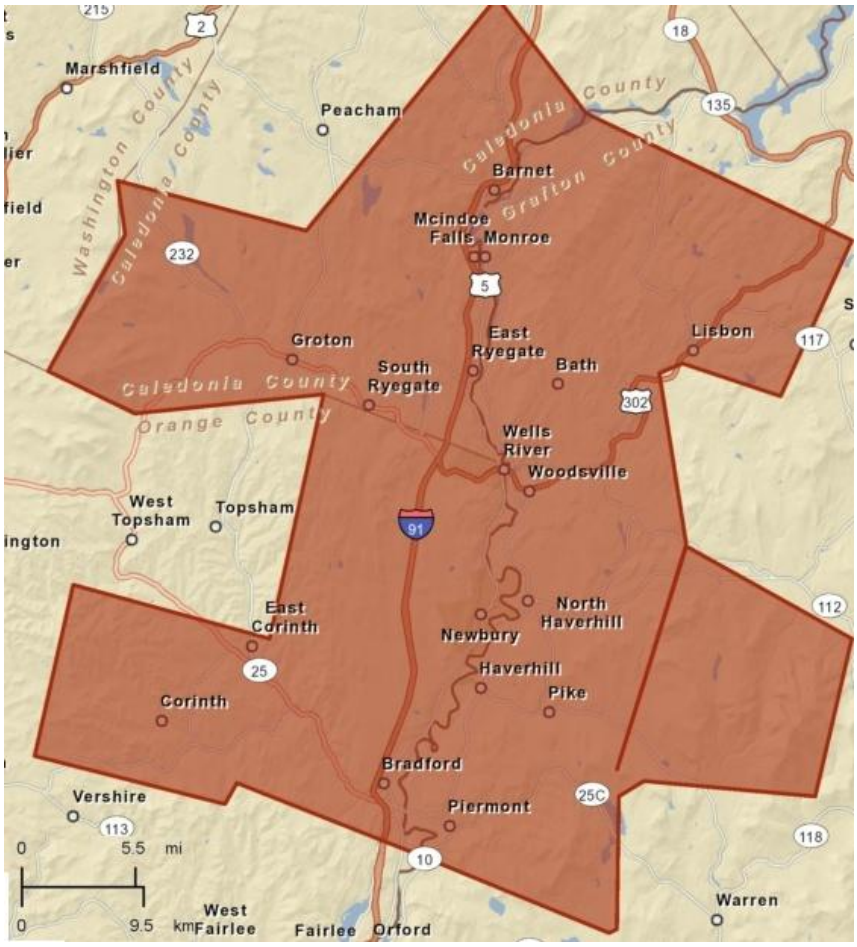
Corinth, VT

Groton, VT

Newbury, VT

Ryegate, VT

Wells River, VT



Assessment Methodology

The Cottage Hospital CHNA methodology includes a combination of quantitative and qualitative research methods designed to evaluate perspectives and opinions of area stakeholders and healthcare consumers – including those from underserved populations. The methodology used helps prioritize the needs and establish a basis for continued community engagement – in addition to simply developing a broad, community-based list of needs.

The major sections of the methodology include the following:

- Strategic secondary research
- Qualitative interviews with Cottage Hospital physicians and other care providers in the PSA
- Qualitative discussion groups with Leadership Team members
- Community surveys
- Needs prioritization using a modified Delphi process

Each of the components of the CHNA methodology is described below.

Strategic secondary research. *This type of research includes a thorough analysis of previously published materials that provide insight regarding the community profile and health-related measures. The "demographics and key indicators" table is shown below while others follow or are included in the appendices of this report.*

Data Source Examples	*Data Goal*

• **Demographic Data**
  ○ U.S. Census
  ○ State of NH, Employment Security
  ○ State of NH, Office of Planning
• **Health Risk Behavior Data from the U.S. Centers for Disease Control and Prevention**
  ○ Behavioral Risk Factor Surveillance System Survey (BRFSS)
  ○ Youth Risk Behavior Survey (YRBS)
• **Existing materials from other organizations**
• **State of NH, Division of Public Health**
• **Hospital Discharge Data**
• **Birth and Death Statistics**
• **Cancer Registry**
	Strategic secondary research data goals include properly framing the service area in terms of lifestyle, demographic factors, and general health trends, and to better understand previous research conducted for the hospital.
	
	In addition, goals include developing a better understanding of community health, morbidity and mortality data, key health-related factors that impact the PSA, and disease-based incidence levels that exceed the New Hampshire or national averages.

Qualitative interviews with Cottage Hospital physicians and other direct care providers in the PSA.

In order to gain a more in-depth understanding of key health issues that are presented at the Hospital and other service sites, Crescendo conducted several interviews with direct care providers in the PSA.

Data Source Examples	*Data Goal*
Cottage Hospital physician interviewees included the following: • Chris Danielson. DO • Blake Spencer, DO • Marlene Sarkis, MD • Jessie Reynolds, MD **Other direct care providers or leaders that were interviewed (telephonically or electronically) include, but are not limited t, the following:** • Edward Shanshala II, MSHSA, MSEd, Ammonoosuc Community Health Services, CEO • Gail Auclair, MSM-HCA, BSN, RN Little Rivers Health Care CEO	The qualitative interviews were designed to identify provider perspectives from within their areas of expertise as well as their observations about the health needs of the community as a whole.

Qualitative discussion groups with Leadership Team members who included healthcare consumers, service providers, and other community opinion leaders. *The discussion groups represent a span of healthcare consumers in the PSA. Although not all groups were represented at each meeting, information and insights were gathered either from their direct participation in a group setting or electronically.*

Data Source Examples	*Data Goal*
A sample of the community groups who were contacted in the research include: • 3 Rivers Business Association • Cottage Hospital Board • Cottage Hospital Board & Rotary Club • Grafton County Nursing Home • Haverhill Police Department • Haverhill School System • Haverhill Town Manager's Office • Local Business Owners • LRHC Executive Director • NH State Legislature • NH State Senator • North Country Hospice • WGSB • Woodsville EMS	Discussion group goals involve creating a broad list of community health needs. To thoroughly do so, the research includes extensive input from community groups, all in an effort to "cast a broad net" across the service area, especially among the underserved.

Community surveys. *Online and paper versions of a brief Community Health Needs Assessment survey were made available at Cottage Hospital, on the Hospital's website, and throughout the community.*

Data Source Examples	*Data Goal*
The Survey was made available at the Hospital and in several online locations. A copy of the survey is included in Appendix A.	The goal of the surveys was to further engage healthcare consumers – especially those who may be higher-risk for health care services. The results of the surveys were integrated with the data-driven secondary research, qualitative interviews and group discussions, and other research to help form the comprehensive list of community health needs.

Based on the breadth of quantitative and qualitative research techniques described above, an extensive list of 34 community needs was identified. As per the requirements of the Affordable

Care Act, Cottage Hospital prioritized the list. The methodology used to create the prioritized list is described below.

Needs prioritization using a modified Delphi process. *The Delphi Method was pioneered by the RAND Corporation in the 1950s and 1960s. It is a quantitative and qualitative survey method that is used to collect, distill, and reach prioritized consensus around creative ideas and/or qualitative issues and questions.*

In this phase of the prioritization research, Leadership Group members rated health initiatives and provided qualitative feedback. The modified Delphi method included three steps.

- Leadership Group members were asked to complete a survey in which they were to quantitatively and qualitatively evaluate each of the 34 community needs identified in earlier research and to submit their responses to Crescendo. They were also asked to provide feedback regarding the rationale for their rating.
- Crescendo rank-ordered the needs based on the average score and aggregated the qualitative comments.
- The results were sent to Leadership Group members in the form of a second survey. The second survey included the same list of 34 needs, as well as the group ranking from the previous survey and qualitative comments. Leadership Group members re-rated the needs based on their own opinions and the insights of others as expressed in the list of aggregated comments. Group members submitted their responses to Crescendo.

Data Source Examples	*Data Goal*
Crescendo worked with Cottage Hospital to implement a modified Delphi process as described above. Detailed descriptions of the top prioritized needs are shown later in the report. The full list of 34 needs is included in Appendix B of this report.	The goal of the modified Delphi process was to prioritize the community health needs and to build consensus among the Leadership Group.

Key Demographic & Economic Indicators

Population, age, and disability status tend to drive the need for healthcare services while income, education, and poverty level highly correlate to them as well. The following analysis of demographic factors such as these highlights the growing need for healthcare services in the area, as well as identifies structural causes of health care service usage.

> *"I've lived in this area all my life except when I traveled to go to school. When I came back [after college], it was like nothing really changed. Since then, a lot has changed, but more has probably stayed the same. People are people. Those that live around here either stay here forever, or they go away to school or something and never return. 'Who lives here' [i.e., the demographics] is going to tell us what we need to do."*
> *– Leadership group member during the second Leadership meeting*

As identified in the most recent 2010 U.S. Census, PSA residents tend to have several characteristics that heighten the urgency of developing a clear, proactive approach to meeting the health needs in their service area. Relative to the current status and compared to state of New Hampshire averages, service area residents have the following characteristics:

- Older median age
- Rapidly aging population
- Lower median household income
- Lower degree of educational attainment
- Higher disability rates

The tables and discussion below present key data reflecting these summary points and some of the impact on community needs and the prioritization of issues.

Population

The Cottage Hospital PSA currently has about 20,000 residents – a slight increase since 2000. Growth is projected to be slow over the next 20 years. However, since the need for healthcare services is more highly linked to age than nominal population levels, demand for services will tend to increase as the population increases.

Population	
Year	**Data**
2000	18,527
2010	19,536
2020	20,821
2030	21,633

Source: U.S. Census Department, American FactFinder, 2010; NH Office of Energy and Planning, 2007 Population Estimates by County, by Town; VT Center for Rural Studies, 2007 Population Estimates by County, by Town.

- The population is projected to grow by approximately 100 people per year, 2000 through 2030.

Service area population growth is concentrated in Haverhill, Bath, and Lisbon – which comprise over two-third (68%) of the expected population increase.

