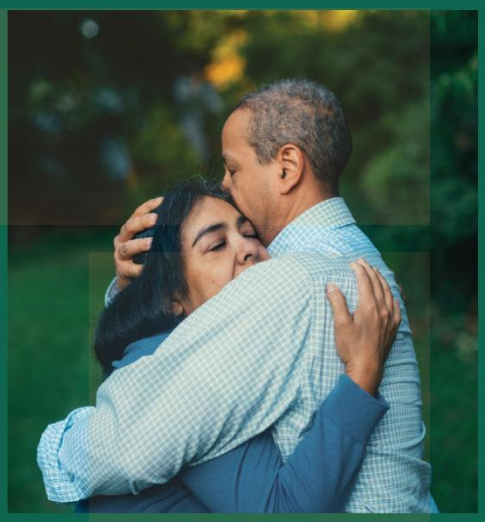
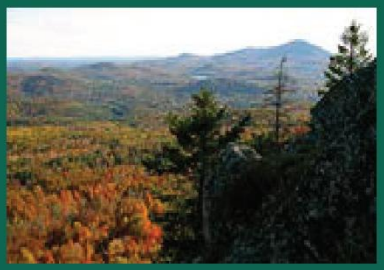
Community Health Needs Assessment

2025





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

Dartmouth Health

Cheshire Medical Center

Cheshire Medical Center

Community Health Needs Assessment

Fiscal Year 2025

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

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The 2025 Community Health Needs Assessment Partnership includes Dartmouth Health, Cheshire Medical Center, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, New London Hospital, Valley Regional Healthcare, Visiting Nurse and Hospice for Vermont and New Hampshire, with technical support from the New Hampshire Community Health Institute/JSI.

Dartmouth Health

Dartmouth Hitchcock Medical Center | Alice Peck Day Memorial Hospital
Cheshire Medical Center | Mt. Ascutney Hospital and Health Center
New London Hospital | Valley Regional Hospital
Visiting Nurse and Hospice for Vermont and New Hampshire

Cheshire Medical Center

2025 Community Health Needs Assessment

Executive Summary

From January 2024 through July 2025, an assessment of Community Health Needs was completed by Cheshire Medical Center in collaboration with Dartmouth Hitchcock Medical Center, Alice Peck Day Memorial Hospital, Mt. Ascutney Hospital and Health Center, New London Hospital, Valley Regional Hospital and Visiting Nurse and Hospice for Vermont and New Hampshire with technical support from the New Hampshire Community Health Institute/JSI. The aims of the assessment are to:

- Better understand the health-related issues and concerns impacting the well-being of area residents;
- Inform community health improvement plans, partnerships, and initiatives; and
- Guide community benefit activities of Cheshire Medical Center and partner organizations.

For the purpose of the assessment, the geographic area of interest was 33 municipalities of the Monadnock Region comprising the service area of the Greater Monadnock Public Health Network. The total resident population of the service area is estimated to be 101,722 people. Methods employed in the assessment included: surveys of community residents made available through social media, email distribution, website links and through paper surveys widely distributed in multiple locations and channels across the region; a direct email survey of community leaders and service providers representing multiple community sectors; a set of eight community discussion groups convened across the region; and assembly of available population demographics and health status indicators including drivers of health characteristics of the hospital service area communities.

Two additional sources of information referenced in this needs assessment include selected statistics from a Social Drivers of Health Screener applied in primary care settings of the Cheshire Medical health system and selected results describing health behaviors, beliefs, and attitudes from the Greater Monadnock Community Survey. The latter survey was a random sample of Monadnock Region residents conducted with the University of New Hampshire Survey Center in 2024.

Information gathering and community engagement sought to focus assessment activities on vulnerable and disproportionately served populations in the region, including populations that could experience limited access to health-related services or resources due to income, age, disability, or social or physical isolation. The quantitative and qualitative information gathered

through the different sources and methods was then synthesized to understand different perspectives, identify common themes, and inform priorities for improvement. The table below and continued on the next several pages provides a summary of the priority community health needs and issues identified through this assessment.

Summary of Community Health Needs and Issues by Information Source			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Availability of mental health services	Mental Health Care was the most frequently mentioned service type people had difficulty accessing (34%). Among people who had difficulty accessing mental health care, the top reasons cited were 'service not available' (63%), 'wait time too long' (61%), and 'not accepting new patients' (51%). A majority of community residents (55%) and community leaders (59%) think the ability to get mental health services has gotten worse in the last few years.	About 15% of all respondents to the 2024 Greater Monadnock Community Survey and 28% of those with household income under $60,000 reported that poor mental health had kept them from doing their usual activities on 5 or more of the last 30 days. The rate of Suicide or Self Harm-Related emergency department visits among females in the Greater Monadnock Public Health Region is significantly higher than the overall NH rate.	Mental health care was identified as a continuing and top priority for community health improvement in community discussion groups, including concerns for insufficient local capacity, particularly for children and youth, insurance coverage limitations, and the need for mental health support of health and human service staff and volunteers.
Availability of primary care and medical sub-specialty services	Primary Health Care was the second most frequently mentioned service type people had difficulty accessing (26%). About 24% of community survey respondents also reported difficulty accessing medical sub-specialty care. 'Not accepting new patients' (43%-56%) and 'Wait time too long' (31%-77%) were the top reasons cited for access difficulty for both primary care and sub-specialties, respectively. About 39% of community resident and 29% of community leader survey respondents think the ability to get primary care services has gotten worse in the last few years.	About 15% of respondents to the 2024 Greater Monadnock Community Survey reported not getting needed medical care for a sickness or illness in the past 12 months. 'Could not get an appointment in a reasonable time' was the most commonly cited reason (43%). The ratio of population to Primary Care Physicians in Cheshire County (1,487:1) is higher than in NH overall (1,149:1).	Issues related to health care provider availability, including turnover, choice, wait time, and responsiveness, was the topic area with the most comments – 28% of all comments - on an open-ended question asking 'one thing you would change to improve health in your community'. Lack of primary care providers and high turnover was a major theme across discussion groups.

Summary of Community Health Needs and Issues by Information Source (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Cost of health care services, including medications, and the affordability of health insurance	About 66% of community resident and 71% community leader survey respondents indicated that the cost of health care and health insurance has 'gotten worse' over the last few years. Only 3% thought this issue has 'gotten better'. 'Can't afford out-of-pocket expenses' was the second most frequently identified barrier preventing people from accessing the health care services they need (after 'service not available') by community leaders (53%).	The estimated proportion of people with no health insurance (6%) is similar to the overall percentage of people who are uninsured in NH overall. 'Lack of insurance' (25%) and 'Couldn't afford out-of-pocket expenses' (22%) were the second and third most commonly cited reasons by people who did not get needed medical care in the past 12 months.	Community discussion participants identified health care costs and financial barriers to care as a significant issue. It was also the third most frequently mentioned topic area in the open-ended question about 'one thing you would change to improve health' Obstacles include the high cost of private pay insurance, misalignment of coverage with the types of insurance providers accepted, and unreasonably high deductibles.
Services for older adults, including opportunities for social interaction and supports for aging in place	About 14% of community survey respondents indicated difficulty getting 'help caring for aging family members'. 'Cost too much' and 'Service not available' were the top reasons cited for access difficulties. 'Services and resources for aging in a safe and supportive environment' was a top 5 area selected by community leaders for focusing efforts to improve health in the community (selected by 43% of respondents).	The service area population has a relatively high proportion of seniors, with about 21% of residents aged 65 years or older. About 29% of the 65+ population in the Greater Monadnock region reports having serious activity limitations resulting from one or more disability. Nearly 1 in 3 area residents age 65+ report having experienced a fall in the past 12 months.	The ability to age in place was a topic raised in discussion groups and written comments, with concerns expressed about shortages of qualified workers to provide home care, issues of cost, lack of options for transportation to medical appointments, and related concerns around social isolation. Long-term care was also identified as difficult to find, and people need more help to plan ahead for long-term caregiving needs.

Summary of Community Health Needs and Issues by Information Source (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Social drivers of health and well-being, such as affordable access to housing, healthy foods, and affordable child care	About 82% of community resident survey respondents said housing affordability has 'gotten worse' over the last few years. The most common social/human service people reported difficulty getting was 'Help with Housing Needs' (19%), followed by difficulty getting Child Care (17%) and 'Help paying bills' (16%). Affordable Housing was by far the top issue selected by community leader respondents (74%) as a priority area for improvement to support a healthy community.	Nearly 1 in 6 screens with Cheshire Medical primary care patients indicate financial strain, meeting basic needs such as food, housing, and medical care. About 12% of area residents experienced food insecurity in the past year. About 1 in 4 owner-occupied housing units and 45% of renters in the service area have housing costs >30% of household income.	Socioeconomic issues and their effect on health and wellbeing came up in every discussion group. These issues included the cost of living outpacing income, housing, childcare, food insecurity, transportation, and insurance. Limited availability of affordable housing options included specific concerns for workforce housing and senior housing.
Health and human service workforce shortages and challenges in navigating the health care system	'Service not available', 'Not accepting new patients', and 'Wait time too long' were the top three reasons cited for access difficulty for primary care, mental health care, and subspecialty medical care. Adult dental care was the exception, where issues of cost and insurance were the top reasons for access difficulties. Top barriers identified by community leaders and service providers preventing people from accessing the health care services they need included 'Service not available; not enough local capacity' (54%), 'Difficulty navigating the health care system' (48%), and 'Long wait times or limited office hours' (47%).	Difficulty navigating the health care system and the related issue of workforce shortages manifest in measures of population health, such as delayed care and inpatient stays for diagnoses potentially treatable in outpatient settings, such as diabetes, hypertension, or asthma. The rate of preventable hospital stays for Medicare enrollee residents of Cheshire County was notably lower (better) than the statewide rate in 2022.	This theme emerged in both discussion groups and survey comments. Health and human service providers are described as understaffed and stretched too thin for the level of need in the region. Frustration was expressed about connecting with provider staff, misuse of emergency care due to lack of access to primary and urgent care, difficulties navigating the process of finding and connecting with local specialists, and other complexities of the health care system.

Summary of Community Health Needs and Issues by Information Source (continued)			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Improved services and supports for pursuing healthy and active lifestyles	'Recreation and fitness programs' was the top service or program type people would use if more available in their community (41%). Other top resources included Nutrition and Cooking programs (31%), Biking and walking paths (31%), and Programs that address body weight (28%).	About 1 in 5 adults in the Greater Monadnock region can be considered physically inactive. One-third (33%) of adults in the region are considered obese, and an additional 37% are considered overweight, percentages similar to the adult population in NH overall. Heart disease is the second leading cause of mortality in the region, and the rate of hospital inpatient discharges for heart attacks was significantly higher in the Greater Monadnock Public Health Region compared to the rest of New Hampshire over the period 2017 to 2021 (most recent data available).	Common topics from survey comments and discussions included improved resources and outlets for healthy food and nutrition, as well as improved community resources for active living, affordable physical activity, and safe recreation.

Cheshire Medical Center

2025 Community Health Needs Assessment

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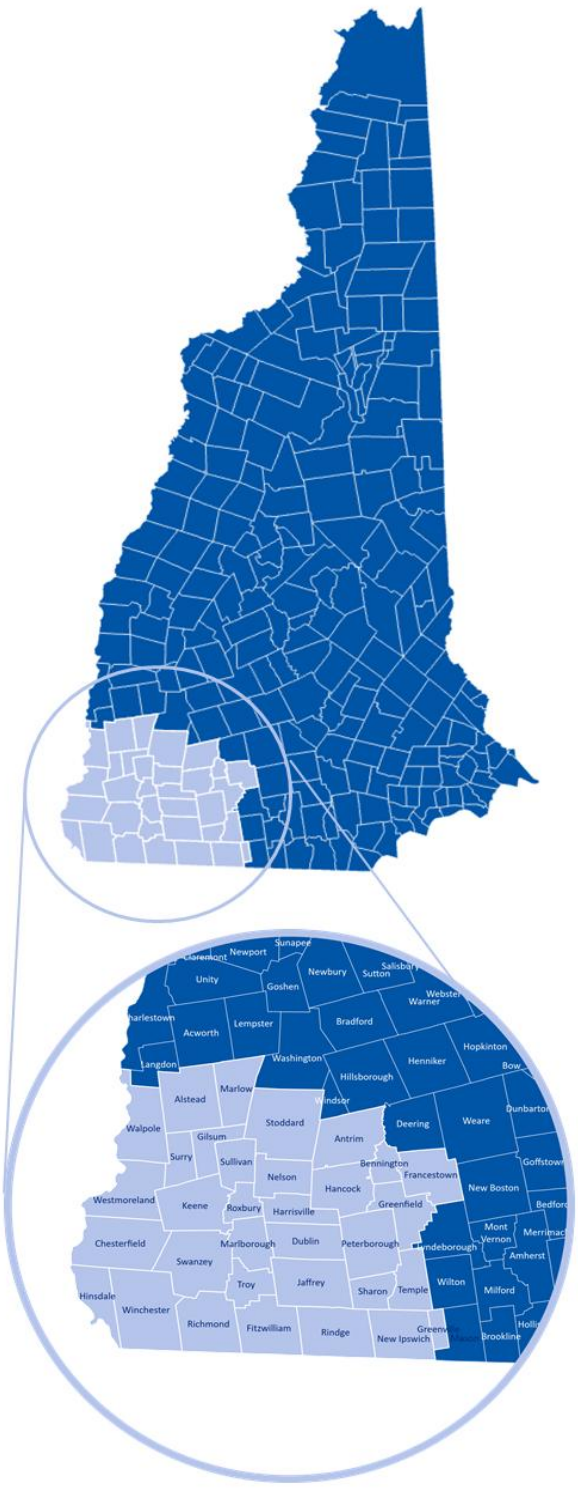
A. COMMUNITY OVERVIEW WITH SELECTED SERVICE AREA DEMOGRAPHICS

The total resident population of the Greater Monadnock Public Health Region is estimated as 101,722 people (United States Census Bureau, American Community Survey, 5-year estimates, 2023). The service area population has increased by about 300 people or 0.3% over the three years since the last Community Health Needs Assessment. Table 1 displays the service area population distribution by municipality, as well as the median age, the proportion of residents who are under 18 years of age, and the proportion who are 65 and older.



Compared to New Hampshire overall, the service area population has a slightly higher proportion of older adults - about 21% are 65+ compared to about 19% in New Hampshire – and the median age of service area residents is similar at about 44 years of age. A substantial range is observed within the region for the older adult statistic, with more than 30% of residents in Harrisville, Hancock, and Sharon aged 65 and older compared to less than 15% of residents in Roxbury, New Ipswich, Bennington, and Temple. A similar inverse range is observed for the percentage of residents who are under 18 years of age, ranging from about 14% in Hancock, Fitzwilliam, and Sullivan to 29% of residents in New Ipswich.

| TABLE 1. Service Area Population by Municipality |

(continued on the next page)

Municipality (in alphabetical order)	2023 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Alstead	1,625	2%	53	15%	24%
Antrim	2,657	3%	46	21%	17%
Bennington	1,494	1%	42	23%	14%
Chesterfield	3,592	4%	51	19%	29%
Dublin	1,632	2%	50	21%	23%
Fitzwilliam	2,317	2%	50	14%	26%
Francestown	1,347	1%	52	20%	24%
Gilsum	719	1%	44	16%	22%
Greenfield	1,816	2%	49	19%	18%
Greenville	2,219	2%	41	20%	19%
Hancock	1,757	2%	55	14%	31%
Harrisville	942	1%	57	16%	32%
Hinsdale	3,987	4%	51	15%	29%
Jaffrey	5,413	5%	44	24%	17%
Keene	22,923	23%	36	15%	18%
Marlborough	2,121	2%	45	24%	21%
Marlow	848	1%	50	22%	27%
Nelson	586	1%	46	25%	25%
New Ipswich	5,274	5%	38	29%	13%
Peterborough	6,456	6%	52	18%	29%
Richmond	1,225	1%	53	18%	28%
Rindge	6,482	6%	36	20%	19%
Roxbury	276	<1%	39	16%	12%
Sharon	440	<1%	50	23%	31%
Stoddard	1,156	1%	50	19%	21%
Sullivan	699	1%	47	14%	22%
Surry	998	1%	45	20%	25%
Swanzey	7,351	7%	52	16%	26%
Temple	1,367	1%	45	16%	14%

Municipality (in alphabetical order)	2023 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Troy	2,034	2%	39	21%	16%
Walpole	3,671	4%	45	24%	24%
Westmoreland	2,146	2%	55	15%	30%
Winchester	4,202	4%	41	22%	17%
Greater Monadnock	**101,772**	**100%**	**44**	**19%**	**21%**
New Hampshire	1,387,834		43	19%	19%

Table 2 displays additional demographic information for the towns of the Greater Monadnock region. In general, the region has somewhat lower median household income ($85,950) compared to New Hampshire ($95,628) overall. The percent of people living in poverty (about 8%) is similar to the New Hampshire statewide statistic (7%). Within the region, there is a substantial range on this and other related measures. For example, the town with the highest median household income (Chesterfield, $110,737) has a median household income nearly double the lowest income community (Alstead, $59,091). Similarly, a substantial range is observed for the percent of people living below the federal poverty level (FPL), with an estimate of 2% in Nelson and New Ipswich compared to about 17% of residents in Winchester. The map following Table 2 displays the distribution of median household income across towns in the service area.