Population Growth Forecast By Service Area Town				
Town	**2010**	**2020**	**2030**	**Growth 2010 to 2030**
Bath	830	1,040	1,110	34%
Benton	371	360	380	2%
Haverhill	4,685	5,170	5,510	18%
Lisbon	1,621	1,850	1,950	20%
Monroe	1,004	890	950	-5%
Piermont	864	810	870	1%
Barnet	1,828	1,779	1,802	-1%
Bradford	2,785	2,907	2,950	6%
Corinth	1,098	1,377	1,363	24%
Groton	918	1,098	1,142	24%
Newbury	2,277	2,342	2,408	6%
Ryegate	1,255	1,198	1,198	-5%
TOTAL	19,536	20,821	21,633	11%

Source: U.S. Census Department, American FactFinder, 2010; NH Office of Energy and Planning, 2007 Population Estimates by County, by Town; VT Center for Rural Studies, 2007 Population Estimates by County, by Town.

- The growth rate is not expected to be consistent across service area towns.
- Higher population growth is concentrated northward from the Cottage Hospital area along the New Hampshire side of the Connecticut River.
- Four service area towns are expected to have a population decrease or flat growth, 2010 – 2030 – Benton, Monroe, Piermont, and Barnet.

Age

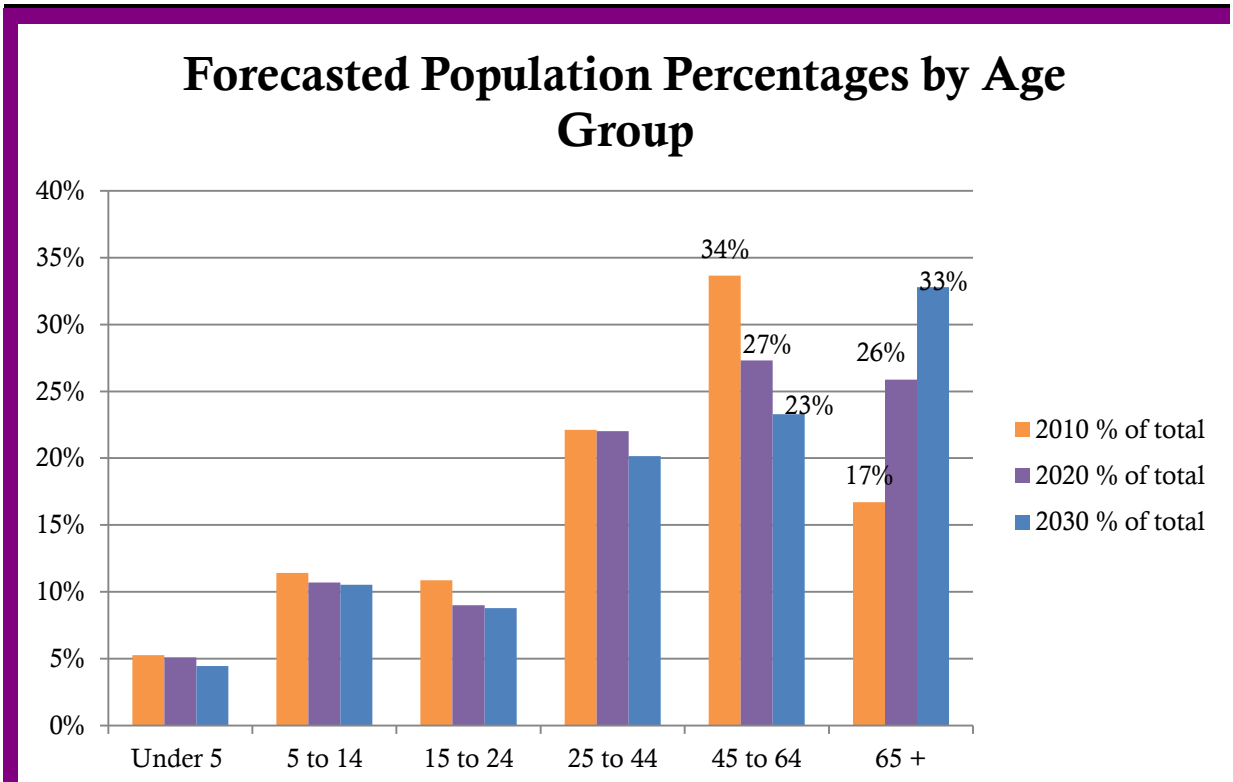
Median age is a leading factor driving the need, and the expected need, for healthcare services and impacting the prioritization of community health needs. The median service area age is four years older than the New Hampshire median and eight years older than the U.S. median.

- When examining town-level data, Benton, NH, Barnet, VT, and Newbury, VT are the towns with the oldest median age.
- Haverhill and Bath (two of the faster growing service area towns) currently have median ages at or above the PSA median indicating that the effect of an aging population may be heightened in these areas.

Sources: American FactFinder, 2011; U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates

Median Age	
Town	**Median Age**
Bath	46.5
Benton	52.8
Haverhill	45.0
Lisbon	39.9
Monroe	49.5
Piermont	46.8
Barnet	53.3
Bradford	34.3
Corinth	44.7
Groton	35.1
Newbury	51.1
Ryegate	44.3
Wells River	41.1
Total	45.1
New Hampshire	41.1
U.S.	37.2

The number of people age 65 or older is expected to double between 2010 and 2030. The population shift will increasingly stress existing healthcare systems – especially those providing chronic care, behavioral health care, and senior-related services.



Service Area Population Shifts – Projected by Age Group

Age Group	2010	2010 % of total	2020 % of total	2030 % of total
Under 5	1,027	5%	5%	4%
5 to 14	2,232	11%	11%	11%
15 to 24	2,122	11%	9%	9%
25 to 44	4,320	22%	22%	20%
45 to 64	6,573	34%	27%	23%
65 +	3,262	17%	26%	33%
Total	19,536	100%	100%	100%

- As shown above, one-third of the population is expected to be age 65 or older in 2030 – doubling between 2010 (17%) and 2030 (33%)
- Although the percentage of people in the 45 to 64 age group will decrease from 34% to 23%, there is still expected to be a net increase in the demand for healthcare services due to the increase in the number of older, higher-use residents.

Income

One of the biggest challenges facing the region is economic stress – the median income is only about two-thirds that of the state of New Hampshire median.

Median Household Income	
Town	**Median Household Income**
Bath	$47,353
Benton	$44,167
Haverhill	$43,806
Lisbon	$43,750
Monroe	$53,750
Piermont	$79,063
Barnet	$72,679
Bradford	$40,000
Corinth	$49,375
Groton	$33,125
Newbury	$52,778
Ryegate	$55,893
Wells River	$33,409
PSA Total	$42,703
New Hampshire	$64,890
U.S.	$52,947

"If you don't have money, you can get free healthcare – even though a lot of people don't realize it. If you have a lot of money, healthcare isn't a problem either. For the great number in the middle, they don't qualify for free care and can't afford it themselves. There is a need to educate the poor about the resources available and figure out some way to serve middle incomers." – Leadership group member at the first Leadership meeting

Sources: American FactFinder, 2011; U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates

- The Primary Service Area's (PSA) median household income is $42,703, that is, more than $20,000 lower than the New Hampshire median.
- There is a great deal of variation between incomes by town – ranging from $33,409 in Wells River to over $79,000 in Piermont.
- Lower population growth towns such as Piermont and Barnet have the highest household income while higher growth ones (e.g., Haverhill, Bath, Lisbon) tend to have household income near the PSA total.

Of the 5,231 families in the service area, over half of them have household incomes less than 400% of the Federal Poverty Level (FPL). Although poverty is associated with healthcare service use, there are tax credits under the Affordable Care Act available to consumers with incomes up to 400% of the federal poverty line ($45,960 for an individual and $94,200 for a family of four).

Families Living in Poverty		
Town	200% FPL	400% FPL
Bath	77	151
Benton	21	57
Haverhill	287	823
Lisbon	116	276
Monroe	38	157
Piermont	13	87
Barnet	123	265
Groton	76	178
Ryegate	63	190
Bradford	148	422
Corinth	85	187
Newbury	141	369
Total	1,188	3,162
Percent of all families	23%	60%

Source: U.S. Census Department, American FactFinder, 2010

- There are nearly 1,200 families in the Primary Service Area; about one in four (23%) of whom with household income below 200% of the Federal Poverty Level.
- Three in five (60%) live at or below 400% of the Federal Poverty Level and, therefore, qualify for tax credits to offset healthcare insurance premiums and improve access to care.

"Living in poverty tends to just be a vicious cycle – no or little education, children who struggle, a lack of aspirations, and so on. Give someone some aspirations and they just might break out of the cycle."
– Community leader interview

Education

Cottage Hospital PSA residents are less likely to have a college education than New Hampshire as a whole. Education tends to be highly correlated with median incomes, employment, and healthcare utilization.

Cottage Hospital Service Area Education Compared to New Hampshire Total		
Population 25 years and over	**Primary Service Area**	**NH**
Less than 9th grade	4%	3%
9th to 12th grade, no diploma	7%	6%
High school graduate (includes equivalency)	40%	30%
Some college, no degree	17%	19%
Associate's degree	10%	10%
Bachelor's degree	13%	21%
Graduate or professional degree	10%	12%
Percent high school graduate or higher	89%	91%
Percent bachelor's degree or higher	23%	33%

Source: U.S. Census Department, American FactFinder, 2010

- Although roughly equal percentages of people have secondary education in New Hampshire compared to the PSA, an additional ten percent of the population of New Hampshire have earned a college degree (33% in New Hampshire; 23% for PSA residents).
- Approximately one in ten residents has not attained a high school diploma or its equivalency.
- Appendix C contains a more detailed table showing educational status by town.

> *"Without a good education, it is tough to make it. That doesn't mean that every kid needs to go to college, but some type of education or training after high school sure makes a big difference. Also, those who don't get educated will likely have a harder time getting a good job. Without income from a good job there's a better chance that they won't be able to access medical care if they ever need it."*
> *– Community leader interview*

Disability Status

Disability rates have a direct correlation to healthcare service use. Nearly one in four PSA residents has a known disability– much higher than the New Hampshire state average.

Disability Status in the Service Area and New Hampshire		
Measure	**New Hampshire**	**Cottage Hospital Service Area**
Population 5 years and over	1,145,557	17,107
Total with a disability	193,893	3,849
Percent with a disability	16.9%	22.5%
Sensory	3.4%	5.2%
Physical	7.2%	9.8%
Mental	4.6%	5.7%
Self-care	2.0%	3.2%

Source: U.S. Census Department, American FactFinder, 2010.

- Nearly 4,000 people (22.5%) in the PSA have a disability.
- Physical disabilities are particularly prominent in the Cottage Hospital PSA, as nearly one in ten people (9.8%) are afflicted with some type of physical disability.
- More than one in 20 (5.7%, or, about 900 people) have a diagnosed mental disability.
- A complete list of the number and type of disabled people by town is shown in Appendix D.