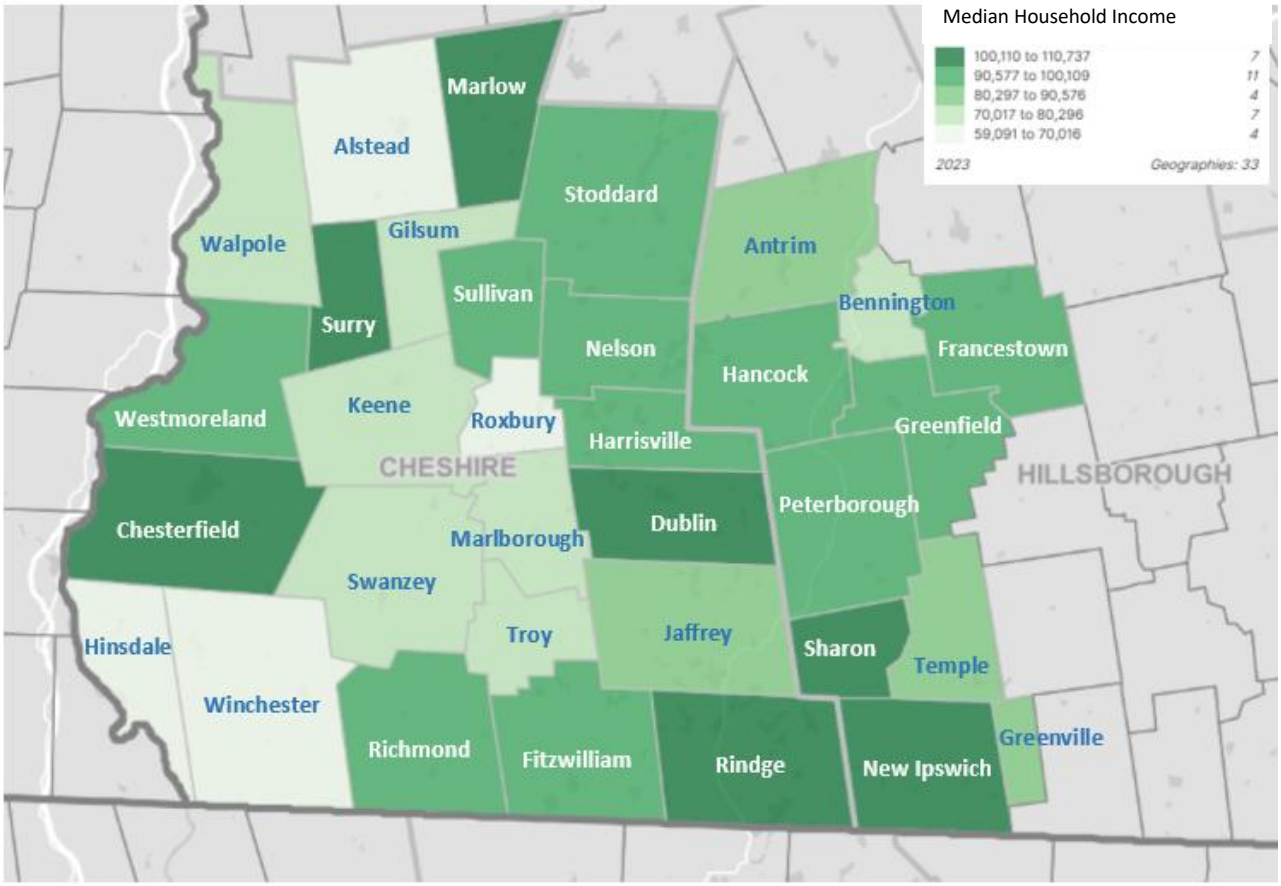
| TABLE 2. Selected Demographic and Economic Indicators |

(continued on the next page)

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Chesterfield	$110,737	8%	21%	12%
Sharon	$110,556	7%	22%	15%
Surry	$109,167	3%	16%	13%
Marlow	$104,605	7%	2%	16%
Rindge	$102,662	10%	11%	8%
Dublin	$100,852	11%	14%	8%
New Ipswich	$100,417	2%	6%	6%
Greenfield	$99,038	8%	12%	18%

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Westmoreland	$98,684	6%	36%	10%
Harrisville	$98,611	5%	17%	13%
Peterborough	$97,319	8%	19%	11%
Francestown	$96,094	7%	7%	8%
New Hampshire	$95,628	7%	27%	13%
Sullivan	$95,625	4%	21%	17%
Hancock	$92,692	3%	5%	11%
Richmond	$92,083	3%	9%	19%
Nelson	$91,250	2%	33%	10%
Stoddard	$91,125	7%	29%	11%
Fitzwilliam	$91,076	8%	18%	11%
Antrim	$88,958	7%	22%	12%
Greenville	$87,974	11%	34%	19%
Jaffrey	$87,527	4%	24%	17%
Temple	$86,528	10%	29%	18%
Greater Monadnock	**$85,950**	**8%**	**25%**	**14%**
Troy	$79,375	6%	19%	8%
Keene	$78,183	10%	36%	17%
Bennington	$78,071	5%	21%	14%
Swanzey	$78,045	10%	43%	19%
Walpole	$76,875	13%	16%	19%
Marlborough	$73,828	15%	31%	12%
Gilsum	$70,833	8%	34%	17%
Roxbury	$69,583	3%	14%	20%
Hinsdale	$68,979	6%	25%	22%
Winchester	$65,943	17%	41%	14%
Alstead	$59,091	10%	23%	19%

Figure 1 – Median Household Income by Town, Greater Monadnock Region



Median Household Income ranges from $110,737 in Chesterfield to $59,091 in Alstead.

As displayed by Table 3, about 93% of the population of the Greater Monadnock region identifies as 'White' and about 5% identify as '2 or more races' according to the U.S. Census Bureau. About 2.5% of the service area population identifies as Hispanic ethnicity (any race). In general, the service area population is similar to New Hampshire overall with regard to diversity of race and ethnicity.

| TABLE 3. Race and Ethnicity Characteristics |

Area	Race							Ethnicity
	White	2 or more races	Black / African American	Asian	American Indian / Alaska Native	Native Hawaiian / Pacific Islander	Other Race	Hispanic or Latino
Greater Monadnock	92.8%	4.8%	0.8%	0.7%	0.1%	<0.1%	0.8%	2.5%
New Hampshire	88.9%	5.5%	1.5%	2.6%	0.1%	<0.1%	1.3%	4.5%

Drivers of Health: The 2025 Community Health Needs Assessment is based on the understanding that the conditions of the communities where we are born, live, age, work, and play are as important to achieving good health as receiving regular health care services, proper nutrition, and adequate physical activity. These conditions can be described as drivers of health that can directly or indirectly affect risks and outcomes related to health and wellness. Drivers of health can include characteristics such as: household wealth; availability of quality health care; access to affordable, healthy food; educational attainment; safe, quality housing; employment status and opportunities; transportation and public infrastructure; and other social, economic, and environmental factors.

The term "drivers" reflects a shift from perhaps more familiar terminology of Social Determinants of Health, since "determinants" can imply health outcomes that are pre-determined. Instead, our focus is on how these factors can actively influence health outcomes while emphasizing the potential for interventions that can positively affect health and well-being. The collective efforts of community organizations, policymakers, and individuals can have profound effects on the health and happiness of community members.

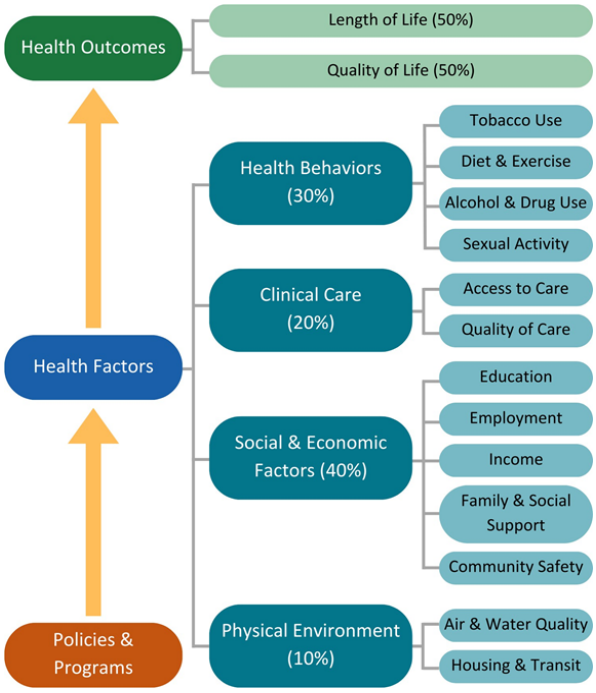


Figure 2: County Health Rankings Model

The County Health Rankings Model (Figure 2), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute[1], provides a framework for population health that emphasizes the many drivers of health which, if improved, can help make communities healthier places to live.

The factors fall into four domains—health behaviors, clinical care, social and economic factors, and physical environment—which together encompass a broad set of modifiable factors influencing individual and community health. The 2025 Community Health Needs Assessment was developed with these considerations in mind, as well as considerations for findings of previous needs assessments and collaborative efforts for community health improvement that are ongoing across the region.

[1] The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org

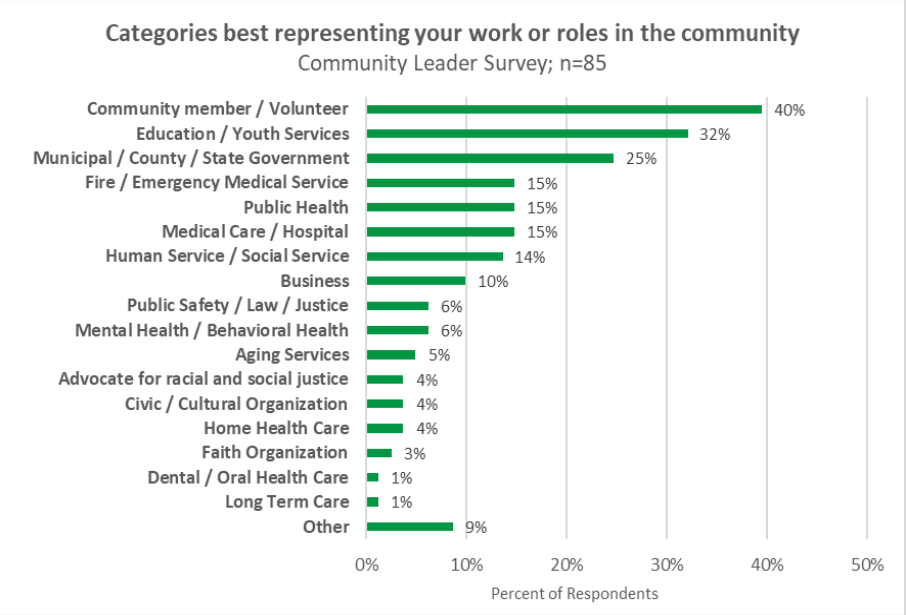
B. COMMUNITY INPUT ON HEALTH ISSUES AND PRIORITIES

Between February and July 2025, the Population Health Team of Cheshire Medical Center fielded two surveys: one with targeted distribution to community leaders and service providers, and one broadly disseminated to residents across the region. The survey instruments were designed to have some questions in common to facilitate comparisons and contrasts in the analysis.

The community leader survey was distributed via a unique email link to 190 individuals in positions of community service and leadership in health and human service agencies, education, business, government, civic, and volunteer organizations across the Greater Monadnock region. The survey distribution list was developed by the planning committee. A total of 85 completed surveys were received for the Community Leader Survey (45% response). Figure 3 displays the range of community sectors represented by these individuals.

Note: Respondents could identify as representatives of more than one sector.

| Figure 3 |



The community resident survey was distributed electronically through email and social media communication channels, on the Cheshire Medical Center, promoted through posters and fliers with links and QR codes posted around the region, and by paper copies made available at a variety of distribution points throughout the region, including food distribution sites and community meeting spaces. The survey was available in English and Spanish language.

A total of 501 community members completed the Community Resident Survey, representing 27 of the 33 towns of the Greater Monadnock region. Table 4 displays the grouping of

respondents by community. Among respondents who provided information on their current local residence, about 44% are residents of Keene and 10% are residents of Swanzey. Service area towns from which no survey responses were received are Greenfield, Greenville. Richmond, Roxbury, Sharon, and Surry. The most common locations for survey responses from outside the service area were Brattleboro, VT (4 responses) and Charlestown, NH (3).

Compared to regional demographics overall, community survey respondents were proportionally more likely to be female and 65 years of age or more. Approximately 20% of respondents have a household income of less than $50,000, while 24% reported a household income of $100,000 or more. About 17% of respondents did not provide household income information. Table 5 displays selected characteristics of respondents to the community survey.

| TABLE 5 |

Age < 45 years	Age >= 65 years
27%	34%
Woman	**Black, Indigenous, and People of Color**
82%	5%
Household Income < $50K	**Household Income > $100K**
20%	24%
Currently Uninsured	**Currently has Medicaid coverage**
2%	7%

| TABLE 4 |

Town	# of respondents	% of total*
Keene	176	44%
Swanzey	40	10%
Winchester	34	8%
Chesterfield	13	3%
Marlborough	12	3%
Alstead	10	2%
Peterborough	9	2%
Hinsdale	9	2%
Fitzwilliam	8	2%
Jaffrey	8	2%
Stoddard	6	1%
Rindge	6	1%
Hancock	6	1%
Walpole	6	1%
Westmoreland	5	1%
Gilsum	5	1%
Dublin	4	1%
Harrisville	4	1%
Troy	4	1%
New Ipswich	3	1%
Marlow	3	1%
Antrim	2	<1%
Bennington	2	<1%
Sullivan	2	<1%
Nelson	2	<1%
Francestown	1	<1%
Temple	1	<1%
Other Locations	20	5%
***Percent of respondents who provided information on the location of their residence. About 20% of respondents did not provide this information.**		

1. Progress on Community Health Priorities and Concerns

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

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

In consideration of this observed consistency over time, the 2025 Community Health Needs Assessment asked respondents to the Community Resident and Community Leader surveys to reflect on a set of statements describing the main priorities and themes identified in the recent past by indicating if there has been improvement or not in those areas. Specifically, the surveys included the following statement and question:

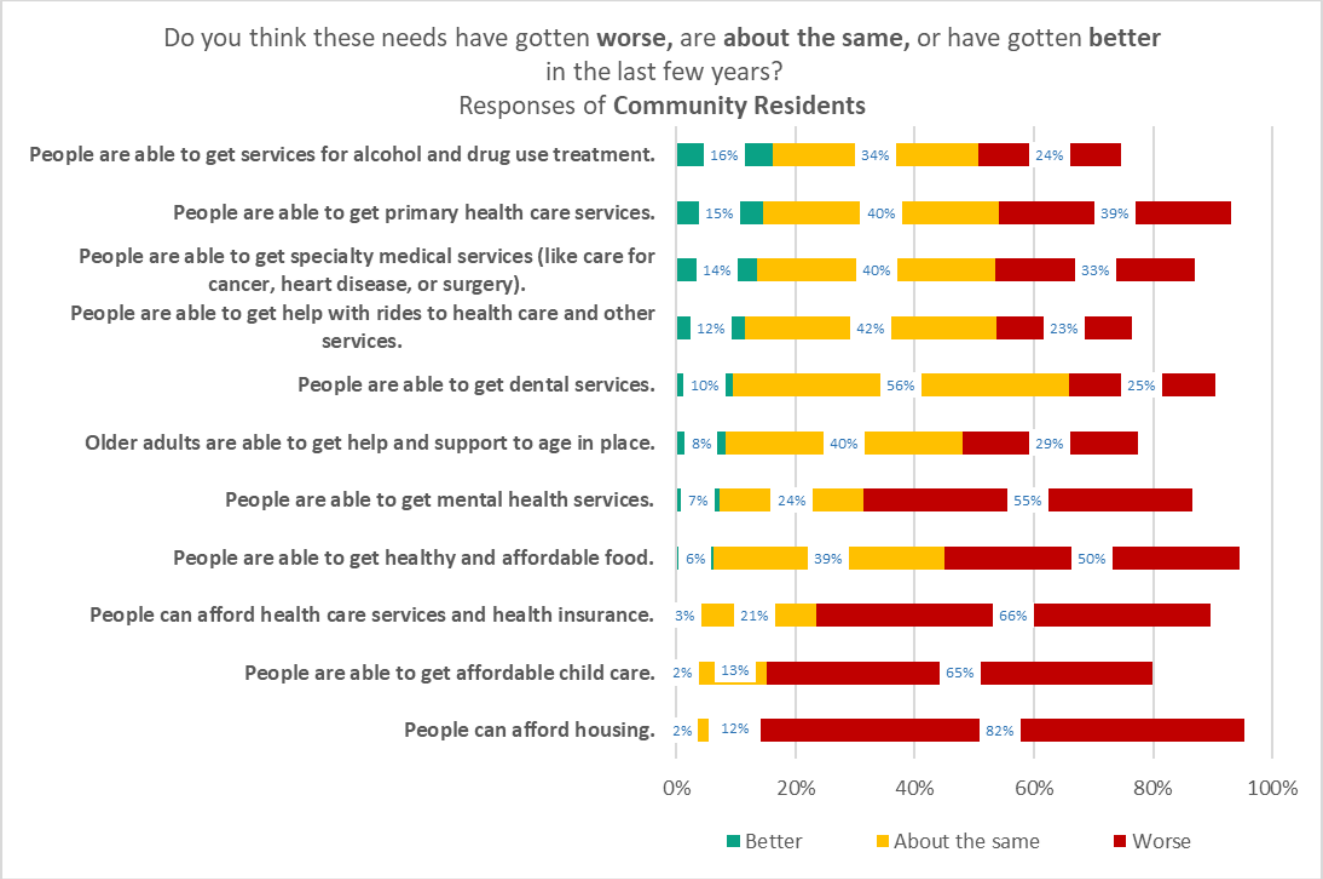
> *"In past surveys like this one, people have said that the health needs listed below are the most important for us to work on. Do you think these needs have gotten worse, are about the same, or have gotten better in the last few years or so?"*

Figure 4 on the next page displays the results for this question set from respondents to the community resident survey. The ability to get services for drug and alcohol treatment was reported to be "Better" by 16% of respondents, which was the highest percentage for any of the areas of need listed. Ability to get primary care services was reported as 'better' by about 15% of respondents, and ability to get specialty medical care services was reported 'better' by a similar percentage.

In general, more community residents reported needs getting worse than those reporting needs getting better in each of the topic areas over the last few years. A majority of survey respondents indicated that the affordability of health care, child care, and housing has gotten worse.