Demographics Summary

As shown above, the Cottage Hospital PSA is characterized by an older, quickly aging population with below state average financial means and educational background. The high number of disabled people, along with growing numbers of seniors, highlights the benefit of making a prioritized list of health needs to address community issues. There is a strong sense of community engagement and a core of people eager to work together to capitalize on community strengths. Many individuals included in the research indicate that leadership from an organization such as Cottage Hospital could help overcome some of the structural challenges presented by the changing demographics and benefit the community.

> *"I love this area! People are great. We have our problems – like everywhere – but this is an area where a lot of people come to get away from the [too] busy city life and enjoy a high quality of life. By getting the right people in the room and working together, we can make a big difference.*
> *– Community leader interview*

The following section presents the results of Delphi prioritization conducted with Leadership Group members.

Leadership Group Presentation Details

Two focus groups were held with the Leadership Group. During the first session, held at the outset of the project, Leadership Group members provided feedback on the project methodology and the strategic purpose of the community assessment, offered their insights regarding effective ways to gather pertinent information (quantitative and qualitative), and helped generate an initial list of community needs, available resources, and potential service gaps.

Among the comments made by Leadership Group members, several highlighted the need to improve access to care and improve communications between area organizations. Some of the paraphrased comments are listed below.

> *"A lot of what we [public safety officials] deal with is linked directly or indirectly to mental illness. … Also, when we bring someone to the hospital, we need to have a deputy stay with them until they are admitted or get treated. This is expensive – there just don't seem to be enough counselors or psychologists to manage the load. Believe me, there are a whole lot more people that we see that could use some mental health care that we don't bring in."*

> *"[I heard that] by 2020, 90% of all dentists in New Hampshire will be over 65 years old. You think it's hard getting an appointment now? It might get worse."*

> *"I don't think that demographics work in our favor. It's hard keeping young people in town after they graduate high school, and few return here if they go to college. It seems like all we'll have left is the older people. That might be good for the hospital [because they are more likely to need care], but it really going to strain the system, too."*

> *"It seems like the number of doctors or psychologists or dentists is only part of the problem. I know some doctors that have plenty of room on their schedule. The other part of the problem is that people don't know what services exist or, sometimes, don't how to find the money to take advantage of what's out there. Maybe we need to do a better job getting the word out."*

The second Leadership Group meeting included a review of community health data and the findings of the community survey. The moderator's guide included in the meeting is attached in a separate appendix (see Appendix E). Throughout the project, information was exchanged as needed via e-mail or telephone conversations with Leadership Group members and others. Some of the Leadership Group members' comments are paraphrased below:

"One of the best things we or anyone could do is find a way to incentivize people. People need to take responsibility for their own health and for getting help when they need it. There are plenty of programs that are underutilized. We have our part [i.e., offering programs and communicating to the community], but they [they community members] need to do their part, too. If we all do our part, we'll be well."

"[In response to the healthcare data that shows that for the eight most often identified causes of death in the PSA, Grafton County is substantially higher than the State of New Hampshire average on seven] That is amazing. I had no idea that that was the case. We obviously need some additional work on the major causes of death in the area."

"I have heard that comment [about dental needs in the area] before. I think that it is especially true in Vermont where I live. I don't have any problem, but I have heard that some people do."

"I see that the results [of the community survey] show that a lot of people don't see affordable health care as a leading priority. I'm not sure about that. I think that better affordability or educating people about what [financial] help is available would improve access and a lot of associated aspects, too."

Community Survey

Cottage Hospital and Crescendo conducted an online community survey in August and September in order to collect direct consumer opinion regarding community needs. The survey was administered to self-selected individuals who chose to take the survey in the Cottage Hospital waiting room or online. Respondent profiles include the following:

- Three of four respondents (73%) are women.
- Half of men and half of women say that they have a chronic condition that requires regular care from a clinician.
- The median income of respondents is about $48,000

Community Survey Income Profile	
Household Income Range	**Percent of Respondents**
Less than $20,000	20%
$20,000 to $34,999	13%
$35,000 to $49,999	20%
$50,000 to $64,999	27%
$65,000 to $79,999	13%
$80,000 to $94,999	7%

- A relatively high percentage have earned a college degree

Community Survey Education Profile	
Less than high school	0%
Graduated high school	19%
Some college or vocational training	19%
Graduated vocational/technical college	13%
Graduated college (4-year Bachelor Degree)	38%
Completed Graduate or Professional school (Masters, PhD, Lawyer)	13%

Community members were asked to prioritize a list of 24 community needs. The summary of their responses is shown below

Community Survey Results	
Community Health Need	**Community Rating**
Affordable dental care	1
Substance abuse education and treatment	2
Exercise and nutrition programs for adults	3
Dental services for adults	4
Mental health care and counseling	5
Obesity education and care	6
Dental services for children	7
Exercise and nutrition programs for children	8
Affordable medical care	9
Services that provide transportation to healthcare appointments and the pharmacy	10
Senior health services	11
Affordable prescription drugs	12
Doctors providing routine medical care (family doctor, pediatrician, primary care)	13
Youth oriented programs (e.g., health services, wellness, career counseling)	14
Hospice or end-of-life care	15
Smoking or tobacco prevention and education	16
Hospital beds for mental health care	17
Support groups for people (and families) suffering from for depression or anxiety	18
Diabetes care and education	19
Doctors providing specialized care for cancer, diabetes, asthma, and other conds.	20
Pain management	21
Home health services such as Visiting Nurses or other in-home care	22
Hospital beds for medical care	23
Preventive health services, such as flu shots, mammograms, and other screenings	24

- In the table above, the data indicates that dental issues, behavioral health (including substance abuse), and lifestyle issues (such as obesity, exercise, and nutrition) are leading community priorities.
- Survey respondents indicate that the availability of primary care physicians and affordable care are of a slightly lower priority than as indicated by the Leadership Group (see next section).

Health Issues Evaluated in the Modified Delphi Method

Leadership group discussion, healthcare consumer surveys, interviews with area physicians and other community stakeholders, and secondary research identified 34 community health needs. Leadership Group members rated each of the needs on a 5-point scale (with 1 = the greatest need) during the prioritization process described above in order to develop a ranked list. The results of the evaluation are contained in the table below.

Health Issues Evaluated in the Modified Delphi Method
Community Need
Access to primary care providers
Affordability of medical and behavioral health care
Drug and alcohol abuse; Drug and alcohol education and early intervention
Cancer screening and other preventive care / education
Chronic disease treatment and co-morbid conditions such as mental health and other disease management initiatives
Exercise and nutrition programs for adults and children
Heart disease care
Obesity / Nutrition / Exercise education and services
Preventive health services (e.g., flu shots, mammograms, and other screenings)
Dental services / availability of providers
Diabetes care and education
Support groups for people (and families) suffering from for depression, anxiety, or other mental health issues
Coordination of care between provider organizations
Transportation for all services, especially outlying areas

Health Issues Evaluated in the Modified Delphi Method

Community Need
Wellness initiatives and the individual's ability to maintain a healthy lifestyle
Adult and senior wellness programs
Care Coordination roles / case management
Home health services
Parenting classes
Youth oriented programs (e.g., health services, wellness, career counseling)
Cancer treatment
Cerebrovascular disease (stroke) treatment
Senior health services
End of life issues (including palliative care)
Medical specialty services - Access to surgery, OB/GYN, etc.
Financial counseling / case management
Prescription drug affordability
Environmental issues - air quality, lead exposure / poisoning, waterborne contaminates
Influenza / pneumonia care
Chronic pain management and treatment
Smoking prevention, education, and cessation services
Alzheimer's disease diagnosis and care
Pain management services
Chronic lower respiratory disease care

Delphi process results are combined with the secondary data analyses and executive interviews to develop a prioritized list of community health needs.

List of Prioritized Needs

Based on input from the Leadership Group meetings; analysis of local, State of New Hampshire, and federal quantitative data; community input; and, the needs evaluation process, the prioritized list of community needs is shown in the table below.

Prioritized Community Needs	
Rank	**Health Need**
1 tie	Access to primary care providers (including the availability of providers, affordability of care, and transportation)
1 tie	Access to behavioral health service providers (including the availability of providers and affordability of care)
3	Drug and alcohol abuse; Drug and alcohol education and early intervention
4	Screening for heart disease, cancer, and other chronic illnesses
5	Chronic disease treatment and co-morbid conditions such as mental health and other disease management initiatives
6	Dental services / availability of providers
7	Obesity / exercise / nutrition programs for adults and children
8	Preventive health services (e.g., flu shots, mammograms, and other screenings)

For the comprehensive list of community needs, see Appendix B.

Below is a brief summary of each of the leading community needs, as established by consensus among key stakeholders and community representatives.

- Access to primary care providers. Healthcare consumers and community stakeholders agree that "access" included the following sub-issues
    - The number of available primary care physicians
    - Wait time required for an appointment
    - Financial resources (or, knowledge of available support) required for care

  One respondent also notes that perceived PCP access issues may drive growing numbers of people using the emergency department for inappropriate (i.e., non-emergency) needs.

  Regarding affordability, Cottage Hospital provided over $1.9 million in charity care and nearly $3.4 million of total unreimbursed community benefits in the most recent fiscal year. However, the cost of healthcare continues to be a tremendous burden on consumers. Increasing costs are cited by the Leadership Group and healthcare consumers as a reason for delayed healthcare treatment. Group members are split as to what impact the Affordable Care Act (ACA) is having in addressing this issue. However, demographic data shows that approximately 60% of residents qualify for tax credits under the ACA.
- Access to behavioral health service providers (including the availability of providers and affordability of care). Behavioral health in the community is seen as a driving force and co-morbid condition highly prevalent in the area. Leaders indicate that effective programs targeted toward behavioral health issues may also have a positive downstream impact on public safety and medical issues.
- Drug and alcohol abuse; Drug and alcohol education and early intervention. Substance abuse education and issues were consistently characterized by Leadership Group members, healthcare consumers, community stakeholders, and others as a driving force behind many "downstream" health, behavioral health, and community needs. According to Behavioral Risk Factor Surveillance Survey (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS) data, 39% of New Hampshire high school students had at least one drink of alcohol on at least one day (during the 30 days before the survey); and, nearly one in four (23%) have had five or more drinks of alcohol within a couple of hours on at least one day (during the 30 days before the survey). One-fourth had used marijuana one or more times during the same time period. "Downstream" effects as noted by research participants include higher incidence of respiratory and several other chronic diseases, organ damage, domestic abuse, loss of employment, and other societal impacts. See Appendix F for BRFSS details.
- Screening for heart disease, cancer, and other preventive care / education. Cancer and heart disease are the leading causes of death in Cottage Hospital PSA.
    - Specifically, for the eight most often identified causes of death in the PSA, Grafton County is substantially higher than the State of New Hampshire average on seven.
    - Grafton County data suggest that major disease and chronic illness screening and treatment are in greater need than in many other parts of the state. See below.