> *"Healthcare is way too expensive and insurance is complicated for individuals and families to navigate."*
>
> *- Community Resident Survey Respondent*

| Figure 4 |



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

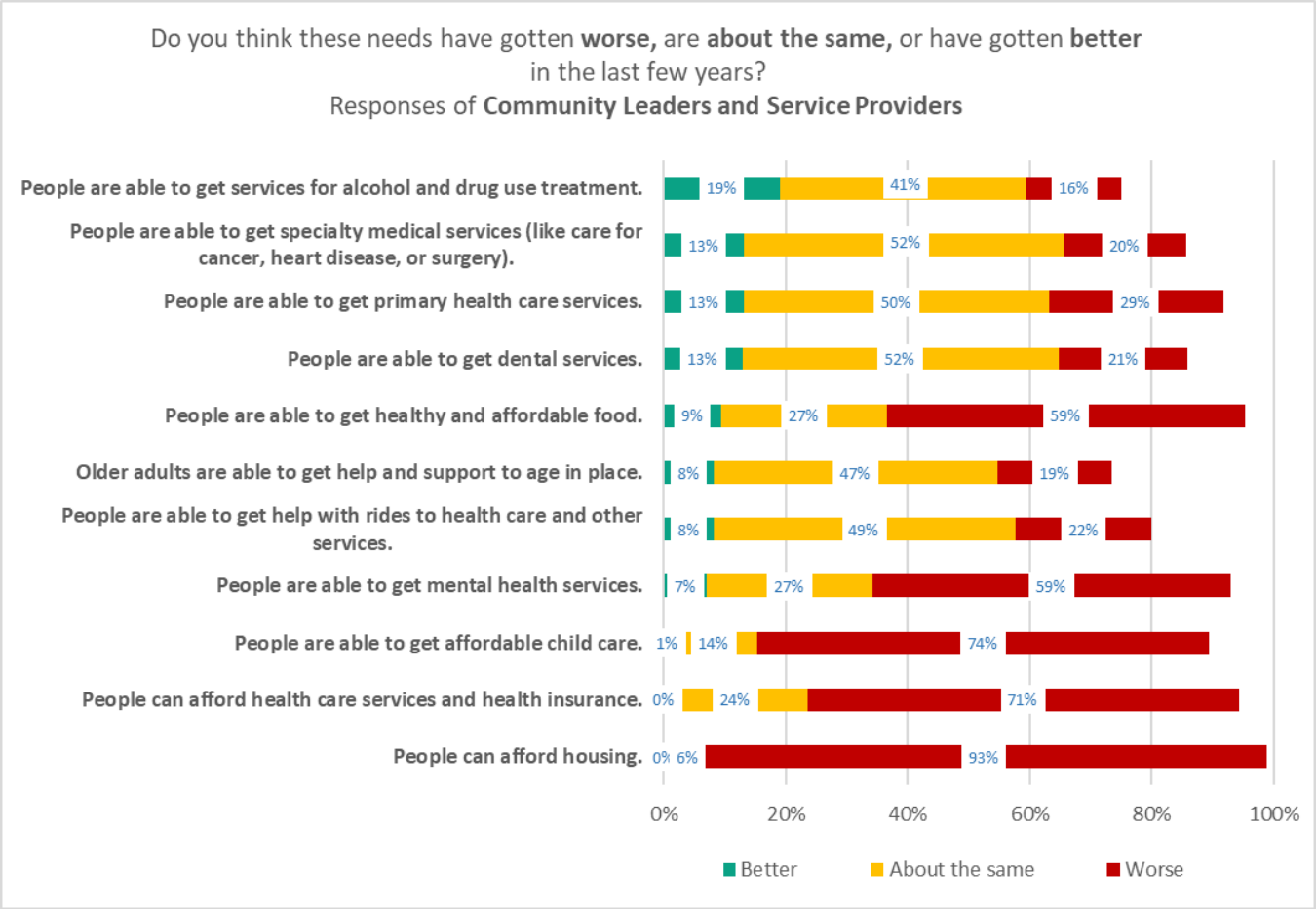
> *"This community needs housing and public transportation. Not 'government' housing either, places for lower-middle class families to live and OWN their home with a way to get around the city. . . . How can we expect our community to be healthy when there is nowhere for anyone to live, and no way to get around?"*
>
> *- Community Resident Survey Respondent*

Figure 5 displays the results for the same set of questions from respondents to the survey of community leaders and service providers. A similar pattern is observed with community leaders also being more likely to indicate that needs overall have gotten worse rather than better.

Nearly all community leader survey respondents indicated that the ability to afford housing has gotten worse, and a majority of community leader respondents also indicated that the affordability of child care and health care services has gotten worse. Similar to the responses

on the community resident survey, community leaders were most likely to indicate that the ability to get substance use treatment has improved (19%, Better). About the same percentage of community leaders (13%) reported that the ability to get specialty medical services, primary care, and dental services has gotten better over the past few years.

| Figure 5 |



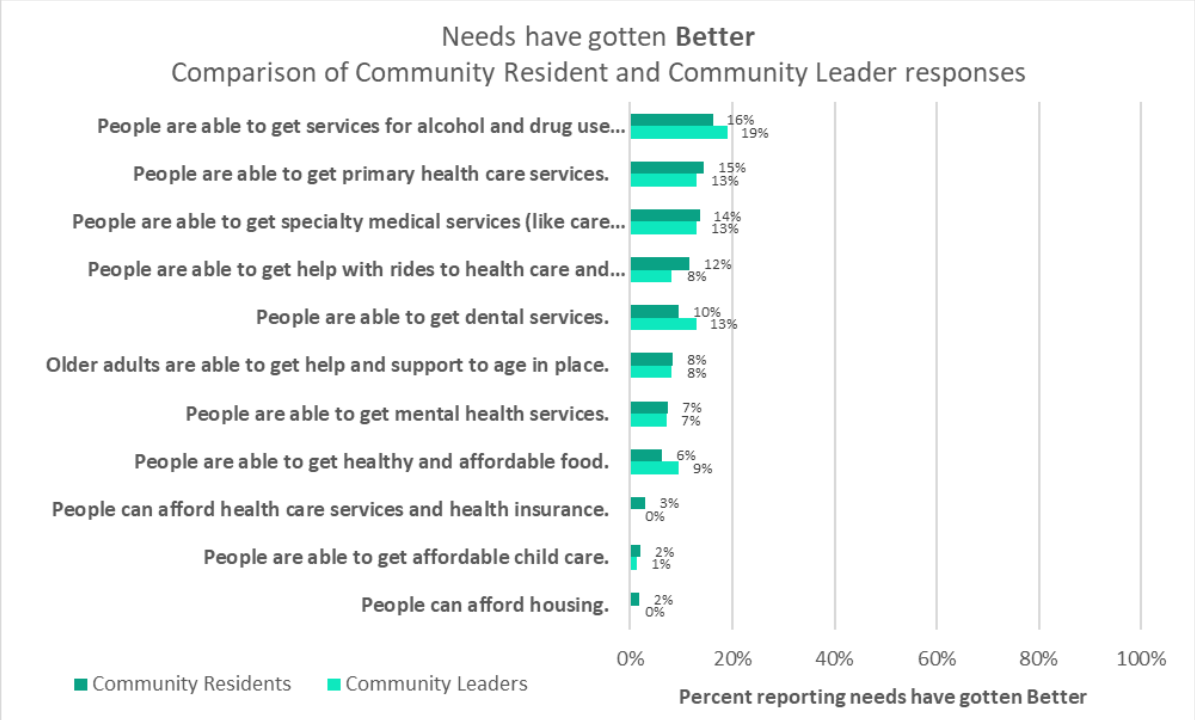
Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the needs are Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

"Many of my clients do not have insurance and do not go for medical treatment until it's so severe they end up hospitalized."

- Community Leader, Local government

The next two charts display comparisons of community residents and community leaders for the percentage of respondents who report needs have gotten better (Figure 6) and the percentage who report needs have gotten worse (Figure 7). In general, there is a high degree of agreement and consistency between the two response groups: agreement with regard to substantially more respondents reporting needs have gotten worse for each topic than those who report needs are better; and general consistency in the order of topics with the greatest number of respondents indicating a need has gotten worse (e.g., issues of affordability are at the top including housing, child care, and health care). Similar percentages of respondents in each survey group reported improvement in the ability to get substance use treatment, primary care, and specialty medical services.

| Figure 6 |

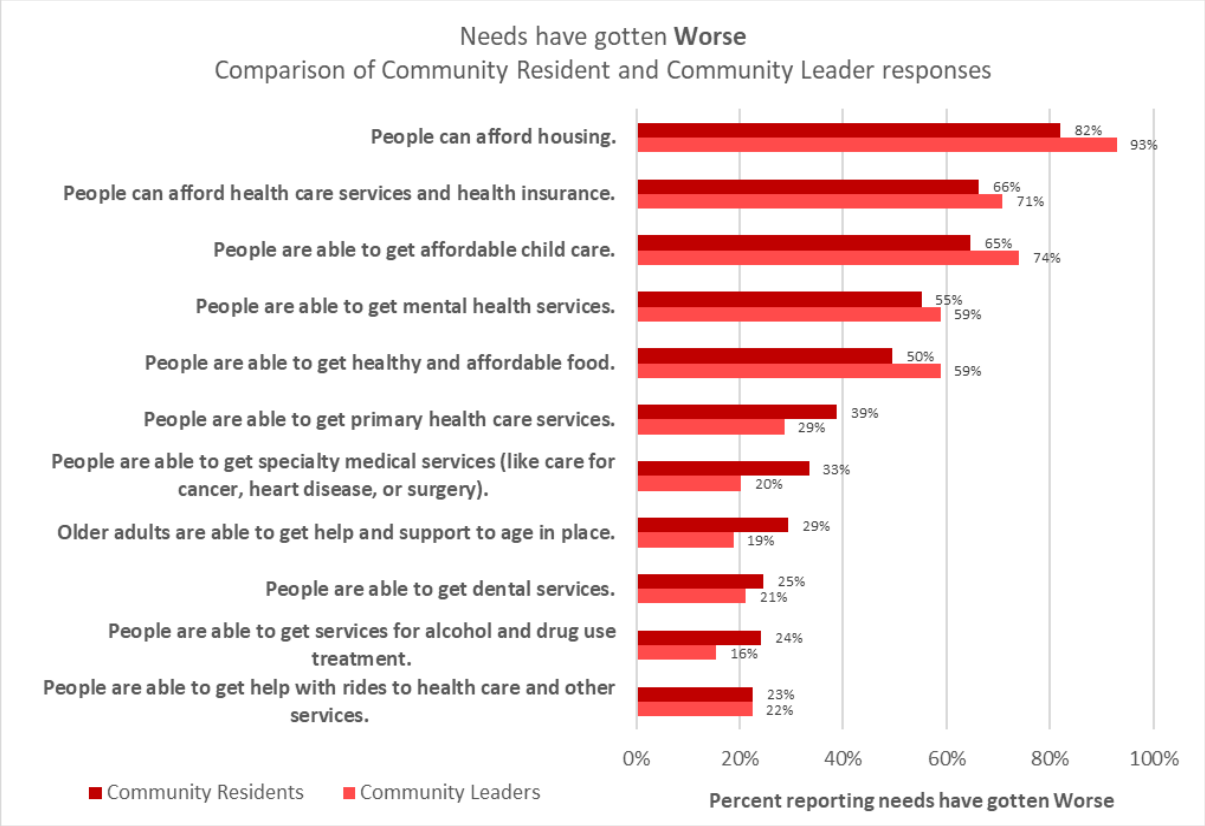


Note: Statements are shown in order of highest to lowest percentage of community resident respondents, indicating the needs are Better.

"(We need) Communication about available resources . . . .Many people feel isolated and lost and don't know where to begin. They give up before starting. If communication was better and resources more easily available and publicized, maybe they'd get more help they need."

- Community Resident Survey Respondent

| Figure 7 |



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

> *"The single biggest complaint I hear is lack of MDs in primary care offices. Second biggest complaint is access to any level provider in primary care offices."*
>
> *- Community Leader, Fire / EMS*

> *"I work with children and parents often ask me about finding therapists because when they reach out, they are turned away due to full caseloads, long waitlists, etc. There is an emphasis on crisis response rather than preventative and ongoing care."*
>
> *- Community Leader, Mental Health*

Each survey also included an open-ended question following the list of historical priority areas, asking*, "Are there other health needs that you think are important for your community to address now?".* A total of 198 comments were received in response to this question. The most common topic areas included:

1. Health care provider availability in general and primary care in particular; wait times, patient-provider communication, and service delivery improvements (32% of all comments addressed this area of concern)
2. Availability of mental health care services
3. Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition
4. Senior services and concerns of aging
5. Housing affordability and availability
6. Multiple, interacting factors affecting health; drivers of health
7. Access to transportation services
8. Affordability of health care and prescription medications
9. Opportunities and facilities for social interaction; reducing social isolation
10. Healthy lifestyles, focus on wellness and exercise

> *"Getting in with a primary care in this area is next to impossible. They send you on a wild goose chase and refer you to the next office, who refers you to the next office, and so on. It took me months to even get an appointment so I ended up looking for a primary care further away from home."*
>
> *- Community Resident Survey Respondent*

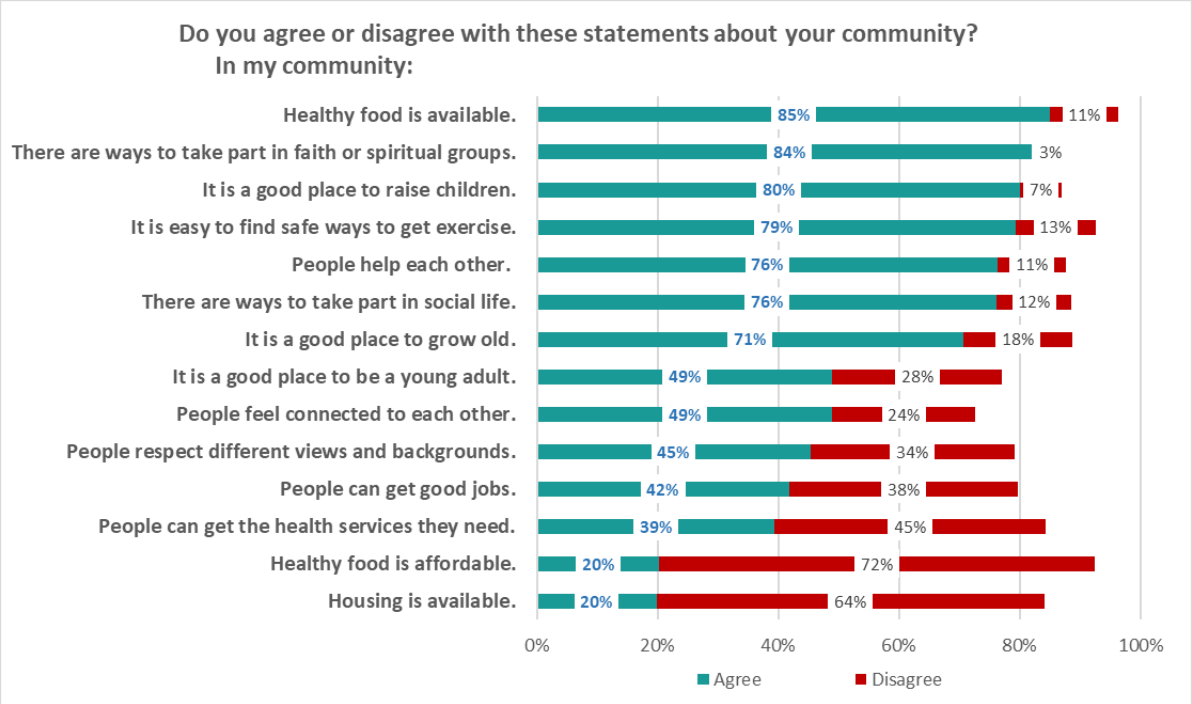
2. Characteristics of a Healthy Community

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

Figure 8 displays the results for this set of questions. Community residents overall were most likely to agree that 'in my community':

- Healthy food is available (85% of survey respondents agree with that statement).
- There are ways to take part in faith or spiritual groups (84% agree).
- It is a good place to raise children (80% agree).
- It is easy to find safe ways to get exercise (79% agree).

| Figure 8 |



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

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

- People can get the health services they need (45% disagree)
- Healthy food is affordable (72% disagree).
- Housing is available (64% disagree).

> *"The price of food has significantly impacted our community's food sources. The use at our food pantries has gone up a lot. Many kids are eating at school and families are not able to pay their lunch/breakfast bills but also are not able to supply breakfast or lunch from home."*
>
> *- Community Leader, Medical Care*

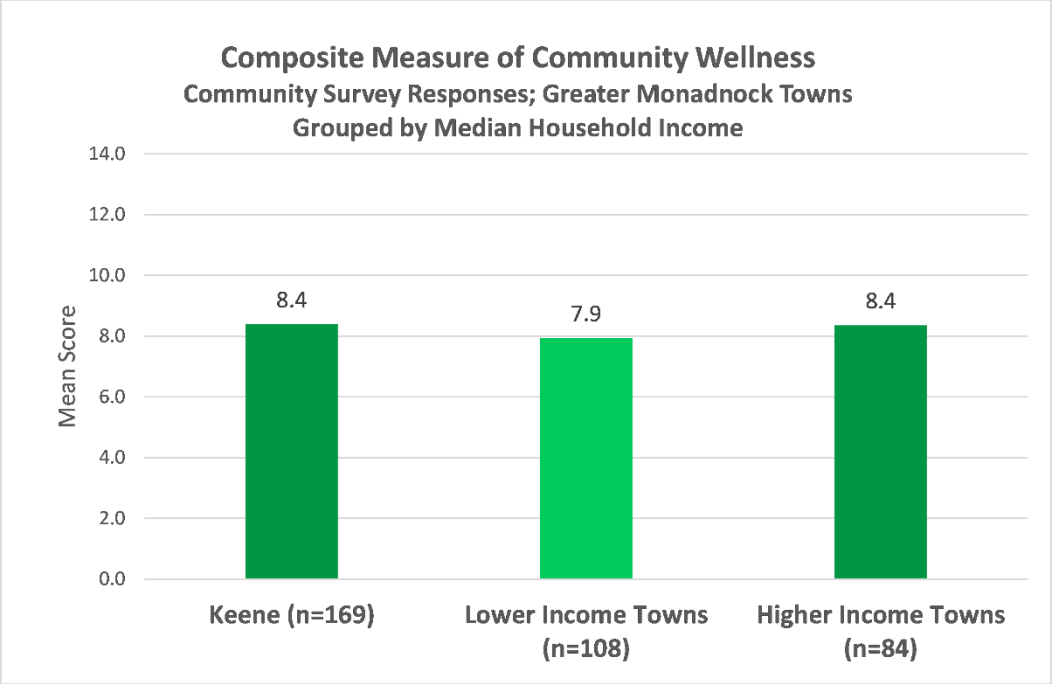
Further analysis of this set of questions was conducted by calculating a composite measure of 'community wellness' for each respondent. Possible scores range from zero to fourteen (14 questions, each question with possible values of 1 or 0), where a score of 14 results when a respondent indicates agreement with each of the 14 statements describing characteristics of a healthy and resilient community. Scores were then aggregated for respondents from 3 sets of communities within the Greater Monadnock region:

1. Keene, the largest community in the region, with 23% of the total population of the region and 44% of respondents to the community survey;
2. Communities other than Keene with median household income less than the regional median of about $86,000 ('Lower Income Towns'; Troy, Bennington, Swanzey, Walpole, Marlborough, Gilsum, Hinsdale, Winchester, Alstead; n=108 survey respondents);
3. Communities with median household income greater than $86,000 ('Higher Income Towns'; Chesterfield, Marlow, Rindge, Dublin, New Ipswich, Westmoreland, Harrisville, Peterborough, Francestown, Sullivan, Hancock, Nelson, Stoddard, Fitzwilliam, Antrim, Jaffrey, Temple, n=84 survey respondents).