Most Common Causes of Death and the Impact on Life Years				
	Overall Leading Causes of Death per 100,000		**Years of Potential Life Lost Per 100,000**	
Condition	**Grafton County**	**NH**	**Grafton County**	**NH**
Cancer	**203.7**	185.4	**1,521**	1,420
Heart disease	**198.0**	174.4	**729**	686
Chronic lower respiratory diseases	52.0	50.5	151	168
Accidents	**50.9**	34.4	**940**	744
Alzheimer's disease	**44.1**	28.6	*	*
Cerebrovascular disease	**38.5**	34.7	*	79
Diabetes	**24.9**	21.7	*	140
Influenza / pneumonia	**21.5**	15.0	*	*

Years of potential life lost for a cause of death group are the sum of each resident's age at the time of death subtracted from 75

- Chronic disease treatment and co-morbid conditions such as mental health and other disease management initiatives. The ability to provide more integrated care – acute medical care and behavioral health care – is seen as an issue for the overall healthcare system that reduces the quality of care, increases the number of patients non-compliant with healthcare regimens, reduces patient satisfaction, wastes system costs, and suboptimizes physicians' ability to provide effective patient care.
- Dental services / availability of providers. Dental issues are identified by community members representing all age groups – children, adults, and senior – as significant needs in the region. One participating stakeholder said that by 2020, 90% of the New Hampshire dentists will be over 65 years of age. Although this data point could not be corroborated, it is consistent with other resources that show a critical lack of dentists in the area – especially those will to see Medicaid, or reduced pay, patients.

- Obesity / Nutrition / Exercise education and services. A major focus of Cottage Hospital's strategic plan, as noted in the recent Annual Report, identifies "Triple Aim" initiatives as a key to the future well-being of the community. Triple Aim is defined by the Institute for Healthcare Improvement (IHI) as "… focusing on three critical objectives simultaneously can potentially lead us to better models for providing healthcare [to:]

  1. "Improve the health of the defined population
  2. "Enhance the patient care experience (including quality, access and reliability)
  3. "Reduce, or at least control, the per capita cost of care"

  Implicit in Triple Aim strategies is the ability to influence population health issues before they turn into healthcare needs. For example, programs designed to promote healthy weight, balanced nutrition, and healthy lifestyles (in addition preventive care) may be considered Triple Aim programs when embedded with system changes. Stakeholders, healthcare consumers, and others identified obesity, nutrition, and exercise as (1) issues that if poorly addressed lead to health needs, and, (2) are an integral part of any plans proposing to improve community health and address current needs.

  IHI suggests that components of a system to accomplish Triple Aim goals include the following:

  1. Focusing health-promotion programs on individuals and families – not just an individual with a healthcare need
  2. Redesign of primary care services and structures
  3. Population health management
  4. A cost-control platform – various "shared savings" models are available for review. In shared savings models, when redesigned care models lead to lower healthcare costs (i.e., insurance claims), insurance companies or other payers share a portion of the savings with providers.
  5. System integration and execution

  Cottage Hospital's efforts to implement Triple Aim-based initiatives are designed to structurally alter healthcare and wellness in the area. The identified community health needs – obesity, nutrition, exercise – reinforce Cottage Hospital's strategy to pursue such initiatives.

- Preventive health services (e.g., flu shots, mammograms, and other screenings). Stakeholders and other research participants often referred to preventive health services in the same manner as obesity, nutrition, and exercise initiatives – perceiving the value of preventive, Triple Aim-style approaches that could benefit community health. They also frequently identified that preventive care screenings were somewhat lacking or that it would be helpful to increase the awareness of them among higher-risk populations in the community.

Appendix A: Community Health Needs Assessment Survey, 2013

We are conducting a community health care needs assessment. We would like to get your opinions about a few important topics so that we can better understand community needs. Below is a list healthcare services or things that impact the ability of people to access services.

How great is the need for more of each of the following?

Community Health Need	We Have Enough - No More Needed	SOME More Needed	MUCH More Needed
Doctors that provide routine medical care (family doctor, pediatrician, primary care)			
Doctors that provide specialized care for cancer, diabetes, asthma, and other conditions			
Diabetes care and education			
Drug and alcohol abuse treatment			
Drug and alcohol education and early intervention			
Counseling or intervention services to deal with home violence			
Home health services such as Visiting Nurses or other in-home care			
Hospice or end-of-life care			
Affordable Dental services for children			
Affordable Dental services for up for adults			
Inpatient hospital care for people with mental health issues			
Inpatient hospital care for people with medical issues			
Obesity education and care			
Affordable medical care			
Mental health care or counseling			
Support groups for people suffering from for depression or anxiety			
Pain management			
Parenting classes			
Preventive health services, such as flu shots, mammograms, and other screenings			
Affordable prescription drugs			
Services that provide transportation to medical appointments and the pharmacy			
Senior health services			
Exercise and nutrition programs for children			
Other youth-oriented programs (e.g., health services, wellness, mentoring, lifestyle and goal setting, career counseling)			
Exercise and nutrition programs for adults			
Exercise and nutrition programs for seniors			
Smoking or tobacco prevention and education			

About You!

So that we can better understand the community needs, please answer a few questions about yourself.

1. What is your gender?

	Check one
Male	
Female	

2. What year you were born? ☐

3. What is your home zip code? ☐

4. What is the highest grade or year in school you completed?

	Check one
Less than high school	
Graduated high school	
Some college or vocational training	
Graduated vocational/technical college	
Graduated college (4-year Bachelor Degree)	
Completed Graduate or Professional school (Masters, PhD, Lawyer)	

5. What was your total annual household income last year?

	Check one
Less than $20,000	
$20,000 to $34,999	
$35,000 to $49,999	
$50,000 to $64,999	
$65,000 to $79,999	
$80,000 to $94,999	
Over $95,000	

6. In general, how would you describe your health?

	Check one
Excellent	
Very Good	
Good	
Fair	
Poor	

7. Have you ever been diagnosed or told by a healthcare professional that you have a health condition that requires ongoing care (e.g., diabetes, asthma, heart disease, high cholesterol, etc.)?

	Check one
Yes	
No	

Appendix B: List of Identified Community Needs

Community Needs Identified From Primary and Secondary Research
Community Needs
Access to primary care providers
Adult and senior wellness programs
Affordability of medical and behavioral health care
Alzheimer's disease diagnosis and care
Cancer screening and other preventive care / education
Cancer treatment
Care Coordination roles / case management
Cerebrovascular disease (stroke) treatment
Chronic disease treatment and co-morbid
Chronic lower respiratory disease care
Chronic pain management and treatment
Coordination of care between provider organizations
Dental services / availability of providers
Diabetes care and education
Drug and alcohol abuse; Drug and alcohol education and early intervention
End of life issues (including palliative care)
Environmental issues air
Exercise and nutrition programs for adults and children
Financial counseling / case management
Heart disease care
Home health services
Influenza / pneumonia care
Medical specialty services Access
Obesity / Nutrition / Exercise education and services
Pain management services
Parenting classes
Prescription drug affordability
Preventive health services (e.g., flu shots, mammograms, and other conditions)
Senior health services
Smoking prevention, education, and cessation services
Support groups for people (and families) suffering from for depression,
Transportation for all services, especially outlying areas
Wellness initiatives and the individual's ability to maintain a healthy lifestyle
Youth oriented programs (e.g., health services, wellness, career counseling)

Appendix C: Education and Poverty Status by Town

Educational Attainment by Service Area Town, 2010													
Subject	**NH**	**Barnet**	**Bath**	**Benton**	**Bradford**	**Corinth**	**Groton**	**Haverhill**	**Lisbon**	**Monroe**	**Newbury**	**Piermont**	**Ryegate**
Less than 9th grade	2.9%	3.8%	2.2%	3.4%	4.2%	3.7%	10.0%	2.5%	5.8%	2.9%	3.0%	2.5%	4.5%
9th to 12th grade, no dipl.	5.9%	3.4%	7.9%	12.0%	4.2%	5.6%	5.9%	7.1%	14.0%	4.9%	7.7%	3.3%	10.5%
High school graduate	29.5%	36.2%	44.4%	55.8%	37.7%	34.5%	36.4%	45.4%	39.0%	35.8%	35.0%	41.0%	41.8%
Some college, no degree	19.1%	11.5%	14.6%	9.7%	12.3%	18.4%	18.9%	18.6%	19.8%	24.4%	18.1%	19.4%	13.6%
Associate's degree	9.5%	11.1%	7.9%	7.1%	12.2%	6.2%	13.9%	9.3%	7.6%	9.0%	10.1%	8.4%	7.9%
Bachelor's degree	21.0%	17.0%	14.8%	7.9%	15.8%	19.5%	6.9%	10.4%	9.9%	13.4%	16.2%	14.8%	13.2%
Graduate or professional deg	12.1%	17.0%	8.1%	4.1%	13.6%	12.1%	8.0%	6.6%	3.9%	9.7%	9.9%	10.7%	8.6%
Percent high school graduate or higher	91.2%	92.8%	89.9%	84.6%	91.6%	90.7%	84.1%	90.4%	80.2%	92.3%	89.4%	94.2%	85.1%
Percent bachelor's degree or higher	33.1%	34.0%	22.9%	12.0%	29.4%	31.6%	14.9%	17.0%	13.8%	23.1%	26.1%	25.4%	21.7%

Source: U.S. Census Bureau, 2007-2011 American Community Survey.