Figure 9 on the next page displays the mean composite measure of Community Wellness calculated from responses of residents for each of these community groupings. The mean scores for Keene and the higher-income town group are essentially the same and slightly higher than the scores for respondents from lower-income towns, although the observed difference is not statistically significant.

> *"We need to educate more on the importance of advocating for our own health and how to take care of ourselves because medical care is getting harder and harder to receive."*
>
> *- Community Resident Survey Respondent*

| Figure 9 |



A similar analysis was completed for responses grouped by town proximity to Cheshire Medical Center. The average Community Wellness score for respondents from towns with estimated drive times to Cheshire Medical Center of less than 20 minutes was the same as the result from towns 20 minutes or more from the medical center (Composite Score = 8.1 for each group).

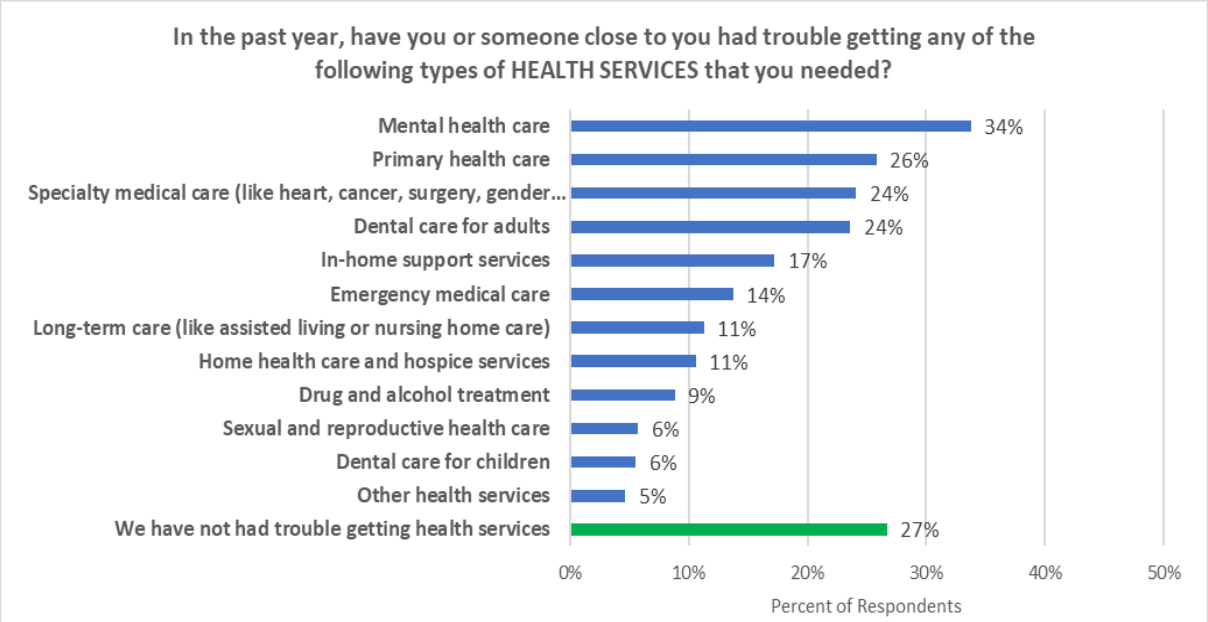
"Too often, people only seek help when something is already wrong, either because they can't afford the care or don't trust the system. By making preventative services not only financially accessible but also normalized and readily available—through mobile clinics, workplace visits, and community partnerships—we could catch issues early, reduce chronic disease, and lighten the burden on emergency services. Prevention isn't flashy, but it works."

- Community Resident Survey Respondent

3. Barriers to Services

Respondents to the Community Resident survey were presented with a list of potential health services and asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **health services** that you needed?"*. As displayed by the chart below, about 34% of respondents reported having difficulty getting 'Mental health care', and 26% had difficulty getting 'Primary health care' over the past year. Other more frequently cited services for access difficulty included 'Specialty medical care' (24%), 'Dental care for adults' (24%), and 'In-home support services' (17%).

| Figure 10 |



"As an educator, I see the need for counseling and mental health services as a priority need. Also, parenting classes that reach more than just the larger towns/cities

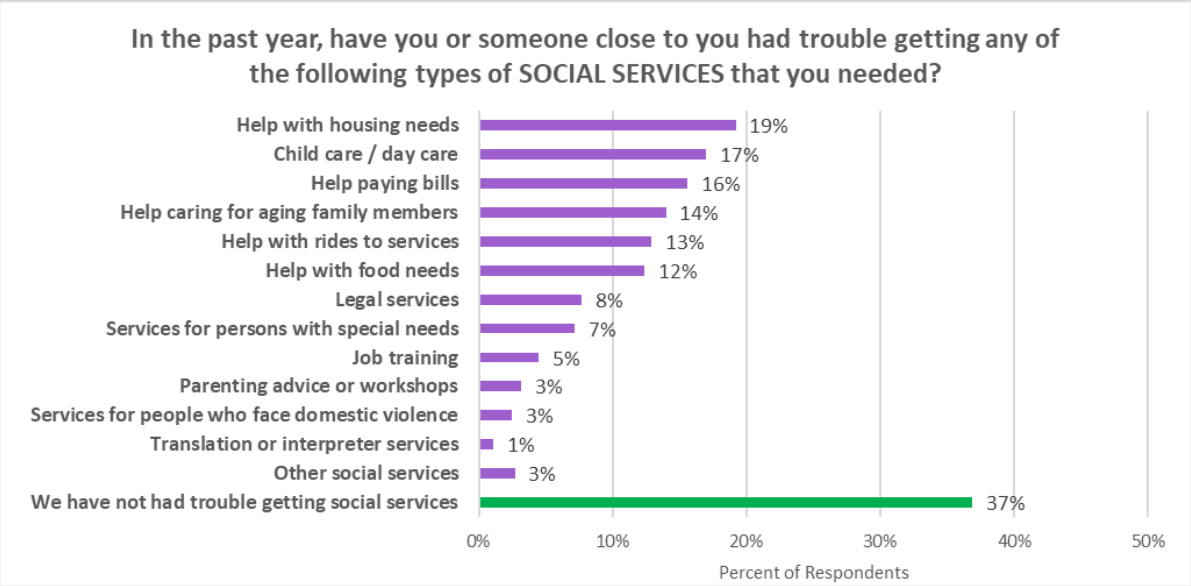
- Community Leader, K-12 Education

"We need to do a better job with primary care and routine health maintenance. The health care system is broken and the majority of people come to the ER for basic Healthcare, things that could easily be handled outpatient."

- Community Resident Survey Respondent

On a similar question, the Community Resident survey asked, *"In the past year, have you or someone in your household had trouble getting any of the following types of **social services** that you needed?"***.*** As displayed by Figure 11, about 19% of respondents indicated having difficulty getting 'Help with housing needs', and 17% had difficulty getting 'Child care / Day care' over the past year. Other more frequently cited social services for access difficulty included 'Help paying bills' (16%), 'Help caring for aging family members' (14%), 'Help with rides to services' (13%), and 'Help with food needs' (12%).

| Figure 11 |



"Many people are isolated and in need of people to people connection, networking and help understanding healthcare, health insurance, finding jobs and housing."

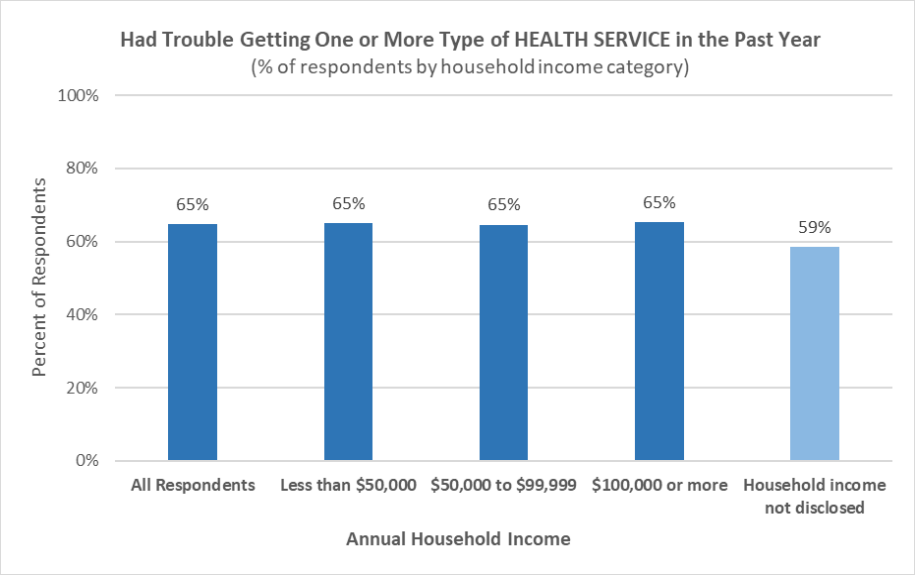
- Community Resident Survey Respondent

"With the aging population & the amount of children caring for their aging parents, it would be nice to see some support groups for the caregivers or resources for respite care so they can have a break... most people do not know how to get help with this."

- Community Resident Survey Respondent

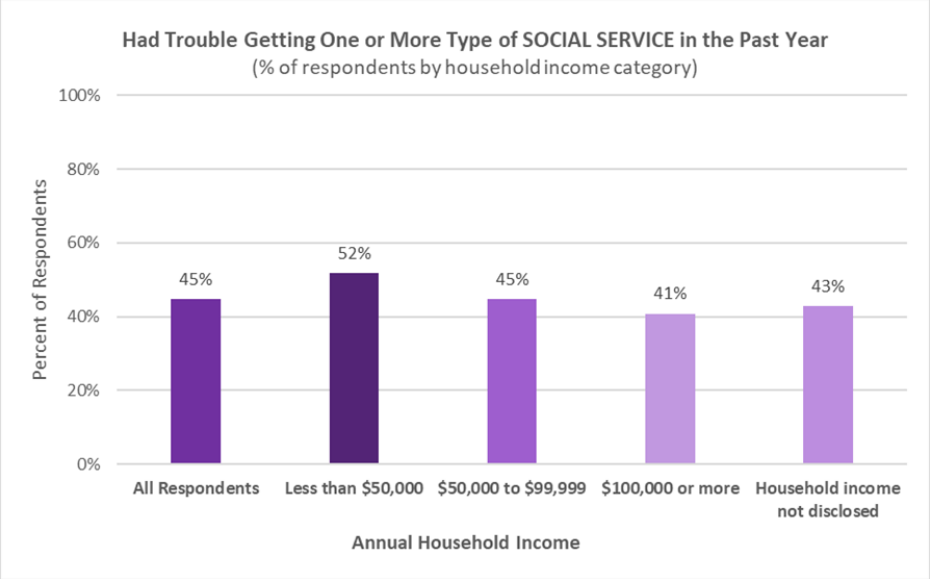
In general, survey respondents were more likely to report difficulties accessing health services than social services, which may in part be a function of different proportions of the population overall attempting to access certain health or social services within a defined period of time. About 65% of all survey respondents reported having difficulty accessing at least one type of health service. Figure 12 displays the percentage of survey respondents reporting any access difficulty by income category. There was no difference across income brackets in the percent reporting difficulty accessing health services. Respondents who declined to report household income were somewhat less likely to report difficulty accessing health services.

| Figure 12 |



As displayed by Figure 13, about 45% of survey respondents reported having difficulty accessing at least one type of social service. Respondents with household incomes less than $50,000 were somewhat more likely to report difficulty accessing at least one type of social service (52%), although this difference is not statistically significant.

| Figure 13 |



Survey respondents who reported difficulty accessing **health services** in the past year for themselves or a household member were asked a follow-up question about the reasons why they had difficulty for each type of service selected. As displayed by Table 6, "Service not available", "Not accepting new patients" and "Wait time too long" were the most common reasons cited for difficulty accessing Mental Health Care, Primary Health Care, and Specialty Medical Care. For Adult Dental Care, issues of cost and insurance were the top reasons cited for access difficulties.

| TABLE 6. Top Reasons Respondents Had Difficulty Accessing Health Care Services by Type of Service |

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

MENTAL HEALTH CARE (n=153, 34% of respondents)	**PRIMARY HEALTH CARE** (n=117, 26% of respondents)	**SPECIALTY MEDICAL CARE** (n=109, 24% of respondents)	**DENTAL CARE FOR ADULTS** (n=107, 24% of respondents)
63% of respondents who indicated difficulty accessing Mental Health Care also selected **"Service not available"** as a reason	**56%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Not accepting new patients"** as a reason	**77%** of respondents who indicated difficulty accessing Specialty Medical Care also selected **"Wait time too long"** as a reason	**56%** of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Cost too much"** as a reason
Wait time too long (61%)	**Wait time too long (31%)**	**Not accepting new patients (43%)**	**No insurance or not enough insurance (56%)**
Not accepting new patients (51%)	**Service not available (30%)**	**Service not available (43%)**	**Not accepting new patients (36%)**
Cost too much (28%)	**Cost too much (23%)**	**Cost too much (29%)**	**Wait time too long (29%)**
No insurance or not enough insurance (27%)	**No insurance or not enough insurance (20%)**	**No insurance or not enough insurance (18%)**	**Service not available (27%)**
Did not know where to go (22%)	**Not open when I could go (16%)**	**Had no way to get there (8%)**	**Did not know where to go (10%)**

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

"Children's mental health providers are even harder to find for families than adult service providers and the lists are long and people are hard to find."
Community Leader, K-12 Education

Survey respondents who reported difficulty accessing **social services** were similarly asked a follow-up question for each type of service selected about the reasons why they had difficulty. As displayed by Table 7, "Cost too much" was the most common reason cited for difficulty accessing 'Help with housing needs' (63%), 'Child care / Day care' (77%), and 'Help caring for aging family members' (56%). 'Did not know who to call' was the most common reason cited for difficulty getting 'Help paying bills' (46%).

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

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

HELP WITH HOUSING NEEDS (n=85, 19% of respondents)	CHILD CARE / DAY CARE (n=75, 17% of respondents)	HELP PAYING BILLS (n=69, 16% of respondents)	HELP CARING FOR AGING FAMILY MEMBERS (n=62, 14% of respondents)
63% of respondents who indicated difficulty accessing Help with Housing Needs also selected **"Cost too much"** as a reason	**77%** of respondents who indicated difficulty accessing Child Care / Day Care also selected **"Cost too much"** as a reason	**46%** of respondents who indicated difficulty accessing Help paying bills also selected **"Did not know who to call"** as a reason	**56%** of respondents who indicated difficulty accessing Help with rides to services also selected **"Cost too much"** as a reason
Wait time too long (58%)	**Wait time too long (63%)**	**Service not available (34%)**	**Service not available (50%)**
Service not available (32%)	**Not accepting new clients (47%)**	**Cost too much (31%)**	**Wait time too long (37%)**
Did not know who to call (24%)	**Service not available (47%)**	**Shame or stigma (26%)**	**Did not know who to call (34%)**
Not accepting new clients (20%)	**Not open when I could go (11%)**	**Wait time too long (12%)**	**Not accepting new clients (19%)**

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

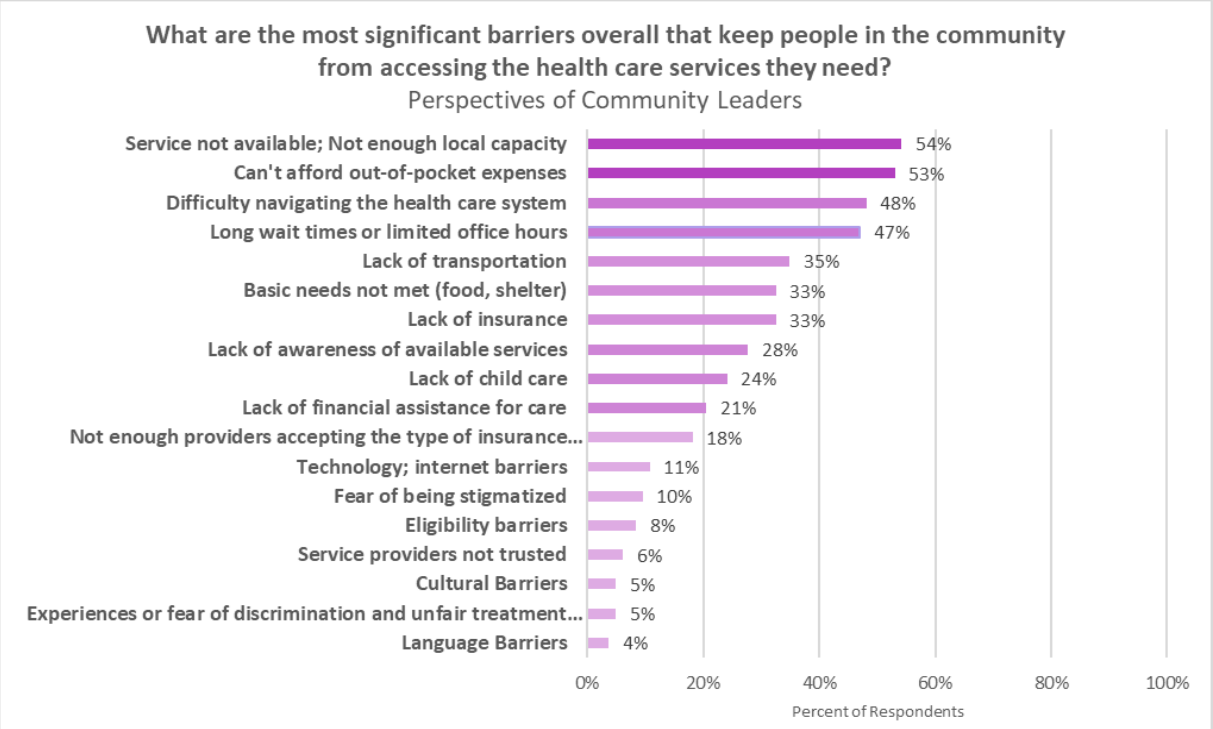
"Another concern is the need for a social worker at the senior center. Many aging adults seeking socialization have questions about medical care, housing, benefits, scams etc., but they don't know what to do."

- Community Resident Survey Respondent

In a separate question, Community Survey respondents were asked: *"In the past year, how often have you or someone close to you missed getting health care or social services because of unfair treatment?"*. 'Unfair treatment' was further specified as "discrimination or stigma based on your race, religion, ethnicity, gender, sexual orientation, age, disability, language, or education". Overall, 3% of respondents indicated that they or someone in their household had "Often" missed getting health care or social services because of unfair treatment, 13% indicated "Sometimes", and 84% indicated "Never" missing health care or social services because of unfair treatment.

Respondents to the Community Leader survey were asked to identify the most significant barriers overall that prevent people in the community from accessing needed health care services. The survey included a list of 18 potential barriers (and a write-in option) from which respondents were asked to select the top 4 barriers to health care access. The top issue identified by this group was 'Service not available; not enough local capacity' (54% of community leaders chose this barrier), followed by 'Can't afford out-of-pocket expenses' (53%), 'Difficulty navigating the health care system (48%), and 'Long wait times or limited office hours' (47%).

| Figure 14 |

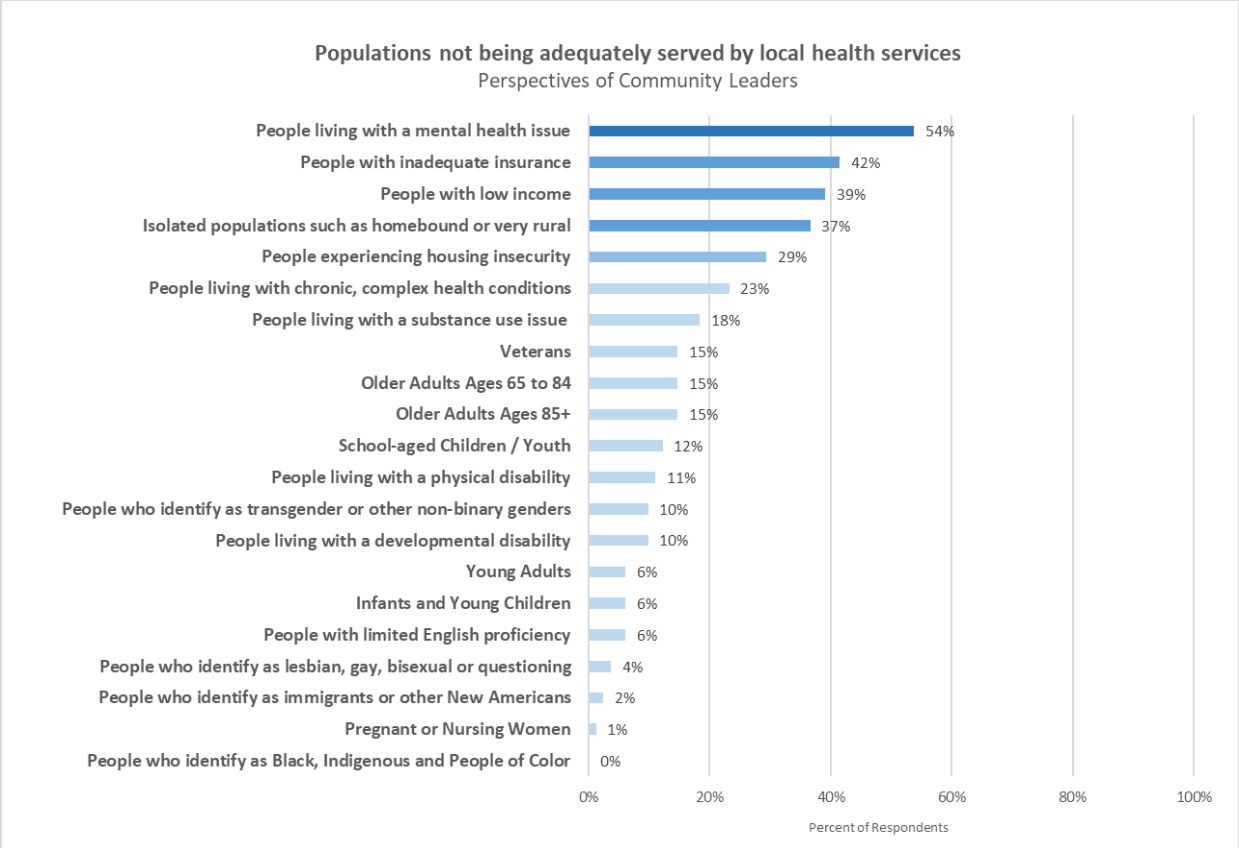


> *"I am hearing from people who are having extreme difficulty accessing urgent and emergency care. Wait times are several hours. People who do have a PCP wait months for an urgent appointment."*
>
> *Community Leader, Fire / EMS*

Community Leaders were also asked if there are specific populations in the community that are not being adequately served by local health services. Populations most frequently identified by Community Leader survey respondents as underserved (Figure 15) were people living with a mental health issue, people with inadequate health insurance, people with low income, isolated populations such as homebound or very rural, and people experiencing housing insecurity.

In a related question, Community Leaders were asked, *"Are there particular types of health providers, specialties, or services that are needed in the community due to insufficient capacity or availability?"* A majority of respondents (71%) responded affirmatively. When asked to comment in an open-ended follow-up question, mental health was the most commonly cited service with insufficient capacity or availability (43% of those indicating any specific type of provider or service), followed by about 24% of community leader respondents reporting a need for additional primary care provider capacity.

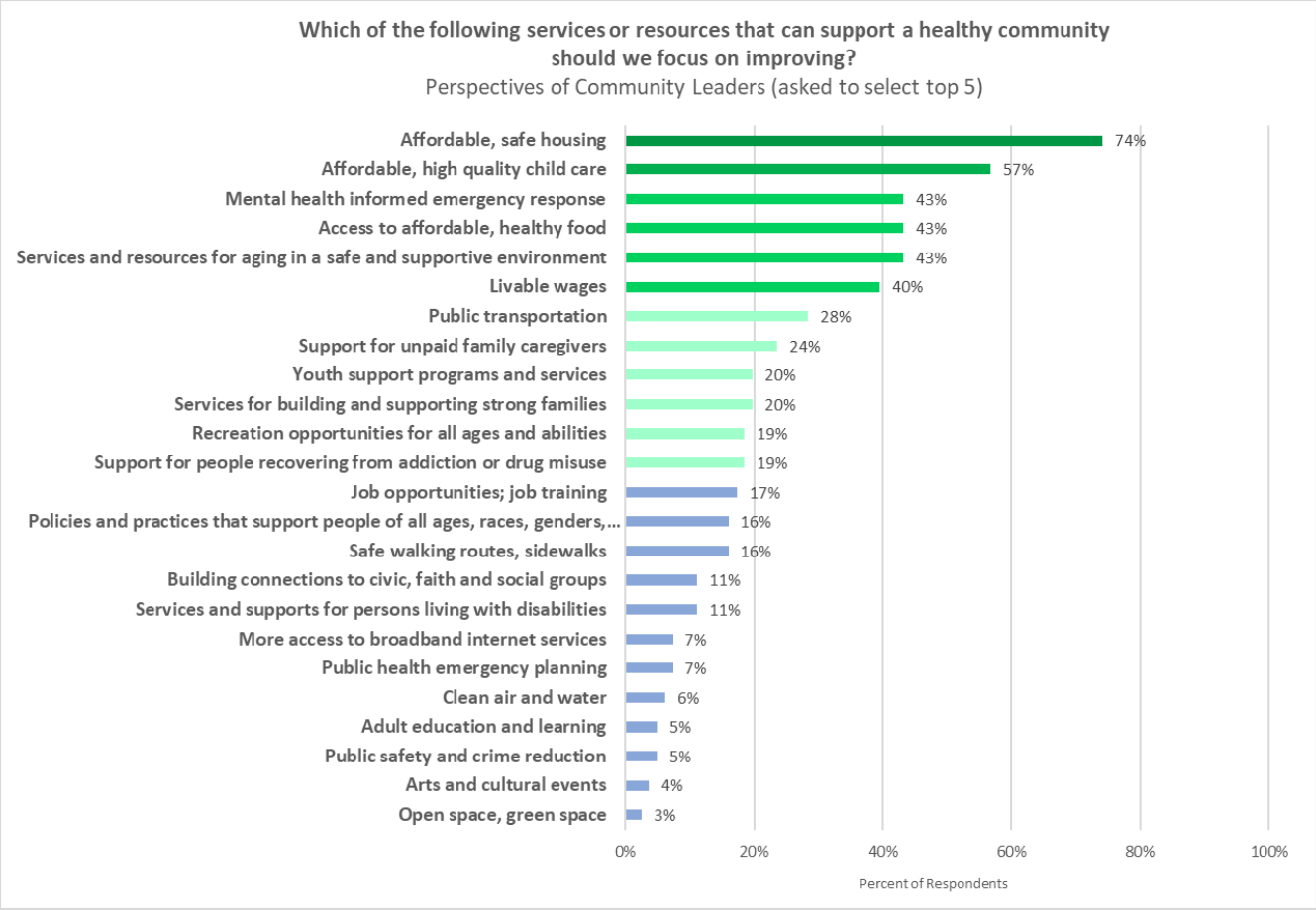
| Figure 15 |



4. Services and Resources to Support a Healthy Community

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

| Figure 16 |



As displayed by Figure 16, 'Affordable, safe housing' was by far the most frequently selected resource, identified by 74% of respondents as an area the community should focus on to support community health improvement. Other top focus areas are Affordable, high-quality child care; Mental health-informed emergency response; Access to affordable, healthy food; and Services and resources for aging in a safe and supportive environment.

5. Interest in Specific Community Health Programs or Services

Community members were asked a variation on the question of community services or resources to support health. Community residents were asked, *"Would you or your family use any of these services if they were more available in your community?".* The survey instrument included a list of 31 topics organized into 6 overall conceptual groups as follows: Services for Children and Parents; Services for Older Adults; Healthy Living Programs; Counseling and Mental Health Services; Health Care Services; Community Services and Supports. Survey respondents could select any number of individual topics from across the different topic groups. The highest amount of interest was reported for Recreation and Fitness programs (Figure 17). Other services most frequently mentioned were mental health services, nutrition programs, bike and walking paths, and public transportation.

| Figure 17 |

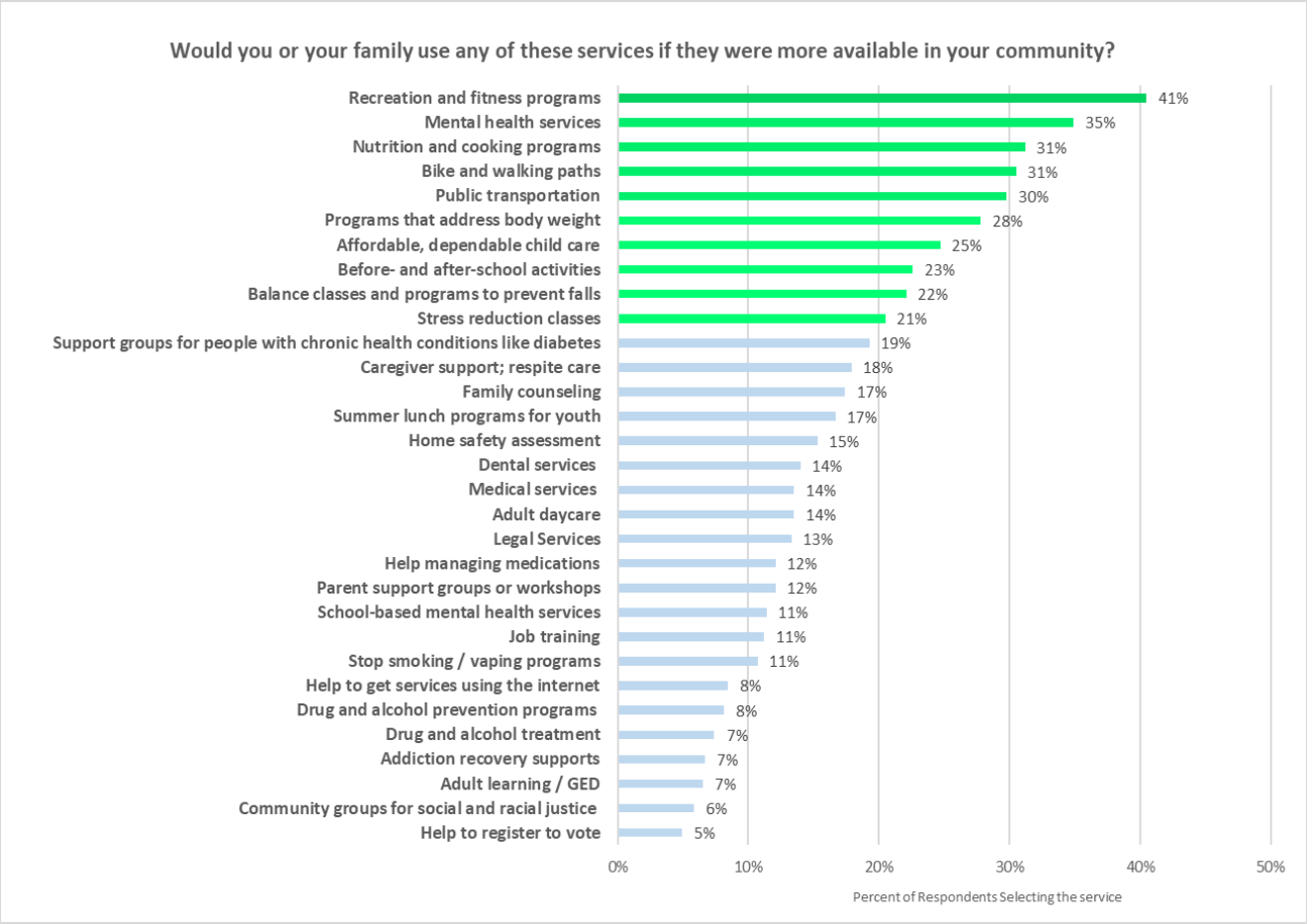


Table 8 displays the top programs or services of interest by age group. 'Recreation and Fitness programs' was the most frequently selected across all ages as a resource people would use if more available. About half of the respondents under age 45 also selected 'Mental Health Services', 'Affordable, dependable child care', and 'Before- and after-school activities'. About one-third of respondents age 65 and older indicated interest in 'Balance classes and programs to prevent falls'. Table 8 also includes a breakdown of responses from people with children in their household. These results are similar to the results for the under-45 age group.

| TABLE 8. Top services or resources people would use if more available, by Age Group |

Age 18-44 (n=112)		Age 45-64 (n=158)		Age 65+ (n=143)		Households with children (n=122)	
Recreation and fitness programs	52%	Recreation and fitness programs	41%	Recreation and fitness programs	34%	Recreation and fitness programs	49%
Mental health services	51%	Mental health services	37%	Balance classes and programs to prevent falls	32%	Mental health services	48%
Affordable, dependable child care	48%	Bike and walking paths	35%	Public transportation	25%	Before- and after-school activities	45%
Before- and after-school activities	46%	Nutrition and cooking programs	34%	Bike and walking paths	23%	Nutrition and cooking programs	40%
Nutrition and cooking programs	42%	Public transportation	32%	Programs that address body weight	22%	Affordable, dependable child care	38%
Summer lunch programs for youth	37%	Programs that address body weight	29%	Mental health services	20%	Summer lunch programs for youth	38%
Bike and walking paths	34%	Caregiver support; respite care	22%	Nutrition and cooking programs	20%	Bike and walking paths	32%

"I think our community would benefit from supporting one another in various ways. How can we rely on one another rather than the systems that continue to fail? This might look like different organizations taking turns putting on free family dinners, creation of affinity groups, clothing swaps, putting more energy into the Monadnock Time Exchange, hosting workshops that help people build useful skills that are affordable, bringing people across socioeconomic statuses together, enhance cultural opportunities, etc."

Community Leader, K-12 Education

Table 9 displays results for the question on services people would use if more were available, grouped by proximity of towns to Keene. Responses from towns with estimated average drive times to Cheshire Medical Center of less than 20 minutes are grouped together in the second column of the table, and responses from towns that are 20 minutes or more from the medical center are in the third column.

Overall, the services or resources of greatest interest are similar across towns, including the same top three services: Recreation and fitness programs, Mental health services, and Nutrition and cooking programs. Residents of Keene were somewhat more likely to select Affordable, dependable child care and Stress reduction classes, while residents of other towns were more likely to select Balance classes and programs to prevent falls.

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

Keene (n=176 respondents)		Nearby Towns (n=78)		Outlying Towns (n=127)	
Recreation and fitness programs	43%	**Recreation and fitness programs**	44%	**Recreation and fitness programs**	42%
Mental health services	35%	**Mental health services**	33%	**Mental health services**	33%
Nutrition and cooking programs	33%	**Nutrition and cooking programs**	32%	**Nutrition and cooking programs**	30%
Bike and walking paths	33%	**Bike and walking paths**	32%	**Public transportation**	29%
Public transportation	30%	**Public transportation**	31%	**Programs that address body weight**	29%
Affordable, dependable child care	28%	**Balance classes and programs to prevent falls**	27%	**Bike and walking paths**	27%
Stress reduction classes	26%	**Programs that address body weight**	26%	**Balance classes and programs to prevent falls**	24%

'Nearby towns' include Swanzey, Marlborough, Gilsum, Sullivan, Westmoreland, Chesterfield, Nelson, and Troy. 'Outlying towns' include Winchester, Hinsdale, Walpole, Alstead, Marlow, Fitzwilliam, Jaffrey, Hancock, Rindge, Stoddard, Dublin, Harrisville, New Ipswich, Antrim, Bennington, Peterborough, Francestown, and Temple.

"I work with a lot of low income families and without transportation they are just limited. We need a reliable public transportation that runs to and from town consistently."

- Community Resident Survey Respondent

The 2025 Community Health Needs Assessment Survey asked people to respond to the question, *"If you could change one thing that you think would improve health in your community, what would you change?"* A total of 241 survey respondents (48%) provided written responses to this question. Table 10 provides a summary of the responses by theme.

| TABLE 10 |
"If you could change one thing that you believe would improve health in your community, what would you change?"