Number of Families in Poverty

Percent of Federal Poverty Level	Bath	Benton	Haverhill	Lisbon	Monroe	Piermont	Barnet	Groton	Ryegate	Bradford	Corinth	Newbury	PSA Total
Total:	228	82	1,285	435	264	248	492	246	338	673	317	623	5,231
Under .50	12	5	69	10	17	4	13	4	-	11	21	3	169
.50 to .74	7	-	16	22	-	-	4	2	-	33	12	4	100
.75 to .99	4	-	59	9	6	2	20	-	19	29	9	24	181
1.00 to 1.24	-	-	11	31	-	-	18	3	7	24	11	41	146
1.25 to 1.49	19	12	65	18	4	7	11	23	11	16	-	25	211
1.50 to 1.74	27	3	29	24	-	-	26	19	15	8	23	16	190
1.75 to 1.84	3	1	27	-	6	-	24	19	8	9	3	11	111
1.85 to 1.99	5	-	11	2	5	-	7	6	3	18	6	17	80
2.00 to 2.99	36	20	277	53	51	47	83	52	72	146	51	113	1,001
3.00 to 3.99	38	16	259	107	68	27	59	50	55	128	51	115	973
4.00 to 4.99	33	10	226	49	33	41	67	29	62	40	43	72	705
5.00 and over	44	15	236	110	74	120	160	39	86	211	87	182	1,364

Source: U.S. Census Bureau, 2007-2011 American Community Survey

Appendix D: Disability Status by Town and Type of Disability

Disability Status of the Civilian Noninstitutional Population							
Measure	NH	Cottage Hospital Service Area	Bath	Benton	Haverhill	Lisbon	Monroe
Population 5 years and over	1,145,557	17,107	845	213	4,032	1,471	746
Total with a disability	193,893	3,849	152	51	1,002	338	127
Percent with a disability	16.9%	22.5%	18	23.9	24.9	23	17
Sensory	3.4%	5.2%	39	10	282	84	44
Physical	7.2%	9.8%	82	23	443	146	58
Mental	4.6%	5.7%	37	11	308	77	42
Self-care	2.0%	3.2%	34	2	168	41	7
Population 5 to 15 years	199,403	3,017	137	32	658	283	124
With a disability	13,558	228	12	0	56	19	7
Percent with a disability	7	7.6%	8.8	0	8.5	6.7	5.6
Sensory	1,724	1.8%	5	0	22	5	0
Physical	1,687	0.8%	7	0	5	0	0
Mental	11,694	6.0%	8	0	34	16	7
Self-care	1,612	0.8%	6	0	5	0	0
Population 16 to 64 years	807,076	11,366	580	158	2629	1004	476
With a disability	126,725	2,499	95	38	580	233	60
Percent with a disability	16	22.0%	16.4	24.1	22.1	23.2	12.6
Sensory	17,276	3.1%	12	5	77	41	17
Physical	44,987	7.6%	39	11	196	86	21
Mental	29,913	4.5%	15	11	158	45	24
Self-care	10,681	2.5%	18	2	70	30	3
Going outside the home	29,933	5.5%	26	11	148	47	12
Employment disability	81,115	15.2%	73	26	425	146	33
Population 65 years and over	139,078	2,724	128	23	745	184	146
With a disability	53,610	1,122	45	13	366	86	60
Percent with a disability	39	41.2%	35.2	56.5	49.1	46.7	41.1
Sensory	20,204	17.9%	22	5	183	38	27
Physical	35,749	28.5%	36	12	242	60	37
Mental	11,629	10.5%	14	0	116	16	11
Self-care	10,108	9.1%	10	0	93	11	4
Going outside the home	22,603	16.9%	12	2	152	34	31

Source: U.S. Census Bureau, 2007-2011 American Community Survey

Disability Status of the Civilian Noninstitutional Population

Measure	Piermont	Barnet	Groton	Ryegate	Bradford	Corinth	Newbury
Population 5 years and over	663	1,582	813	1,101	2,399	1,383	1,859
Total with a disability	139	224	140	163	653	444	416
Percent with a disability	21	14.2	17.2	14.8	27.2	32.1	22.4
Sensory	51	59	33	36	108	65	82
Physical	52	122	71	120	260	115	177
Mental	37	62	26	54	173	61	90
Self-care	20	42	24	44	60	37	71
Population 5 to 15 years	118	283	156	205	439	277	305
With a disability	17	24	10	15	32	6	30
Percent with a disability	14.4	8.5	6.4	7.3	7.3	2.2	9.8
Sensory	6	4	0	5	0	2	6
Physical	2	2	3	0	0	0	4
Mental	9	22	7	10	32	6	30
Self-care	2	0	0	0	2	0	8
Population 16 to 64 years	458	1057	525	724	1616	925	1214
With a disability	84	119	78	95	487	358	272
Percent with a disability	18.3	11.3	14.9	13.1	30.1	38.7	22.4
Sensory	19	24	10	19	56	39	32
Physical	30	58	27	78	151	66	106
Mental	16	21	13	28	115	28	38
Self-care	8	18	15	22	34	15	44
Going outside the home	12	36	4	21	79	169	58
Employment disability	61	59	49	52	331	263	214
Population 65 years and over	87	242	132	172	344	181	340
With a disability	38	81	52	53	134	80	114
Percent with a disability	43.7	33.5	39.4	30.8	39	44.2	33.5
Sensory	26	31	23	12	52	24	44
Physical	20	62	41	42	109	49	67
Mental	12	19	6	16	26	27	22
Self-care	10	24	9	22	24	22	19
Going outside the home	22	41	17	37	27	44	41

Source: U.S. Census Bureau, 2007-2011 American Community Survey

Appendix E: Leadership Group / Focus Group Moderator's Guide

Cottage Hospital
Community Assessment

Focus Group Discussion Guide

Focus Group Discussion Guide

Introduction

- *Welcome participants and introduce yourself.* Good evening. I'm _____ . Thank you for taking the time to join us for this important discussion.
- *Explain the general purpose of the discussion.* As you were told in the recruiting process, the purpose of the discussion is to learn more about community health-related needs and currently available resources, and to collect your insights regarding service gaps, and ways to better meet needs.
- *Explain the necessity for note-taking, audiotaping, and confidentiality.* The session is being audiotaped for future reference. I will be taking notes for a summary of the session which will indicate the themes that emerged. However, specific comments and experiences will not be attributed to any one individual in the summary report. Please consider what you hear here to be confidential.
- *Describe logistics.* The restrooms are located _____. There will be a break approximately half way through the discussion. Your total time here should not last more than two hours.
- *Seek participants' honest thoughts and opinions.* Frank opinions are the key to this process. There is no right or wrong answers to questions I'm going to ask. I'd like to hear from each of you and learn more about your opinions, both positive and negative.
- *Describe protocol for those who have not been to a group before.* We would like the discussion to be informal, so there's no need to wait for us to call on you to respond. In fact, I'd encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. We are here to ask questions, listen, and make sure everyone[*] has a chance to share.
- *Questions?* Do you have any questions for me before we start?

CURRENT INVOLVEMENT AND EXPERIENCE IN THE COMMUNITY

1. To start, let's take a minute to introduce ourselves around the table. Please tell us your name, the organization where you work, your job title, and a little about what your does in the community.
    - PROBES: What was your role in the community activities listed?
    - What was the outcome of your efforts?
2. You all encompass a wide variety of community services. Let's think about the framework for a minute and define "community health." What does the phrase mean in terms of objectives and services – "how wide do we cast the net"? [DEVELOP WHITE BOARD LISTS]
    - PROBES: Types of issues (disease management, behavioral health, social services, etc.), target groups, or individuals?
3. I'd like to quickly go around the room. In **your particular area of service or knowledge**, what are the biggest community health issues that YOUR ORGANIZATION addresses?

[*] Please note: We will not address every issue with every person or even every group, but we will cover the subject areas as they arise. Also, specific topics may be emphasized for specific user insight.

CURRENT NEEDS

4. Next, I'd like to talk about the most **critical community health** needs and their impact – particularly as they relate to activities where Cottage Hospital may be able to contribute. Based on what you've said so far, you've mentioned three broad categories of needs: disease management / general healthcare, behavioral health, and social services. [I WILL MODIFY THIS LIST BASED ON ACTUAL RESPONSES.] Let's take them one at a time.
    - Disease management and general healthcare (e.g., diabetes, cancer, cardio-vascular disease, hypertension, infectious disease, Alzheimer's, wellness initiatives, etc.)
        1. PROBE: What are the more important issues in the community?
        2. [FOR EACH] How well are they met? Who currently provides the services?
    - Behavioral health (e.g., responses to stress, domestic violence, risky behaviors, general clinical MH issues, etc.)
        1. PROBE: What are the more important issues in the community?
        2. [FOR ONES POTENTIALLY WITHIN Cottage Hospital's PURVIEW] How well are they met? Who currently provides the services?
    - Social services (e.g., D&A abuse, homelessness, youth-oriented programs, elder care, smoking cessation, etc.).
        1. PROBE: What are the more important issues in the community?
        2. [FOR ONES POTENTIALLY WITHIN Cottage Hospital's PURVIEW] How well are they met? Who currently provides the services?

GAPS

5. [IF NOT CLEAR FROM EARLIER DISCUSSIONS] Which of the issues that you mentioned affect the largest numbers of people?
6. Given the community health needs that we've discussed, describe the gap between the community need and the services available to meet the need. [WE WILL REVIEW MAJOR ONES AS NOTED IN PRIOR SECTION.]
    - Where should we be more vigilant?
7. Over the next three to five years, what community health needs do you expect to grow fastest?

ADDRESSING GAPS

Now I would like to speak a little about the ways to better meet community health needs, as well as the role of Cottage Hospital and your organization or the target populations you serve.

8. What are the critical challenges to better serving the target populations?
    - PROBE: Where are the overlaps across organizations?
9. ["SILOS" vs "COOPERATIVE EFFORTS" ISSUE] You've done a good job naming community health needs, available resources, and gaps. You also just mentioned that – generally speaking – efficient use of resources and clarity of focus, [AND OTHER THINGS AS LISTED] are important. To what degree do groups that you represent work cooperatively on projects?
10. Regarding the needs and gaps that we've discussed, where do you think Cottage Hospital could make an impact? Why? How?

11. If there was ONE project that Cottage Hospital would develop that impacted target populations with whom **YOU** provide services, what would be your first choice?
    - PROBE: Why? What do you think that Cottage Hospital could bring to the table?
    - Is this a short-term project or a long-term project?
12. Are there any other community health objectives that are unique to this area? If so, what are they and why are they unique?
13. Is there anything about the area that makes it easier or more difficult to meet community health needs compared to other places?
14. Can we assume that different population segments have different health needs?
        1. Children
        2. Young adults
        3. Middle aged adults
        4. Seniors
    - What do you think would be the greatest needs for each of the following population groups?
    - Why?
    - Is it a growing issue?
    - PROBE: How do you think that they can be reached?