Health care provider availability, including primary care and other specialties; Workforce shortages; Health care delivery system improvements, including wait times, patient-provider communication, quality, and options;	**68 comments (28% of total)**
Availability, affordability of mental health services; Mental health awareness and stigma;	**26 (11%)**
Affordability of health care, including prescriptions, low-cost or subsidized services; Health insurance costs; Health care payment reform;	**24 (10%)**
Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition;	**18 (8%)**
Improved resources, programs, or environment for physical activity, active living; Affordable recreation and fitness;	**15 (6%)**
Affordable housing; Workforce housing;	**14 (6%)**
Caring community, culture; Community diversity and acceptance; Facilities and opportunities for social interaction; Reducing social isolation;	**13 (5%)**
Senior services; Concerns of aging; Home health care, assisted living; Supports for adults with disabilities;	**11 (5%)**
Improved transportation services, public transportation; Medical transportation;	**9 (4%)**
Community Safety / Environment; Physical infrastructure and accessibility;	**9 (4%)**
Substance misuse prevention and treatment; Illegal drug availability;	**9 (4%)**
Healthy lifestyle education; Focus on wellness and prevention;	**6 (3%)**
Resources for supporting healthy youth and families; Cost of living, including affordable child care;	**6 (3%)**
Improved awareness, communication of available services and resources;	**2 (1%)**
Other comments; No changes, satisfied	**12 (5%)**

C. COMMUNITY HEALTH DISCUSSION THEMES AND PRIORITIES

Between March 2024 and May 2025, the Community Health Needs Assessment Planning Committee worked with community partners to convene discussion groups with residents representing a variety of communities, lived experiences, and perspectives. In total, eight discussion groups were conducted, four of which were specifically focused on the Greater Monadnock region, and four discussion groups were convened in collaboration with Dartmouth Health partners and with a broader regional focus across the wider Dartmouth Health system service area.

The discussion groups sought to obtain more in-depth qualitative input on common health needs and issues; to identify perceived improvements in services, supports, or resources; and to gather suggestions from participants about what healthcare organizations could do better to support health in our communities. Discussion groups sought input from a variety of community groups, interests, and resources, including the Monadnock Youth Coalition, the Cheshire Patient Family Advisory Council, The Community Kitchen, and the Keene Senior Center. Broader system discussion groups included Behavioral Health Case Managers from agencies across the region, representatives of the LGBTQIA+ community, the Dartmouth Affinity and Belonging Council, and regional business leaders.

As part of the discussion activities, priority issues from similar community conversations in previous needs assessments were shared. Participants were asked if they thought those issues were still the most important, and if there were new or different issues they considered a higher priority. The priorities informed by previous Community Health Needs Assessments were listed as:

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

The following sections summarize the main health-related themes identified through the discussion groups. Anonymous quotes from discussion group participants are included to illustrate important themes.

Health Concerns and Priorities

This section outlines responses to the first three questions asked of discussion group participants:

1. *What do people you know worry about most when it comes to their health and their family's health?*
2. *A few years ago, a similar round of community conversations helped to identify some high-priority health issues for our region. Some of these priorities were: (list on previous page displayed, reviewed).*

   Do you think these are still the most important health-related issues for our community to address?
3. *Are there other health issues that should be added to the list or are of a higher priority?*

Areas of Improvement

Accompanying these questions was a prompt to ask participants if they had observed any improvements in the past few years in the previously identified health priorities and concerns. Any improvements noted are included within each section as applicable.

The discussion groups reflected diverse concerns about health and well-being. A qualitative analysis with key themes and recurring messages has been summarized into five priority health sections:

1. Health Care Access
2. Health Care Insurance
3. Specialty Care Needs, including mental health, substance use, LGBTQIA+, and senior care
4. Community Cohesion, including social isolation and civic engagement
5. Socioeconomic Barriers

> *"It's like we're watching a shoe drop in slow motion, but not knowing where it's going to land."*
>
> *- Discussion Group Participant*

Overall, responses to these questions indicate frustrations with systemic barriers to healthcare, such as accessibility and affordability, including insurance coverage. Specialized care – such as behavioral health, aging-related services, and substance use treatment and recovery – emerged as critical areas for intervention. Discussion group feedback also highlighted a strong sense of urgency to address several foundational social determinants of health, particularly housing, childcare, and economic stability, and a desire for greater community cohesion to help decrease rising isolation.

Health Care Access

Access to health care remains a significant challenge throughout the community. Contributing factors described by group participants included high provider turnover, long wait times for appointments of any kind of care, a lack of public or reliable transportation, particularly in more rural areas, and communication issues.

People specifically noted a lack of primary care providers (PCPs) and high turnover, which interrupts continuity of care. People want to see a healthcare provider who knows them and their medical history, but in the current healthcare landscape, people feel that does not seem possible.

Areas of Improvement

Internships among hospitals that help supplement physician availability have been a step in the right direction.

Physical barriers to care like transportation are top-of-mind for local partners and organizations, and there have been modest improvements.

This 'revolving door' of providers has forced patients – especially seniors – to cycle through multiple doctors in increasingly shorter periods of time. Those without a PCP face even greater challenges, as many practices will not accept new patients without referrals.

These staffing challenges are further exacerbated by the relatively rural nature of the region, with socioeconomic factors impeding new providers from moving to the area, such as low housing stock, few social opportunities, and higher costs of living.

Many participants also noted that there was significant emergency department overuse in the community, with the emergency room (ER) being used as a fallback when other systems fail. This practice is perceived as being widespread among residents, leading to overcrowding and increased frustration for both patients and providers. This situation also results in a lack of access to necessary urgent care or, for true medical emergencies, as people will often say whatever they need to in order to get seen quickly (e.g., "I might be having a heart attack" is reportedly used as a shortcut to care).

> *"Our community members often use the ER like urgent care… which isn't helped by the urgent care centers also being flooded. We need to find a better way to educate the community about what is appropriate ER use."*
>
> *- Discussion Group Participant*

In the broader regional system discussion sessions, marginalized groups, such as the uninsured, those with complex healthcare needs, LGBTQIA+, and racial or ethnic minorities, shared the sense of being underserved and underrepresented by the healthcare system.

Finding and accessing culturally competent and diverse healthcare providers is a challenge that exacerbates care disparities. Implicit bias and the lack of diversity among healthcare providers are perceived to negatively impact the quality of care for Black, Indigenous, and People of Color (BIPOC). Quality of care was also noted as an issue in these discussions, where perceived stigma and bias – especially for minority groups and individuals needing substance use treatment – affect delivery of appropriate services.

> *"Cheshire needs to have a greater presence in the community, acting as health experts, training residents about ER usage, addressing community perceptions (and misconceptions), and providing clarity about the broader system. We need to be viewed as a trusted entity."*
>
> *- Discussion Group Participant*

Discussion placed emphasis on the importance of connections among community organizations and providers, and that more leadership or accountability is needed in this area. Bringing all the various service providers together and finding more ways to regularly connect and share resources seemed a possible solution to the access issues residents are having. Some participants were unaware of what resources or services other individuals in the discussion groups knew about or worked with, which offered an example of how the residents, overall, were likely to also be unaware of what is available to them.

Areas of Improvement

Some towns have pulled together helpful materials with clear information on resources and services available to residents.

Communication in general was noted as problematic. Whether between various types of providers, providers and insurance, or local organizations that offer services patients may need, finding a way to ensure all systems are communicating effectively was mentioned frequently as a need for improvement.

Health Care Insurance

Health insurance coverage was described as a labyrinth of misinformation, denials, and gaps. Providers often seem unsure or unclear about what insurers will cover, leading to confusion and delays for patients.

Referral processes were described as excessive and redundant, with patients required to repeat the same appointments for chronic conditions, wasting both time and money.

Senior participants and those who work with or have loved ones who are seniors note that navigating the constantly shifting Medicare options creates unnecessary struggle and confusion. This situation can create decision fatigue and insecurity around healthcare planning for seniors.

For people without insurance, participants noted that medical care feels virtually inaccessible. If individuals are able to find a provider, eligibility requirements, electronic portals, and miscommunication between providers and insurance companies present major hurdles. Even when insured, discussion participants described situations where a necessary service was not covered.

> *"People have a really hard time navigating all of the different Medicare options that are available as they age into eligibility, and everything seems to change from year to year which makes it difficult and confusing to try and offer help."*
>
> *- Discussion Group Participant*

Insurance was cited as a key reason for delays in mental health treatment, whether for a lack of insurance or because their existing insurance does not sufficiently cover such mental health care. Families reported being forced to settle for inappropriate levels of care (e.g., outpatient care when inpatient care is needed, or nothing at all when step-down care is needed).

Specialty Care Needs

Access to various kinds of medical specialty care in the Monadnock region is particularly limited, according to participants, who note that wait times for appointments are often months-long. Travel to tertiary health centers or hospitals can be burdensome, requiring half-day commitments and creating barriers for those with mobility or transportation limitations.

Dental care was also mentioned in most groups as having low availability or access. While mentioned in every group, it was primarily touched upon as a persistent issue without further details specified in comparison to other topics of discussion, such as mental health.

Mental Health Care: Participants described a growing mental health and substance use crisis, both individually and where these two conditions overlap. These concerns are marked by limited access to timely and appropriate services. Long wait times and inadequate Medicaid coverage, especially for children and youth, have worsened access to mental health care. And, despite a noted increase in community awareness about these issues, funding and resources are perceived as inadequate to meet the rising demand.

Participants stressed that youth are underserved in their mental health needs within the region. Embedded mental health counselors in schools face overwhelming caseloads, leaving many students underserved. Resources for individuals with serious mental illness and those in recovery remain scarce. The lack of integrated services for individuals with dual diagnoses further complicates care.

> *"We don't have nearly as many step-down programs as we need for kids. Having some kind of transitional/in-between support would be so beneficial. And understanding levels of care is essential – some people need higher levels of care, but not the HIGHEST level of care."*
>
> *- Discussion Group Participant*

Even where services do exist, waitlists are long, and turnover undermines provider or therapist trust. Some participants voiced discouragement when children they work with or their own children would finally get connected to a therapist, only to lose the provider months later. This lack of continuity leaves patients feeling discouraged and unheard, compounding their already existing mental health struggles.

There are broader impacts of a lack of adequate mental health care. Concerns mentioned within the groups were tied to community burnout, social isolation, and civic disengagement. Some feel that COVID amplified this and that there are still remnants of the pandemic that affect communities currently. Participants feel people are still struggling to "show up" through community engagement or volunteerism, all of which directly impact well-being.

> *"There's a general need to decompress and find help… we are often asked 'Where can I go to talk to somebody?' "- Discussion Group Participant*

Concerns for the mental health of providers was noted frequently as well. Mental health trainings were mentioned as helpful – when available or cost-effective – for staff members in certain lines of work, not just mental health professionals. Community organizers or workers mentioned that the mental stress of their work impacts their volunteers as well as employees. In places where individuals are attempting to access basic needs, such as food pantries or shelters for those experiencing homelessness, staff can be really affected by the stress residents are feeling. Proper and timely resources for mental health support of staff and volunteers are needed.

Substance Use: Another common theme among discussion groups was a perceived lack of resources for substance use recovery and treatment across a variety of specific populations. A particular gap exists in youth-focused recovery, treatment, and transitional programs, with most existing services for these needs focused on serving adults. It was noted that most youth-focused efforts are in the area of substance misuse prevention. This "massive lack" was seen as a key reason why some young people cycle deeper into substance use without support.

For adults in the area, there were some perceived improvements in the availability and capacity of substance use treatment and recovery resources. However, those services are still described as overburdened and hard to access. Insurance referral hurdles add delays, and people in need of these services often lack reliable transportation to consistently reach them. Some participants identified the need for outpatient detox programs and more long-term treatment beds. Another issue identified along the continuum of care is the lack of post-treatment continuity with recovery services and transition back into the community.

> *"There are so many complexities to consider that really compound issues… like unhoused people, they can't access medical care, insurance coverage, community resources, stable employment… how are they expected to recover?"*
>
> *-Discussion Group Participant*

Senior Care: Discussion group participants described certain vulnerabilities specific to seniors in the region. Both short- and long-term care were noted as issues. Long-term care was identified as being extremely difficult to find, especially if seniors do not have a personal support system. Participants felt that more education is needed to help individuals plan ahead for long-term caregiving needs, have conversations about aging with providers, and understand the different services available to them. It was noted that seniors with medical care needs often end up using the wrong services – such as longer than necessary inpatient hospital stays or frequent calls for ambulance services – because of a lack of adequate support systems and more appropriate caregiving resources.

Transportation is one of the most persistent barriers for older adults, especially in rural areas who often cannot drive long distances and where public transportation is lacking. While some volunteer programs help, the demand exceeds volunteer availability. Longer trips for medical sub-specialty care appointments are particularly taxing for drivers and patients.

Without reliable transportation, seniors not only face delays in attending (sometimes urgent) medical appointments, but also have challenges accessing groceries or attending social events, leading to poor nutrition and heightened isolation. In some cases, rides to medical

appointments with volunteer drivers may be the only social interaction some seniors have for days at a time.

Financial insecurity among seniors, with many living on fixed incomes, is a widespread, underlying source of vulnerability. Even modest expenses (such as a $75 annual membership at a senior center) can become barriers. Rising costs of food, housing, and healthcare services have been outpacing fixed budgets.

Areas of Improvement

Organizational leaders in the area note that social events with a healthy food component are particularly successful, because people are more likely to eat well as they are engaging with others.

Programs offering chair yoga at senior centers have been successful and well-attended, as well as other chair-exercises to promote strength and balance.

Food insecurity is a related concern for seniors in the area, compounded by a lack of funds, transportation, and social needs. Participants noted how essential nutrition is to health and well-being, and that there is room for improving the tie between food support programs and social needs. Additionally, ensuring seniors get the requisite exercise they need is especially important, as aging populations tend to get less and less exercise and start to lose more muscle mass. Participants voiced concern about limited opportunities or methods of safe exercise for seniors due to inaccessibility or cost.

Medicare coverage was described as confusing and ever-changing, leaving many seniors uncertain about what care is covered year-to-year. Seniors often rely on their providers to interpret their coverage and provide clarity, but misinformation and/or miscommunication can add stress and increase delays in care.

LGBTQIA+: Mental health and substance use issues among people in the LGBTQIA+ community were a topic of discussion. The ability for young people in this community to access care and support and to understand resources available to them is crucial. Social stigmas and a lack of competent care for LGBTQIA+ individuals are seen as increasing the risk of substance use and mental health problems.

LGBTQIA+ individuals (and particularly LGBTQIA+ youth) face unique mental health challenges. In addition to general challenges and barriers to accessing mental health services, the absence of culturally-responsive, gender-affirming care options is a specific need. The lack of these services can reinforce feelings of being unheard and unsupported, compounding a sense of isolation, stigma, and other strains on mental health.

Community Cohesion

Discussion groups touched on issues of community cohesion, often framed around social isolation, civic participation, and the overall "climate" of their communities. Some of these concerns describe a community that feels socially disconnected, with residents who are stretched too thin, and the universal need for intentional spaces of belonging and engagement.

Several groups expressed concern about the erosion of civility and empathy in their communities. Distrust of institutions was a common theme, including, in some cases, distrust of the health care system. For example, the frustration previously described that some patients experience regarding responsiveness of the health care providers (e.g., calls not being returned, appointments being cancelled, high turnover) can lead to skepticism about their hospital or doctor's office commitment to treating their patients.

> *"We have clients who don't feel assured that we will be able to actually offer certain resources. We're all resource-insecure, and it only worsens the lack of trust."*
>
> *-Discussion Group Participant*

Social Isolation: Participants described youth, families, and seniors in rural areas as being increasingly isolated, with many parents burned out from economic pressures and lacking the capacity to engage in community events. Exacerbating this issue, existing community events are often either under-advertised, cost money, or have their own specific barriers to entry. Such barriers tend to further exclude more vulnerable populations, such as low-income families, and further perpetuate social isolation across socioeconomic demographics.

Participants noted that children and youth can face loneliness due to unsupportive home environments or parental work obligations, emphasizing the need for safe spaces and affordable programs to help foster connections.

Areas of Improvement

- Outreach by volunteer organizations and faith-based groups are having some success in the region and have been essential for reaching people that might otherwise go unnoticed
- Some faith-based organizations have "loneliness ambassadors"

Adults with disabilities and seniors, as previously described, face challenges with social isolation and disconnection, reporting long stretches without meaningful interactions. Programs like meal services or ride programs are valued not just for their practical support but also for the human connection they provide. Opportunity for promoting multi-generational

interaction - such as creating a 'buddy system' with seniors and local high school or college students – was discussed.

There are also physical barriers to isolation for residents, beyond just rural communities and related travel barriers. For example, some participants mentioned a lack of actual spaces that are safe for groups to gather, especially for youth.

Social isolation touches everyone in different ways, but participants cited specific groups or demographics with heightened isolation or barriers to connection. The most frequently mentioned groups were individuals within the LGBTQIA+ community, unhoused individuals, and BIPOC individuals. A concern specific to youth is the rise of a social media-driven environment in which people are exposed to negativity "over and over," reinforcing divisions rather than connection. These concerns include heightened bullying in school environments, especially towards LGBTQIA+ classmates.

> *"Building community is incredibly important right now – especially given the state of the country. We need more opportunities for folks to come together and create more connections, more empathy. There's just a lot of hate right now."- Discussion Group Participant*

Civic Engagement

Participants noted a decline in volunteerism, even though such opportunities exist and can boost mental health and strengthen social ties. Community members are described as simply not having the bandwidth to give extra time due to financial or caregiving pressures. This circumstance has a trickle-down effect, as some community agencies and civic organizations rely heavily on volunteer support. Senior centers, food pantries and meal services, volunteer ride-sharing programs, and other community-based organizations struggle to recruit and retain help, which severely limits their ability to provide services.

> *"People just want to feel like they matter in their community, and that they have a place."*
> *-Discussion Group Participant*

Socioeconomic Barriers

Socioeconomic issues and their effect on health and wellbeing came up in every discussion group. These issues included income and cost of living, housing, childcare, food insecurity, transportation, and insurance. These issues are of concern across all demographics, touching nearly all residents and their ability to thrive in varied ways.

The general cost of living was the most frequent issue, with participants emphasizing how incremental cost increases can tip households into crisis, especially for those juggling multiple priorities like housing, childcare, and healthcare. And, as mentioned in previous sections, many seniors, in particular, live on fixed, limited incomes, making relatively modest cost increases unaffordable.

Affordable and manageable housing was a recurring topic for families and for seniors. For seniors, concerns about assisted living communities were voiced due to a lack of capacity, closures, and affordability. Consequently, senior residents who may prefer to age in place are living in unsuitable or unsafe housing situations.

Discussion group participants – especially those who are parents or who work with families – described how the rising costs of childcare are stretching daily living expenses to an unsustainable extent. Burnout from juggling work, childcare, and basic day-to-day needs has left parents with little time or energy to take care of themselves, to engage with their communities, and find meaningful social connections. For services and programs that exist to help with these barriers, many have access barriers in and of themselves, such as only being offered during limited time periods that are not conducive to work schedules or child care availability.

> *"It's like saying, 'We're here for you… but only from this time to this time'."*
>
> *-Discussion Group Participant*

Another area of concern for families in the region is food insecurity. Those familiar with community food programs in the region described a surge in demand and shrinking resources to meet that demand. Families experiencing risk in other aspects of their lives, such as those who are unemployed, uninsured, with unstable housing, or without a vehicle, are especially vulnerable. In addition, a need for more family emergency preparedness was encouraged. In the event of a disaster, nearly all families are just three days away from food insecurity.

Areas of Improvement

Mobile food pantry trucks are helping to reach people in more rural areas.

"Food is medicine. We cannot live without it, and it matters what we eat."
-Discussion Group Participant

As mentioned previously, transportation limitations are noted as disproportionately affecting low-income residents and seniors. Similarly discussed in a previous section, insurance was described repeatedly as both financially and administratively burdensome. Copays, deductibles, and uncovered services create hidden costs that low-income families and many seniors are unable to absorb.

Discussions linked socioeconomic issues to the current political environment and policy changes, noting decreased federal food support and looming Medicare/Medicaid cuts as examples. Political divisions and the partisanship of healthcare issues was a large concern as well, especially for youth in the LGBTQIA+ community. The cumulative impact of all these factors has left some residents feeling vulnerable and drained.

"Every day I wake up feeling like there's a new issue to worry about."
-Discussion Group Participant

D. COMMUNITY HEALTH STATUS INDICATORS

This section of the 2025 Community Health Needs Assessment report provides information on key indicators and measures of community health status. Some measures associated with health status have been included earlier in this report, such as measures of income and poverty. Where possible, statistics are presented specifically to the 33-town service area identified as the Greater Monadnock Public Health Region. That region includes the City of Keene and all 22 towns of Cheshire County, as well as 10 towns in western Hillsborough County. In some instances, population health data is only available at the county level.

Also included in this section are selected findings from two additional primary data sources. The 2024 Greater Monadnock Community Survey was a random sample survey of community residents on health behaviors, beliefs, and attitudes. Complete results of this survey can be found on the Cheshire Medical Center, Center for Population Health website here. An additional source of data for assessing community need is the aggregate results of routine screening of adult Cheshire Medical Center patients for Social Drivers of Health (SDoH) concerns. The SDoH screening tool includes questions on potential needs, such as financial strain, housing insecurity, food insecurity, and social isolation. Routine screening helps to inform care teams of unmet needs that may affect a patient's health, facilitating connections to patient assistance and community resources.

From January 1, 2024 through June 30, 2025, nearly 13,000 SDoH screens were completed with Cheshire Medical Center patients. About 31% of these screens* were positive for at least one SDoH concern.

*Note: Individual patients may be screened more than once.

1. Demographics and Drivers of Health

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

General Population Characteristics

The prevalence of many health conditions varies by age, and different age groups can have different health-related needs and priorities. Awareness of the age distribution within a

population can help to anticipate healthcare needs, allocate resources appropriately, and plan for future healthcare demand.

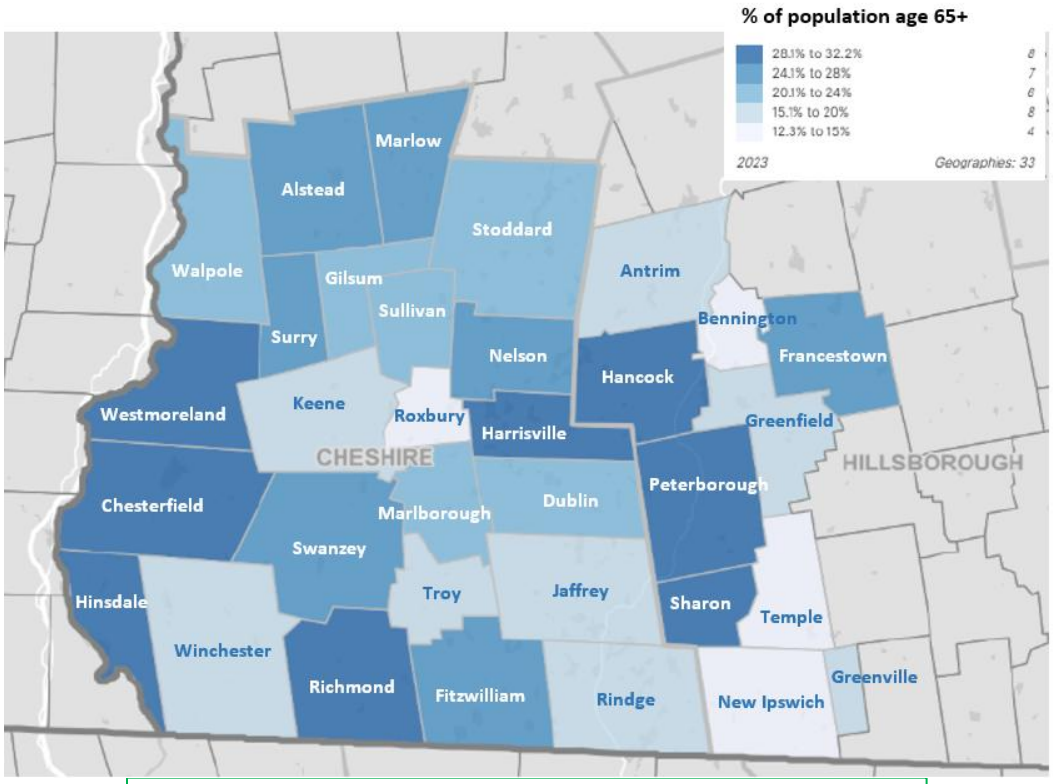
Between 2020 and 2023, the population of the service area grew by about 300 people or 0.3% overall. The population of the Greater Monadnock region is somewhat older on average than in New Hampshire overall (Table 11). The service area map (Figure 18) displays the percentage of the population 65 years of age and older by town.

| TABLE 11 |

Indicators	Greater Monadnock Region	New Hampshire
Total Population	101,772	1,387,834
Age under 5 years	4.7%	4.6%
Age 5 to 17 years	14.0%	14.0%
Age 65 and older	21.4%	19.5%
Age 85 and older	2.6%	2.0%
Change in population (2020 to 2023)	+0.3%	+2.4%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 - 2023

| Figure 18. Percent of Service Area Population 65 years of age and older |



The estimated percentage of service area residents age 65 years and older ranges from about 12% in Roxbury to about 32% in Harrisville.

Disability Status

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

The percentage of residents in the Greater Monadnock region who report having at least one disability - about 14% - is slightly higher than in New Hampshire overall.

| TABLE 12 |

Total Population (Noninstitutionalized) with a Disability		
Age Group (in years)	Greater Monadnock Public Health Region	New Hampshire
Age <18 with a disability	4.8%	4.9%
Age 18-64 with a disability	11.3%	10.7%
Age 65+ with a disability	29.2%	28.6%
Total population (%) with a disability	14.3%	13.3%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

About 23% of adults in the Greater Monadnock Region, including 33% of residents between ages 50 and 64, report that they are 'currently providing care or assistance to a friend or family member who is aging, has a health problem, or has a disability'.

- 2024 Greater Monadnock Community Survey

Education

Educational attainment is also considered a key driver of health status. One reason education level is associated with health status is that adults with more education tend historically to have more opportunities for earning higher income and access to more comprehensive health-related benefits. The percent of service area residents ages 25 and older who have earned at least a high school diploma (Table 13) is similar to New Hampshire overall, while the percent

of the population with a Bachelor's degree or higher – over one-third of area residents - is slightly lower in comparison to the state statistic.

| TABLE 13 |

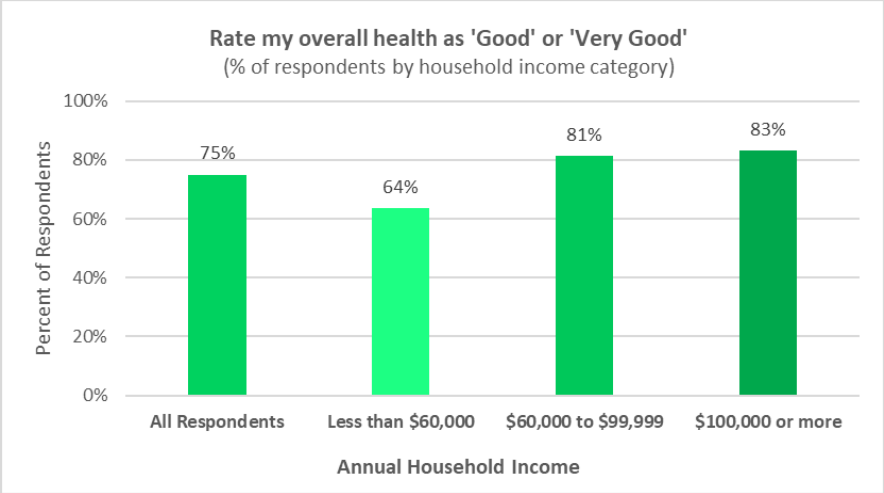
Percent of Population Aged 25+	Greater Monadnock	New Hampshire
High School Diploma (or Equivalent) and Higher	94%	94%
Some College or an Associate's Degree	27%	27%
Bachelor's Degree or Higher	37%	40%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

Income and Poverty

The strong connection between economic prosperity and health is widely recognized. For example, the absence of economic prosperity or poverty can lead to obstacles in obtaining health services, nutritious food, and a healthy physical environment, all of which are fundamental for maintaining good health. As displayed by Figure 18, respondents to the 2024 Greater Monadnock Community Survey with household income under $60,000 were less likely than people with higher income to rate their overall health as 'Good' or 'Very Good'.

| Figure 18 |



Some information describing household income and poverty status was included in the first overview section of this report. Table 14 displays the percent of people in the hospital service area living in households with income below the

About 16% of patient screens indicate financial strain meeting basic needs such as food, housing, and medical care including about 21% of screens with patients identifying as Hispanic/Latino and 24% of screens with patients identifying as Black/African American.

- Cheshire Med Adult Patient SDoH Screener

Federal Poverty Level (FPL), the percent of children under age 18 in households with income below the FPL, and the percent of adults 65+ years in households with income below the FPL. For context, the Federal Poverty Level for an individual in 2023 was $14,580, and for a family of four was $30,000.

The regional estimate of children in households with income below the poverty level – 9.2% - is somewhat higher than the statewide statistic.

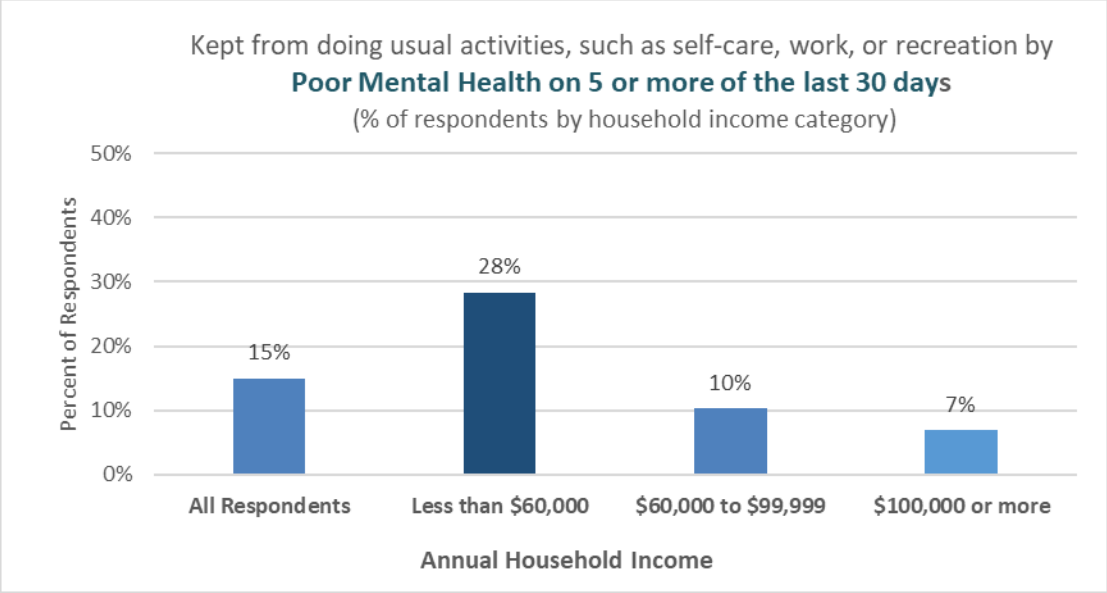
| TABLE 14 |

Percent of people in households with income below the Federal Poverty Level (FPL)		
Population Group	**Greater Monadnock**	**New Hampshire**
All people with household income below the FPL	8.3%	7.2%
Children (under 18) in households with income below the FPL	9.2%	7.8%
Adults 65+ years in households with income below the FPL	6.9%	7.4%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

Respondents to the 2024 Greater Monadnock Community Survey with household income under $60,000 were significantly more likely than people with higher income to report that poor mental health had kept them from doing their usual activities, such as self-care, work, or recreation, on 5 or more of the last 30 days.

| Figure 19 |



Language

An inability to speak English well can create barriers to accessing services, communication with service providers, and ability to understand and apply health information (health literacy). Language barriers can also contribute to feelings of isolation, frustration, and anxiety, especially when unable to effectively express health concerns or understand information provided by healthcare professionals. An estimated 47 households in the service area (0.2%) are considered limited-English speaking households. A limited English speaking household is defined as one in which no member 14 years old or older either speaks only English or speaks a non-English language and speaks English very well.

| TABLE 15 |

	Monadnock Region	New Hampshire
Limited English Speaking Households (%)	**0.1%**	**1.2%**

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

About 1% of SDoH screens indicate help is needed to read instructions or written materials from doctors or pharmacies.

- Cheshire Med Adult Patient SDoH Screener

Housing

Housing characteristics, including housing quality and cost burden as a proportion of income, can influence the health of families and communities. Households that spend a high proportion of their income on housing can experience financial strain, with fewer resources available for essential needs such as food, healthcare, education, transportation, and clothing. Other implications of high housing cost burden include housing insecurity and sub-standard living conditions.

Table 15 displays the percentage of households with housing costs (with or without a mortgage) or rental costs exceeding 30% of household income. The U.S. Department of Housing and Urban Development defines affordable housing as housing for which the occupant is paying no more than 30 percent of gross income, including mortgage or rent, utilities, taxes, and insurance. About 1 in 4 owner-occupied housing units and nearly 1 in 2 renters in the service area have housing costs exceeding this threshold.

Physical housing conditions can also contribute to health hazards. Some examples include inadequate ventilation, which can lead to exposure to mold, pests, or lead-based paint; incomplete kitchen facilities, which can limit nutritional options and increase reliance on heavily processed foods; and complete plumbing facilities, which can cause sanitation and hygiene challenges and increased exposure to sewage or waste. Table 15 also presents data on the percentage of occupied housing units in the service area that have characteristics of sub-standard housing, such as lacking complete plumbing facilities or complete kitchen facilities.

| TABLE 15 |

Percent of Households with High Cost Burden or Substandard Housing	Greater Monadnock PHR	New Hampshire
Housing Costs >30% of Household Income (%)	**24.6%**	24.8%
Rental Costs >30% of Household Income (%)	**44.8%**	47.6%
Occupied Housing Units Lacking Complete Plumbing Facilities (%)	**0.2%**	0.5%
Occupied Housing Units Lacking Complete Kitchen Facilities (%)	**0.2%**	0.7%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019 – 2023

About 9% of SDoH screens with patients between the ages of 18 and 64 indicate housing insecurity such as not being able to pay rent or mortgage on time or possibility of utility shut off. About 2% of screens with patients ages 65+ indicate housing insecurity.

- Cheshire Med Adult Patient SDoH Screener

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

New Hampshire has a relatively high percentage of older structures in general, with more than half of occupied housing units within structures that were built before 1980. In the Greater Monadnock region, the percentage is even higher, with 61% of housing units built before 1980.

| TABLE 16. Housing Units – Year Structure was Built |

Area	1939 or earlier	1940 to 1959	1960 to 1979*	1980 to 1999	2000 to 2019	2020 or later
Greater Monadnock PHR	27%	11%	23%	23%	16%	<1%
New Hampshire	19%	10%	23%	29%	18%	<1%

Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates.

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

Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. About 4% of households in the service area report having no vehicle available, a percentage similar to New Hampshire overall. Towns with the highest estimates for households with no vehicle available are Alstead (13%), Keene (7%), and Swanzey (7%).

| TABLE 17 – Vehicle Availability|

Area	Percent of Households with No Vehicle Available
Greater Monadnock Public Health Region	4.3%
New Hampshire	4.5%

Data Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates.

About 3% of SDoH screens indicate transportation as a barrier to appointments, meetings, or other activities of daily life.

- Cheshire Med Adult Patient SDoH Screener

2. Access to Care

Access to care refers to the ease with which an individual can obtain needed services. Access is influenced by a variety of factors, including affordability of services and insurance coverage, provider capacity in relation to population need and demand for services, and related concepts of availability, proximity, and appropriateness of services.