Closing

15. Finally, if you could change one thing with COMMUNITY HEALTH in the area, what would it be?

Thank you very much again for your time and thoughtful responses to our questions.

Appendix F: BRFSS and YRBS Data

Comparison Between NH Students and U.S. Students 2009 YRBS

The Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. The national YRBS is conducted every two years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools throughout the United States. The New Hampshire YRBS is also conducted every two years and provides data representative of 9th through 12th grade students in public schools throughout New Hampshire.

New Hampshire, High School Youth Risk Behavior Survey, 2009

BRFSS and YRBS Data, 2009					
	Percent by Gender (95% confidence interval)		*Statistical Significance at 95% Confidence*		
Question	*Female*	*Male*	*Female More Likely Than Male*	*Male More Likely Than Female*	*No Difference*
Rarely or never wore a bicycle helmet (among students who had ridden a bicycle during the 12 months before the survey)	57.0 (50.1–63.8)	66.3 (60.6–71.6)		X	
Rarely or never wore a seat belt (when riding in a car driven by someone else)	11.4 (8.5–15.2)	14.0 (10.6–18.4)			X
Rode with a driver who had been drinking alcohol one or more times (in a car or other vehicle during the 30 days before the survey)	24.6 (20.2–29.6)	21.7 (18.8–24.9)			X
Drove when drinking alcohol one or more times (in a car or other vehicle during the 30 days before the survey)	7.8 (5.5–10.9)	9.0 (6.7–12.1)			X

BRFSS and YRBS Data, 2009					
	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
Question	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Carried a weapon on school property on at least 1 day (for example, a gun, knife, or club during the 30 days before the survey)	3.4 (2.1–5.3)	13.7 (10.7–17.4)		X	
Did not go to school because they felt unsafe at school or on their way to or from school on at least 1 day (during the 30 days before the survey)	4.8 (2.8–8.2)	4.2 (2.8–6.4)			X
Threatened or injured with a weapon on school property one or more times (for example, a gun, knife, or club during the 12 months before the survey)	—	—			
In a physical fight on school property one or more times (during the 12 months before the survey)	6.8 (4.8–9.5)	11.2 (8.6–14.4)		X	
Bullied on school property (during the 12 months before the survey)	24.4 (20.5–28.8)	19.9 (16.0–24.4)			X
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	32.1 (28.3–36.2)	18.4 (15.4–21.9)	X		
Seriously considered attempting suicide (during the 12 months before the survey)	13.8 (10.7–17.7)	10.2 (7.8–13.3)			X
Made a plan about how they would attempt suicide (during the 12 months before the survey)	11.9 (8.8–15.9)	7.7 (5.8–10.2)	X		
Attempted suicide one or more times (during the 12 months before the survey)	5.1 (3.1–8.3)	4.2 (2.7–6.6)			X
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	1.6 (0.7–3.6)	1.6 (0.9–2.8)			X
Carried a weapon on at least 1 day (for example, a gun, knife, or club during the 30 days before the survey)	—	—			
Carried a gun on at least 1 day (during the 30 days before the survey)	—	—			

BRFSS and YRBS Data, 2009

	Percent by Gender (95% confidence interval)		***Statistical Significance at 95% Confidence***		
Question	***Female***	***Male***	***Female More Likely Than Male***	***Male More Likely Than Female***	***No Difference***
In a physical fight one or more times (during the 12 months before the survey)	20.3 (16.0–25.5)	31.1 (27.2–35.2)		X	
Injured in a physical fight one or more times (injuries had to be treated by a doctor or nurse, during the 12 months before the survey)	3.6 (2.3–5.6)	4.3 (3.0–6.2)			X
Hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (during the 12 months before the survey)	8.0 (6.0–10.5)	11.1 (8.4–14.4)			X
Ever physically forced to have sexual intercourse (when they did not want to)	9.4 (7.1–12.3)	4.8 (3.4–6.7)	X		
Ever tried cigarette smoking (even one or two puffs)	—	—			
Smoked a whole cigarette for the first time before age 13 years	9.8 (7.5–12.7)	11.0 (8.9–13.6)			X
Smoked cigarettes on at least 1 day (during the 30 days before the survey)	20.0 (16.0–24.6)	21.6 (18.2–25.4)			X
Smoked cigarettes on 20 or more days (during the 30 days before the survey)	9.6 (6.9–13.3)	9.2 (6.9–12.2)			X
Smoked more than 10 cigarettes per day (among students who currently smoked cigarettes, on the days they smoked during the 30 days before the survey)	—	—			
Smoked cigarettes on school property on at least 1 day (during the 30 days before the survey)	—	—			
Ever smoked at least one cigarette every day for 30 days	—	—			
Did not try to quit smoking cigarettes (among students who currently smoked cigarettes, during the 12 months before the survey)	—	—			

BRFSS and YRBS Data, 2009					
	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
Question	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Usually obtained their own cigarettes by buying them in a store or gas station (among the students who were aged <18 years and who currently smoked cigarettes, during the 30 days before the survey)	—	—			
Used chewing tobacco, snuff, or dip on at least 1 day (during the 30 days before the survey)	2.6 (1.3–5.2)	13.8 (11.3–16.8)		X	
Used chewing tobacco, snuff, or dip on school property on at least 1 day (during the 30 days before the survey)	—	—			
Smoked cigars, cigarillos, or little cigars on at least 1 day (during the 30 days before the survey)	9.7 (6.8–13.6)	22.1 (18.9–25.7)		X	
Smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day (during the 30 days before the survey)	23.8 (19.4–28.8)	33.8 (29.3–38.5)		X	
Ever had at least one drink of alcohol on at least 1 day (during their life)	69.8 (64.1–74.9)	67.2 (62.4–71.6)			X
Drank alcohol for the first time before age 13 years (other than a few sips)	11.5 (9.1–14.4)	17.7 (14.9–20.9)		X	
Had at least one drink of alcohol on at least 1 day (during the 30 days before the survey)	39.4 (33.4–45.7)	39.2 (34.5–44.1)			X
Had five or more drinks of alcohol in a row within a couple of hours on at least 1 day (during the 30 days before the survey)	24.6 (20.4–29.3)	23.4 (19.4–27.9)			X
Usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol during the 30 days before the survey)	33.7 (27.9–40.1)	28.4 (22.6–35.2)			X
Had at least one drink of alcohol on school property on at least 1 day (during the 30 days before the survey)	3.9 (2.3–6.6)	4.6 (3.3–6.3)			X

BRFSS and YRBS Data, 2009

	Percent by Gender (95% confidence interval)		***Statistical Significance at 95% Confidence***		
Question	***Female***	***Male***	***Female More Likely Than Male***	***Male More Likely Than Female***	***No Difference***
Ever used marijuana one or more times (during their life)	37.7 (32.1–43.7)	43.1 (38.5–47.9)			X
Tried marijuana for the first time before age 13 years	7.3 (5.2–10.1)	9.4 (7.4–11.7)			X
Used marijuana one or more times (during the 30 days before the survey)	22.9 (18.8–27.6)	28.1 (22.8–34.0)			X
Used marijuana on school property one or more times (during the 30 days before the survey)	5.3 (3.5–7.9)	8.3 (6.3–10.9)			X
Ever used any form of cocaine one or more times (for example, powder, crack, or freebase, during their life)	5.9 (3.9–8.8)	7.0 (5.2–9.4)			X
Used any form of cocaine one or more times (for example, powder, crack, or freebase, during the 30 days before the survey)	3.3 (1.8–6.1)	4.4 (2.9–6.8)			X
Ever sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times (during their life)	13.6 (10.1–18.0)	10.2 (7.6–13.4)			X
Ever used heroin one or more times (also called "smack", "junk", or "China white", during their life)	2.3 (1.2–4.1)	3.4 (2.1–5.4)			X
Ever used methamphetamines one or more times (also called "speed", "crystal", "crank", or "ice", during their life)	5.0 (3.4–7.3)	4.2 (3.0–5.9)			X
Ever used ecstasy one or more times (also called "MDMA", during their life)	6.3 (3.8–10.1)	7.1 (4.8–10.2)			X
Ever took steroid pills or shots without a doctor's prescription one or more times (during their life)	1.4 (0.7–2.8)	0			X
Ever used a needle to inject any illegal drug into their body one or more times (during their life)	—	—			
Offered, sold, or given an illegal drug by someone on school property (during the 12 months before the survey)	18.3 (14.4–23.1)	25.4 (21.0–30.4)			X

BRFSS and YRBS Data, 2009

	Percent by Gender (95% confidence interval)		***Statistical Significance at 95% Confidence***		
Question	***Female***	***Male***	***Female More Likely Than Male***	***Male More Likely Than Female***	***No Difference***
Ever had sexual intercourse	46.2 (41.5–51.0)	46.1 (41.5–50.9)			X
Had sexual intercourse for the first time before age 13 years	1.9 (1.1–3.2)	6.4 (4.4–9.2)		X	
Had sexual intercourse with four or more persons (during their life)	10.9 (8.3–14.1)	11.6 (9.0–14.9)			X
Had sexual intercourse with at least one person (during the 3 months before the survey)	39.5 (34.9–44.2)	32.9 (28.9–37.2)	X		
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	19.5 (14.8–25.2)	23.5 (17.9–30.2)			X
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	46.3 (37.9–54.8)	39.3 (32.0–47.0)			X
Did not use birth control pills before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	59.2 (51.6–66.4)	75.6 (68.8–81.3)		X	
Were never taught in school about AIDS or HIV infection	9.1 (6.8–12.1)	10.8 (8.1–14.2)			X
Did not use Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	97.5 (93.3–99.1)	95.4 (86.9–98.5)			X
Did not use birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	56.7 (49.1–64.0)	70.9 (62.6–78.1)		X	
Did not use both a condom during last sexual intercourse and birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	85.7 (79.7–90.1)	88.8 (83.4–92.7)			X

BRFSS and YRBS Data, 2009					
	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
Question	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Ate fruits and vegetables less than five times per day (100% fruit juices, fruit, green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	—	—			
Did not drink 100% fruit juices (during the 7 days before the survey)	—	—			
Did not eat fruit (during the 7 days before the survey)	—	—			
Did not eat green salad (during the 7 days before the survey)	—	—			
Did not eat potatoes (excluding French fries, fried potatoes, or potato chips, during the 7 days before the survey)	—	—			
Did not eat carrots (during the 7 days before the survey)	—	—			
Did not eat other vegetables (excluding green salad, potatoes, or carrots, during the 7 days before the survey)	—	—			
Drank a can, bottle, or glass of soda or pop at least one time per day (not including diet soda or diet pop, during the 7 days before the survey)	14.5 (11.1–18.6)	29.6 (26.2–33.3)		X	
Drank less than three glasses per day of milk (during the 7 days before the survey)	85.8 (82.5–88.6)	72.1 (67.4–76.3)	X		
Ate fruit or drank 100% fruit juices less than two times per day (during the 7 days before the survey)	—	—			
Ate vegetables less than three times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	—	—			
Overweight (students who were >= 85th percentile but < 95th percentile for body mass index, by age and sex, based on reference data)	12.9 (9.6–17.1)	13.6 (10.9–16.9)			X

BRFSS and YRBS Data, 2009

	Percent by Gender (95% confidence interval)		***Statistical Significance at 95% Confidence***		
Question	***Female***	***Male***	***Female More Likely Than Male***	***Male More Likely Than Female***	***No Difference***
Obese (students who were >= 95th percentile for body mass index, by age and sex, based on reference data)	7.7 (5.9–10.1)	16.4 (12.2–21.7)		X	
Described themselves as slightly or very overweight	31.5 (26.9–36.5)	25.3 (21.5–29.5)			X
Did not exercise to lose weight or to keep from gaining weight (during the 30 days before the survey)	31.9 (27.1–37.1)	47.7 (44.7–50.7)		X	
Did not eat less food, fewer calories, or low-fat foods to lose weight or to keep from gaining weight (during the 30 days before the survey)	46.6 (42.7–50.5)	71.6 (68.5–74.5)		X	
Went without eating for 24 hours or more to lose weight or to keep from gaining weight (during the 30 days before the survey)	13.1 (10.1–16.7)	4.5 (3.4–6.1)	X		
Took diet pills, powders or liquids to lose weight or to keep from gaining weight (without a doctor's advice, during the 30 days before the survey)	6.0 (4.3–8.3)	4.1 (2.7–6.2)			X
Vomited or took laxatives to lose weight or to keep from gaining weight (during the 30 days before the survey)	5.7 (3.5–9.1)	2.0 (1.1–3.7)	X		
Physically active at least 60 minutes per day on less than 5 days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	62.9 (57.3–68.1)	47.1 (42.5–51.7)	X		
Did not attend physical education classes in an average week (when they were in school)	61.5 (53.9–68.5)	56.4 (48.7–63.8)			X
Did not attend physical education classes daily (when they were in school)	77.6 (71.3–82.9)	74.4 (68.3–79.7)			X
Did not play on sports teams (run by their school or community groups during the 12 months before the survey)	—	—			
Watched television 3 or more hours per day (on an average school day)	18.6 (15.2–22.7)	27.1 (24.0–30.3)		X	

BRFSS and YRBS Data, 2009					
	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
Question	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Used computers 3 or more hours per day (played video or computer games or used a computer for something that was not school work on an average school day)	16.6 (13.9–19.6)	30.9 (27.5–34.6)		X	
Physically active at least 60 minutes per day on less than 7 days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	85.1 (82.2–87.7)	68.6 (64.4–72.5)	X		
Did not participate in at least 60 minutes of physical activity on any day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	16.2 (12.3–21.0)	10.1 (7.8–13.0)	X		

Compared to U.S. students, based on t-test analyses, $p < .05$. 2. 95% confidence interval. NA = Not available.

Appendix G: Existing Healthcare Resources and Facilities

Type of Resource or Facility	***Location and Contact Information***
Shelters / Housing (in order by distance, closest to Cottage)	
	Bancroft House 104 Harvard St. Franconia, NH 03580 (603) 823 - 8842 Bob Gorgone, Dir
	The Support Center at Burch House PO Box 965 Littleton, NH 03561 (800) 774 - 0544 www.tccap.org/support_center.htm
	Good Samaritan Haven 105 North Seminary St. Barre, VT 05641 (802) 479 - 2294 Kim Woolaver, Exec Dir http://goodsamaritanhaven.org
	Upper Valley Haven 713 Hartford Ave. White River Junction, VT 05001 (802) 295 - 6500 Sara Kobylenski, Exec Dir http://uppervalleyhaven.org
	Pemi-Bridge Shelter 260 Highland Ave. Plymouth, NH 03264 (603) 536 - 7631 Catherine Bentwood, Dir www.tbhshelter.org
	Tyler Blain House 56 Prospect St. Lancaster, NH 03584 (603) 788 - 2344 Jill Gorman www.tccap.org/homeless-tbh.htm

Type of Resource or Facility	***Location and Contact Information***
	Open Arms Outreach 756 Union Ave. Laconia, NH 03246 (603) 524 - 4580 Ken Peters, Exec Dir www.oaoutreach.org
	Salvation Army Shelter 177 Union Ave. Laconia, NH 03246 (603) 524 - 1834 Stephen & Sally Warren www.use.salvationarmy.org/laconia
	The Carey House 6 Spring St. Laconia, NH 03246 (603) 528 – 8086 Ryan Robinson
Teen Centers (in order by distance, closest to Cottage)	
	Boys & Girls Club of the North Country 2572 US Route 302 Lisbon, NH 03585 (603) 838 - 5954 Eric Frydman, Exec Dir http://bgcnorthcountry.org
	The Living Room 24 Bagley St. Saint Johnsbury, VT 05819 (802) 748 - 8732 Marion Stuart, Exec Dir http://nekys.org/the-living-room.html
	Hartford Teen Center 338 North Hartland Rd. White River Junction, VT 05001 (802) 295 – 0900

Type of Resource or Facility	***Location and Contact Information***
	The Junction: Listen's Teen Life Skills Center 18 North Main St. White River Junction, VT 05001 (802) 295 - 2612 Merilynn Bourne, Exec Dir www.listencs.org/content/view/37/55
	Boys & Girls Club of the Lakes Region 719 North Main St. Laconia, NH 03247 (603) 528 - 0197 Cheryl Avery, Exec Dir www.bgclronline.org
Social Service Organizations (in order by distance)	
	Tri-County Community Action Program, Inc 6 School St. Woodsville, NH 03785 (603) 747 - 3013 www.tccap.org
	AHEAD Inc 161 Main St. Littleton, NH 03561 (603) 444 - 1377 Mike Claflin, Exec Dir www.homesahead.org
	Casey Family Services 551 Meadow St. Littleton, NH 03561 (603) 444 - 9909 Edward Rennells, Division Dir. www.caseyfamilyservices.org
	Granite United Way (Upper Valley Region) 21 Technology Dr, Ste 4 West Lebanon, NH 03784 (603) 298 - 8499 Leah Dillon, Dir, Community Impact www.graniteuw.org

Type of Resource or Facility	***Location and Contact Information***
	Department of Health and Human Services 129 Pleasant St. Concord, NH 03301 (603) 271 - 4440 Maggie Bishop, Dir www.dhhs.state.nh.us
	Family Resource Connection 20 Park St. Concord, NH 03301 (800) 298 - 4321 Nancy Cristiano, Coordinator www.nh.gov/nhsl/frc
	Child and Family Services of New Hampshire 464 Chestnut St. Manchester, NH 03105 (800) 640 - 6486 Michael Ostrowski, President / CEO www.cfsnh.org
	Southern New Hampshire Services 40 Pine St. Manchester, NH 03103 (800) 322 - 1073 www.snhs.org
Health Centers / Clinics (in order by distance)	
	ACHS - Woodsville 79 Swiftwater Rd, Ste 3 Woodsville, NH 03785 (603) 747 - 3740 Alexandria Noble, APRN, Aaron Solnit, MD, Loren Solnit, MD, Sarah Young-Xu, MD www.ammonoosuc.org
	Dr. Patricia Pratt 79 Swiftwater Rd, Ste 1 Woodsville, NH 03785 (603) 747 - 2743 Patricia Pratt, MD

Type of Resource or Facility	***Location and Contact Information***
	Woodsville Internal Medicine 79 Swiftwater Rd, Ste 2 Woodsville, NH 03785 (603) 747 – 2900 Marlene Sarkis, MD, Cynthia Holloran, ARNP
	LRHC - Wells River 65 Main St. Wells River, VT 05081 (802) 757 - 2325 Marlene Bristol, APRN, Stephen Generaux, MD, Fay Homan, MD, Angela Welch PA-C www.littlerivers.org
	Newbury Health Clinic 4628 Main St South Newbury, VT 05051 (802) 866 - 3000 Melanie Lawrence, MD http://newburyhealth.org
	LRHC - Bradford 437 South Main St. Bradford, VT 05033 (802) 222 - 5562 Maureen Boardman, APRN, Margarethe Chobanian, MD, Kevin Connolly, MD, Jessie Reynolds, MD www.littlerivers.org
	Upper Valley Pediatrics 331 Upper Plain Bradford, VT 05033 (802) 222 - 4722 Claire Bolon, DO, Mark Harris, MD, Rebecca Yukica, DO http://uppervalleypediatrics.com
	ACHS - Franconia 155 Main St. Franconia, NH 03580 (603) 823 - 7078 Danielle Beaulieu, PA-C, Barbara MacGregor Ford, APRN, Charles Wolcott, MD www.ammonoosuc.org

Type of Resource or Facility	***Location and Contact Information***
	ACHS - Littleton 25 Mount Eustis Rd. Littleton, NH 03561 (603) 444 - 2464 Nicole Fischler, APRN, Elizabeth Harman, PA-C, Philip Lawson, MD, David Nelson, DO, Jessica Thibodeau, APRN www.ammonoosuc.org
	ACHS - Warren 333 NH Route 25 Warren, NH 03279 (603) 764 - 5704 Caitlin O'Donnell, MD, Michael Scanlon, APRN www.ammonoosuc.org
	LRHC - East Corinth 720 Village Rd. East Corinth, VT 05040 (802) 439 – 5321 Richard Crandall, MD, Caroline Evans, FNP www.littlerivers.org
	ACHS - Whitefield 14 King's Sq. Whitefield, NH 03598 (603) 837 - 2333 Evelyn Hagan, APRN www.ammonoosuc.org
	The Good Neighbor Health Clinic 70 North Main St. White River Junction, VT 05001 (802) 295 - 1868 Armando Alfonzo, Exec Dir www.goodneighborhealthclinic.org
Domestic Violence Centers (in order by distance)	
	The Support Center at Burch House PO Box 965 Littleton, NH 03561 (800) 774 - 0544 www.tccap.org/support_center.htm

Type of Resource or Facility	***Location and Contact Information***
	Voices Against Violence PO Box 53 Plymouth, NH 03264 (877) 221 - 6167 http://voicesagainstviolence.net
	WISE 38 Bank St. Lebanon, NH 03766 (866) 348 - WISE (9473) Peggy O'Neil, Exec Dir www.wiseoftheuppervalley.org
	Starting Point: Services for Victims of Domestic and Sexual Violence PO Box 1972 Conway, NH 03818 (800) 336 - 3795 www.startingpointnh.org
	Turning Points Network 11 School St. Claremont, NH 03743 (800) 639 - 3130 www.free-to-soar.org
	New Beginnings Without Violence and Abuse PO Box 622 Laconia, NH 03247 (603) 528 - 6511 www.newbeginningsnh.org
Counseling Centers (in order by distance, closest to Cottage)	
	Connecticut River Counseling 139 Central St. Woodsville, NH 03785 (603) 747 - 2801 Sarah Davis, LCMHC, Jams Ohearn LCMHC
	White Mountain Mental Health - Woodsville 27 Central St. Woodsville, NH 03785 (603) 747 - 3658

Type of Resource or Facility	***Location and Contact Information***
	Clara Martin Center 1483 Lower Plain Bradford, VT 05033 (802) 222 - 4477 Kevin Buchanan, MD, Emily Hawes, LADC, Renee Thayer, LADC, Dawn Littlepage, Clin Dir, Gretchen Pembroke, Dir of Adult Care Svcs, Christie Everett, Dir of Acute Care Svcs www.claramartin.org
	Center for New Beginnings 229 Cottage St. Littleton, NH 03561 (603) 444 - 6465 http://centerfornewbeginnings.org
	White Mountain Mental Health - Littleton 29 Maple St. Littleton, NH 03561 (603) 444 - 5358
	Washington County Mental Health Services, Inc PO Box 647 Montpelier, VT 05601 (802) 229 - 0591 Paul Dupre, Exec Dir www.wcmhs.org
	West Central Behavioral Health 85 Mechanic St, Ste 360 Lebanon, NH 03766 (603) 448 - 5610 www.wcbh.org
Hospices (in order by distance, closest to Cottage)	
	North Country Home Health & Hospice Agency 536 Cottage St Littleton, NH 03561 (603) 444 – 5317 Elaine Bussey, Exec Dir www.nchha.com

Type of Resource or Facility	***Location and Contact Information***
	Caledonia Home Health Care and Hospice 161 Sherman Dr. Saint Johnsbury, VT 05819 (802) 748 - 8116 Margaret Baldor, Clin Dir www.nchcvt.org/chhc.html
	Central VT Home Health & Hospice 600 Granger Rd. Barre, VT 05641 (802) 223 - 1878 Kristin Burdick, Hospice Medical Dir www.cvhhh.org
	Bayada Hospice 309 Main St. Norwich, VT 05055 (802) 526 - 2380 Kristin Barnum, Dir http://bayada.com
	Visiting Nurse Association & Hospice of VT and NH 66 Benning St, Ste 6 West Lebanon, NH 03784 (888) 300 - 8853 www.vnavnh.org
	Pemi-Baker Home Health & Hospice 101 Boulder Point Dr, Ste 3 Plymouth, NH 03264 (603) 536 - 2232 Mary Ellen McCormack, Homecare/Hospice Dir www.pemibakercommunityhealth.org
	Northwoods Home Health & Hospice 278 Main St. Lancaster, NH 03584 (603) 788 - 5020 www.weeksmedical.org
	Central NH VNA & Hospice 780 North Main St. Laconia, NH 03246 (603) 524 - 8444 Andrea Huertas, Hospice Dir www.centralvna.org

Type of Resource or Facility	***Location and Contact Information***
Drug / Alcohol Treatment Centers (in order by distance)	
	Clara Martin Center 1483 Lower Plain Bradford, VT 05033 (802) 222 - 4477 www.claramartin.org
	Valley Vista 23 Upper Plain Bradford, VT 05033 (802) 222 - 5201 www.vvista.net
	Friendship House 2957 Main St. Bethlehem, NH 03574 (603) 869 - 2210 www.tccap.org/aod_friendship_house.htm
	Health Care and Rehabilitation Services 49 School St. Hartford, VT 05047 (802) 295 - 3031 www.hcrs.org
	West Central Behavioral Health 85 Mechanic St, Ste 360 Lebanon, NH 03766 (603) 448 - 5610 www.wcbh.org
	Chrysalis Recovery Center 20 Canal St, Ste 316 Franklin, NH 03235 (603) 998 - 4210 www.chrysalisrecovery.com
	Webster Place Recovery Center 27 Holy Cross Rd. Franklin, NH 03235 (603) 934 - 2020 www.netreatment.com

Type of Resource or Facility	***Location and Contact Information***
	Maple Leaf Farm 10 Maple Leaf Rd. Underhill, VT 05489 (802) 899 - 2911 www.mapleleaf.org
	Brattleboro Retreat Anna Marsh Ln. Brattleboro, VT 05302 (800) 345 - 5550 www.brattlebororetreat.org
Nursing Homes / Assisted Living Facilities	
	Grafton County Nursing Home 3855 Dartmouth College Hwy. North Haverhill, NH 03774 (603) 787 - 6971 Eileen Bolander, Adm www.co.grafton.nh.us/departments/nursing-home
	Atkinson Residence 4717 Main St. Newbury, VT 05051 (802) 866 – 5582 Jane Grimes, Adm
	On the Green 412 Dartmouth College Hwy. Haverhill, NH 03765 (603) 989 - 5545 Janice Estes, Adm
	Glencliff Home for the Elderly 393 High St. Glencliff, NH 03238 (603) 989 - 3111
	Blue Spruce Home for the Retired 70 Birch St. Bradford, VT 05033 (802) 222 - 5332 Sharon Sylvester, Adm

Type of Resource or Facility	***Location and Contact Information***
	Oasis Home 92 Cottage St. Bradford, VT 05033 (802) 222 - 5516 Sandra Sapounas, Adm
	Lafayette Center, Genesis Healthcare 93 Main St. Franconia, NH 03580 (603) 823 - 5502 Charlene Bedor, Adm www.genesishcc.com/Lafayette
	Riverglen House 55 Riverglen Ln. Littleton, NH 03561 (603) 444 - 0458 Jason Purdy, Exec Dir www.riverglenhouse.com
	St. Johnsbury Health & Rehab 1248 Hospital Dr. Saint Johnsbury, VT 05819 (802) 748 - 8757 Shawn Hallisey, Exec Dir www.reverastjohnsbury.com
	Sunset Home 73 Prospect St. Saint Johnsbury, VT 05819 (802) 748 - 2735 Vicki Quatrini, Adm
	Valley View Home for the Retired 69 Oak Ln. Fairlee, VT 05045 (802) 333 – 4829 Deborah Hodge, Adm
	Kendal at Hanover 80 Lyme Rd. Hanover, NH 03755 (603) 643 - 8900 Becky Smith, Exec Dir http://kah.kendal.org

Type of Resource or Facility	***Location and Contact Information***
	Kindred Nursing & Rehabilitation - Hanover Terrace 49 Lyme Rd. Hanover, NH 03755 (603) 643 - 2854 Cheryl Day www.hanoverterrace.com
	Brookside Nursing Home 1200 Christian St. White River Junction, VT 05001 (802) 295 - 7511 www.brooksidenursinghome.com
	Lebanon Center, Genesis Healthcare 24 Old Etna Rd. Lebanon, NH 03766 (603) 448 - 2234 Martha Chesley, Adm www.genesishcc.com/Lebanon
	Country Village Center, Genesis Healthcare 91 Country Village Rd. Lancaster, NH 03584 (603) 788 - 4735 Linda Rodger, Adm www.genesishcc.com/CountryVillage
Sources of Health Information (in alphabetical order)	
	AgingFit.com www.agingfit.com
	American Association of Poison Control Centers www.aapcc.org
	Centers for Disease Control and Prevention www.cdc.gov
	ClinicalTrials.gov www.clinicaltrials.gov
	Department of Health and Human Services 129 Pleasant St Concord, NH 03301 (603) 271 - 4440 Maggie Bishop, Dir www.dhhs.state.nh.us

Type of Resource or Facility	***Location and Contact Information***
	Dietary Supplements Labels Database http://dietarysupplements.nim.nih.gov/dietary
	Families USA 200 Baker Ave, Ste 309 Concord, MA 01742 (978) 371 - 7400 Philippe Villers, Pres www.familiesusa.org
	FamilyHealthInformation.com http://family-health-information.com
	Genetics Home Reference http://ghr.nim.nih.gov
	HealthCare.gov www.healthcare.gov
	HealthCentral.com www.healthcentral.com
	Health.com www.health.com
	Healthfinder.gov www.healthfinder.gov
	Health.gov http://health.gov
	Healthline www.healthline.com
	Household Products Database http://householdproducts.nim.nih.gov
	KidsHealth.org http://kidshealth.org
	Mayo Clinic www.mayoclinic.com
	MedHelp www.medhelp.org

Type of Resource or Facility	***Location and Contact Information***
	MedicineNet.com www.medicinenet.com
	MedlinePlus www.nim.nih.gov/medlineplus
	National Institutes of Health 9000 Rockville Pike Bethesda, MD 20892 (301) 496 - 4000 Francis Collins, MD PhD, Dir www.nih.gov
	New Hampshire Health Data Inventory http://nhhealthdata.org
	New Hampshire Public Health Association 4 Park St, Ste 403 Concord, NH 03301 (603) 228 - 2983 www.nhpha.org
	NH Citizens Health Initiative 501 South St, 2nd floor Bow, NH 03304 (603) 573 - 3373 Jeanne Ryer, Dir http://citizenshealthinitiative.org
	NH Family Voices 129 Pleasant St, Thayer Bldg. Concord, NH 03301 (800) 852 - 3345 Martha-Jean Madison and Terry Ohison-Martin, Co-Dir http://nhfv.org
	NH Quality Care www.nhqualitycare.org
	NIH SeniorHealth https://nihseniorhealth.gov
	SeniorResource.com www.seniorresource.com
	WebMD www.webmd.com