Insurance Coverage

Table 18 displays town-level estimates of the proportion of residents in the Greater Monadnock region who do not have any form of health insurance coverage, as well as the proportion of residents with Medicare, Medicaid, or Veterans Administration coverage. The percent of the service area population with no insurance (6%) is similar to the percent in New Hampshire overall (6%), although there is a notable range in the region from 13% uninsurance in Sharon to about 2% in Peterborough and Marlborough. The percentage estimates for the population with Medicare and Medicaid coverage are also similar to the statewide rates. The map after the table (Figure 20) displays the percentage of residents with no health insurance coverage by municipality.

| TABLE 18: Health Insurance Coverage Estimates |

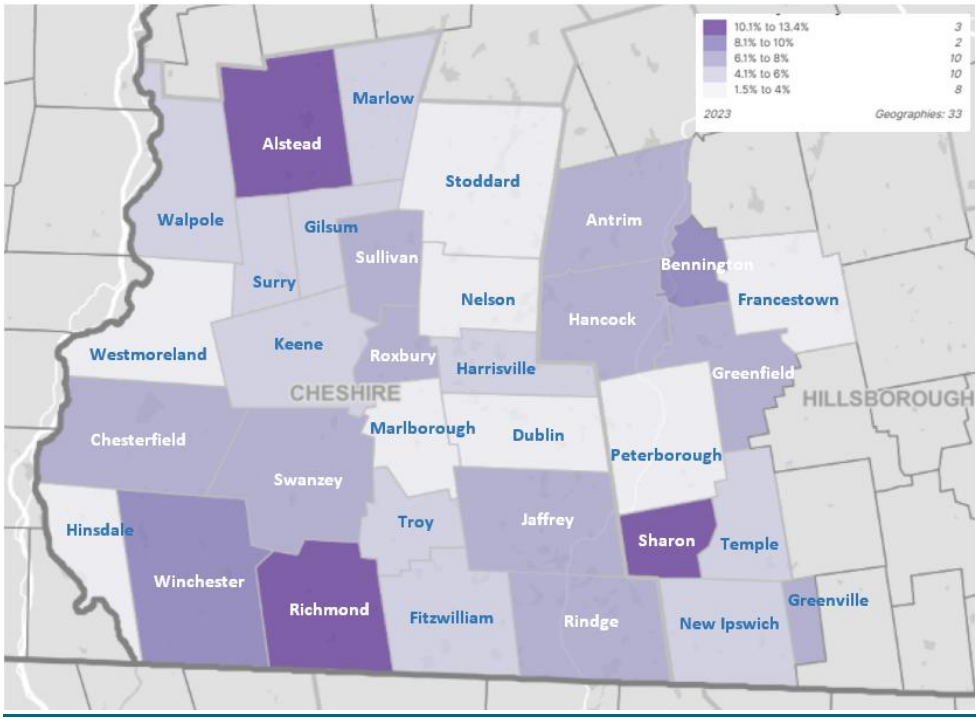
Area (in order of highest to lowest % uninsured)	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Sharon	13%	31%	10%	3%
Richmond	11%	29%	13%	3%
Alstead	11%	30%	20%	2%
Winchester	9%	20%	30%	2%
Bennington	9%	16%	16%	6%
Antrim	8%	23%	17%	2%
Chesterfield	7%	33%	11%	2%
Swanzey	7%	29%	16%	5%
Hancock	7%	30%	11%	2%
Rindge	6%	20%	9%	2%
Sullivan	6%	21%	16%	3%
Greenfield	6%	21%	14%	1%

Area (in order of highest to lowest % uninsured)	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Jaffrey	6%	17%	14%	3%
Roxbury	6%	13%	28%	3%
Greenville	6%	24%	18%	7%
New Ipswich	6%	14%	12%	1%
Keene	6%	20%	13%	2%
Greater Monadnock PHR	**6%**	**23%**	**14%**	**3%**
New Hampshire	6%	21%	13%	2%
Surry	5%	25%	16%	2%
Marlow	5%	28%	12%	4%
Gilsum	5%	26%	12%	5%
Fitzwilliam	5%	27%	12%	4%
Temple	5%	16%	21%	2%
Harrisville	5%	34%	10%	2%
Walpole	4%	26%	14%	4%
Troy	4%	16%	16%	1%
Hinsdale	4%	32%	16%	5%
Stoddard	4%	22%	21%	3%
Dublin	3%	22%	18%	2%
Francestown	3%	23%	4%	2%
Westmoreland	3%	25%	10%	2%
Nelson	3%	25%	18%	4%
Marlborough	2%	26%	22%	4%
Peterborough	2%	27%	8%	2%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

**Coverage alone or in combination*

| Figure 20 Percent Uninsured Residents, Greater Monadnock Towns |

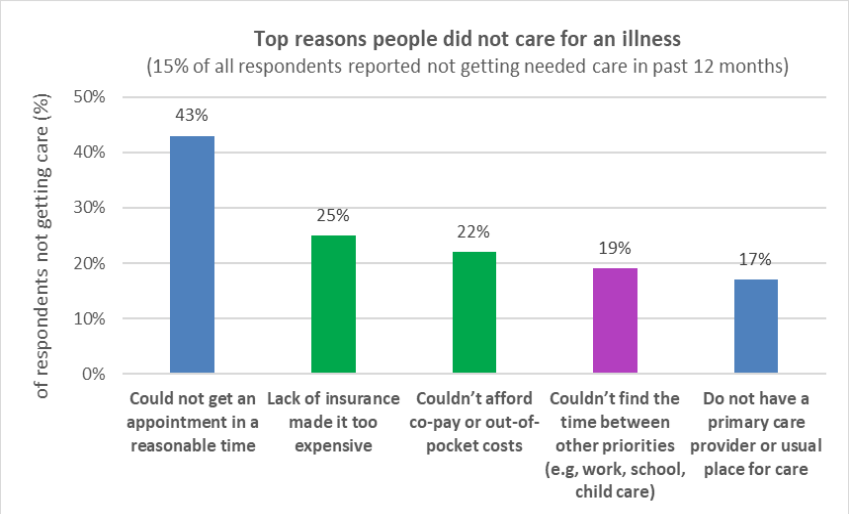


The estimated percentage of service area residents with no health insurance coverage ranges from 2% in Peterborough and Marlborough to 13% in Sharon.

Delayed or Avoided Care

About 15% of respondents to the 2024 Greater Monadnock Community Survey reported that they or another adult in their household did not or could not get needed or wanted medical care for a sickness or illness in the past 12 months. As displayed by Figure 21, the top reason cited for not being able to access care for an illness was 'Could not get an appointment in a reasonable time', followed by 'Lack of insurance made it too expensive' and 'Couldn't afford co-pay or out-of-pocket costs'.

| Figure 21 |



Provider Capacity

Access to high-quality, cost-effective healthcare is influenced by adequate health care professional availability in balance with population needs. Table 19 displays a measure of availability – population to provider ratio – at the county level for primary care physicians, dentists, and mental health professionals. After Belknap and Strafford counties, Cheshire County has the third highest ratio of NH's ten counties for population per primary care provider.

| TABLE 19 |

Area	Ratio of Population to Primary Care Physicians	Ratio of Population to Dentists	Ratio of Population to Mental Health Providers
Cheshire County	1,487:1	1268:1	247:1
New Hampshire	1,149:1	1,302:1	250:1

Data Source Area Health Resources Files, US DHHS via County Health Rankings, 2021-2024

The next table displays the percentage of adults who self-reported not having a primary care provider. About 14% of Cheshire County adult residents responded on the Behavioral Risk Factor Survey (BRFS) that they do not have a 'personal doctor or health care provider', a somewhat lower percentage than found on the 2024 Monadnock Community Survey. (Note: Most recently available sub-state BRFS data for New Hampshire on this measure is from 2019).

| TABLE 20 |

Area	Percent of Population (18+) Without a Primary Care Provider
Greater Monadnock Public Health Region	14%
New Hampshire	12%

Data Sources: Behavioral Risk Factor Surveillance System; NHDHHS, 2019

Travel Time or Distance

The NH State Office of Rural Health (SORH) classifies Public Health Network regions throughout the state as rural or non-rural, including the Greater Monadnock Public Health Region, which is classified as rural. The SORH has reported that health disparities exist between rural and non-rural populations as measured by select primary care-associated health indicators, including primary care access.[2] One measure of access to primary care is

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

travel time to health care visits. As displayed by Table 21, about twice as many primary care visits for rural populations require one-way travel time of 30 minutes or more compared to non-rural populations. In the Greater Monadnock region, about 25% of health care visits require a one-way travel time of 30 minutes or more.

| TABLE 21 |

Area	Percentage of primary medical care visits with travel times greater than 30 minutes, one way
Greater Monadnock PH Region	24.8%
All Rural New Hampshire	27.5%
All Non-Rural New Hampshire	15.3%

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2022

The number of hospitals providing obstetric services has been in decline in rural communities across the country. The loss of hospital-based obstetric services in rural areas is associated with increases in out-of-hospital births and pre-term births, which may contribute to poor maternal and infant outcomes.[3] Compared to other rural counties in New Hampshire, a lower percentage of the population of Cheshire County (11%) lives more than 15 miles from the nearest hospital providing birthing services.

| Table 25 |

Area	Greater than 15 Miles to Nearest Birthing Center, % of total population
Cheshire County	11%
All Rural New Hampshire	41%
All Non-Rural New Hampshire	5%

Data Source: New England Rural Health Association, Rural Data Analysis Dashboard, 2023.

[3] Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas. Government Accountability Office, GAO-23-105515, Oct 19, 2022.

Preventable Hospital Stays

Preventable Hospital Stays are hospital discharges for diagnoses potentially treatable in outpatient settings, also known as ambulatory care sensitive conditions, such as diabetes, hypertension, asthma, and chronic obstructive pulmonary disease. A high rate of inpatient stays for ambulatory care sensitive conditions may indicate limited access, availability, or quality of primary and outpatient specialty care in a community. This measure is reported below for Medicare enrollees. The rates of preventable hospital stays for Medicare enrollee residents of Cheshire County was notably lower than the statewide rate in 2022.

| Table 22 |

Area	Number of hospital stays for ambulatory care sensitive conditions per 100,000 Medicare enrollees
Cheshire County	1,895
New Hampshire	2,348

Data Source: Centers for Medicare & Medicaid Services; accessed through County Health Rankings, 2022 data

Dental Care Utilization (Adult)

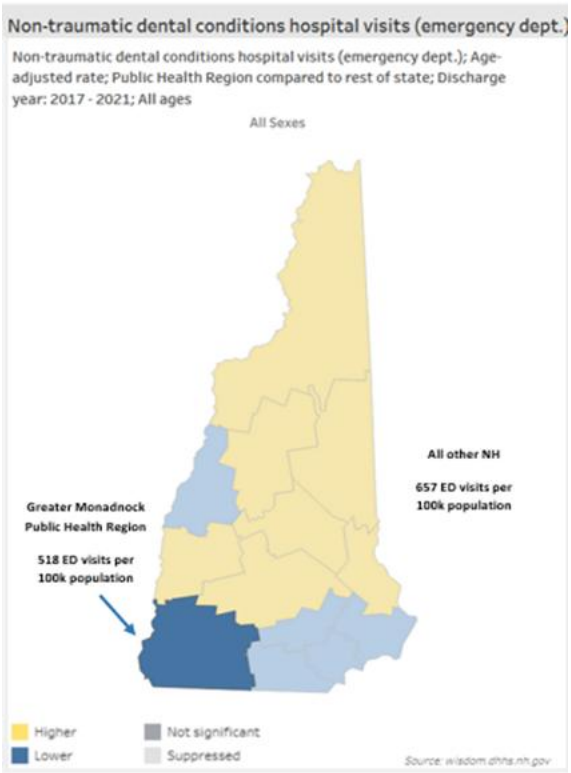
This indicator reports the percentage of adults aged 18 and older who self-report that they have visited a dentist, dental hygienist, or dental clinic within the past year. About one-third of adults in Cheshire County report not having had a dental visit in the past year.

| TABLE 23 |

Area	Percent of adults who visited a dentist or dental clinic in the past year
Cheshire County	65%
New Hampshire	69%

Data Source: CDC, Population Level Analysis and Community Estimates (PLACES), Behavioral Risk Factor Surveillance System 2022

Emergency department visits for non-traumatic dental conditions provide a measure of unmet oral health needs where timely primary dental care could potentially prevent the need for emergency care. Ambulatory care sensitive dental conditions represent approximately 3% of all emergency department visits in New Hampshire. The Greater Monadnock region experiences significantly fewer hospital emergency department dental visits for non-traumatic reasons (i.e., not resulting from an acute injury) than across the state overall. The difference is even more notable in comparison to other rural areas of New Hampshire, where the rate of ED visits for non-traumatic dental conditions is nearly 60% higher than in non-rural regions of the state.



| TABLE 24 |

Area	Emergency Department visits for non-traumatic dental conditions; Age-adjusted rate per 100,000
Greater Monadnock Public Health Region	**518***
New Hampshire	657

Data Source: NH Hospital Discharge Data, 2017-2021
**Regional rate is significantly different and lower than the state rate*

3. Health Promotion and Disease Prevention

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

This section encompasses both environmental conditions and individual behaviors that influence personal health and well-being. It also highlights indicators of clinical prevention practices, including cancer and heart disease screenings.

Food Insecurity

Food insecurity is described by the United States Department of Agriculture as the lack of access, at times, to enough food for an active, healthy life. About 12% of households in Cheshire County experienced food insecurity in the past year (2023 data), defined as the percentage of households unable to provide adequate food for one or more household members due to a lack of resources.

| TABLE 25 |

Area	Percent of Households Experiencing Food Insecurity
Cheshire County	11.7%
New Hampshire	10.7%

Data Source: Feeding America, Map the Meal Gap, 2023

About 9% of patient screens indicate food insecurity including 15% of screens with patients identifying as Hispanic/Latino and 15% of screens with patients identifying as Black/African American. About 4% of screens with patients age 65 and older indicate food insecurity.

- Cheshire Med Adult Patient SDoH Screener

About 19% of respondents to the 2024 Greater Monadnock Community Survey reported that it is somewhat or very difficult to buy healthy foods like fresh fruits or vegetables. The most common reason by far for difficulty buying healthy foods was cost. Among those reporting difficulty, 82% indicated the cost of healthy foods as the reason. As displayed by Figure 22, younger age groups were more likely than older age groups to report difficulty buying healthy foods.

| Figure 22 |

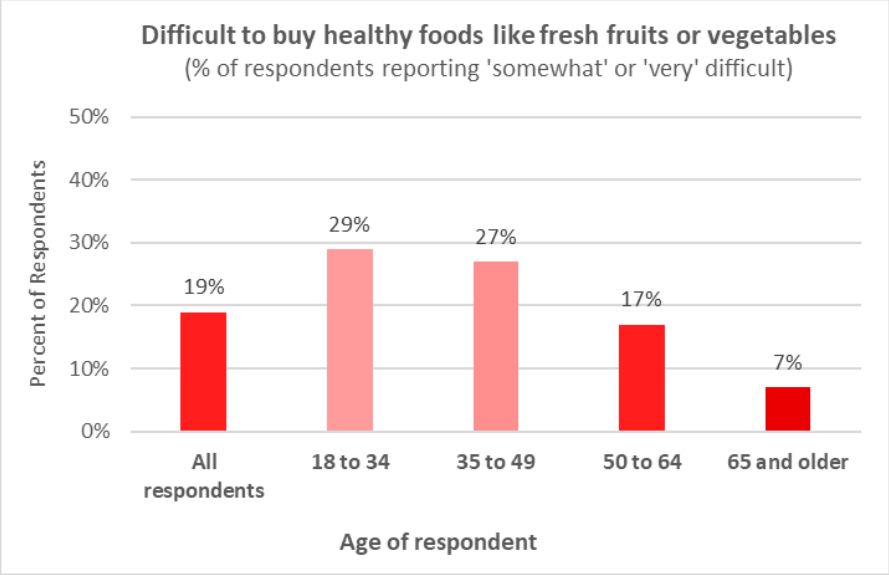


Table 26 shows the percentage of households receiving support through the Supplemental Nutrition Assistance Program (SNAP). About 6% of households in the Greater Monadnock region receive SNAP support. Among these households, about 32% have children in the household, and about 43% have at least one household member aged 60 years or older.

| TABLE 26 |

Area	Percent of All Households Receiving SNAP	With Children Under 18 (% of households receiving SNAP)	With one or more people in the household 60 years and over (% of households receiving SNAP)
Greater Monadnock PHR	**6%**	**32%**	**43%**
New Hampshire	6%	45%	39%

Data Source: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates

Physical Activity (Adults)

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

| TABLE 27 |

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

Data Source: CDC, Population Level Analysis and Community Estimates (PLACES), BRFSS 2022; State estimates, BRFSS via County Health Rankings, 2022

Pneumonia and Influenza Vaccinations (Adults)

The table below displays the percentage of adults who self-report that they received an influenza vaccine (either shot or sprayed in their nose) in the past year (at the time of the survey) or have ever received a pneumococcal vaccine. In addition to measuring the population proportion receiving preventive vaccines, these measures can also highlight access to preventive care issues or opportunities for health education, including addressing concerns for vaccine safety and efficacy.

| TABLE 28 |

Area	+Percent of Medicare enrollees receiving an annual flu vaccine	^Ever had a Pneumococcal Vaccination, ages 65+
Cheshire County	52%	75%
New Hampshire	53%	76%

^Data Source: New England Rural Health Association, Rural Data Dashboard, 2020
+Data Source: Centers for Medicare & Medicaid Services via County Health Rankings, 2022

Substance Misuse

Substance misuse, involving alcohol, illicit drugs, and misuse of prescription drugs, or a combination of these behaviors, is associated with a complex range of negative health consequences for individuals, families, and communities. Detrimental effects range from physical health issues, both acute and chronic; impaired cognitive functioning, including memory, attention, and decision-making deficits; mental health disorders such as depression, anxiety, and psychosis; addiction and dependence; and destructive social conditions such as family dysfunction, financial strain, domestic violence, and social isolation.

> About 16% of SDoH screens indicate feelings of social isolation including 17% of screens with patients between the ages of 18 and 64 and 10% of screens with patients ages 65+ that indicate feelings of social isolation.
>
> - Cheshire Med Adult Patient SDoH Screener

Alcohol

Excessive drinking: Excessive alcohol use, either in the form of heavy drinking (drinking 15 or more drinks per week for men or eight drinks or more per week for women), or binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women where one occasion means within 2-3 hours), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Table 29 shows the percentage of adults who reported binge and heavy alcohol use. Regional estimates are similar to statewide percentages for excessive drinking among adult residents.

| TABLE 29 |

Area	Binge Alcohol Use			Heavy Alcohol Use, All Adults
	All Adults	Adult females	Adult males	
Greater Monadnock Public Health Region	13%	12%	14%	11%
New Hampshire	16%	12%	19%	8%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2023 (female statistic for region imputed)

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

The percentages of high school-aged youth who self-report recent alcohol use and binge drinking are similar to the overall state rate, as is the percentage of high school students who feel it would be 'very easy' to get alcohol. Female high school students in the Greater

Monadnock region were significantly more likely to report current alcohol use (24%) than male high school students (15%).

| TABLE 34 |

Area	High School Students		
	Currently Drink Alcohol (in past 30 days)	Reported Binge Drinking (in past 30 days)	Think it would be 'very easy' to get alcohol
Greater Monadnock Public Health Region	19%	9%	23%
New Hampshire	21%	11%	25%

Data Source: Youth Behavior Risk Survey (YRBS), NH 2021. Note: State-level data is available from the 2023 YRBS, but a Monadnock region report is not available due to insufficient survey participation.

Prescription Drugs & Opioids

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

- *Over-prescription of Opioids*: The misuse of prescription drugs, particularly prescription pain relievers, poses a significant risk to individual health and can be a contributing factor leading to misuse of other drugs and a cause of unintentional overdose and mortality.
- *Transition to Heroin and Fentanyl*: As prescription opioids became harder to obtain due to increased awareness of their addictive potential, individuals turned to illicit use of potent synthetic opioids such as fentanyl.
- *Access to Treatment and Suppo*rt: Access to addiction treatment services, including medication-assisted treatment (MAT), counseling, and support programs, has not always been readily available to those who need it.
- *Stigma*: Opioid addiction is often accompanied by stigma and misconceptions, deterring individuals from seeking help.

Table 30 on the next page shows an estimate for the percent of NH adults who have ever taken prescription pain relievers and the percent who also reported having ever used a prescription pain medication more frequently or in higher doses than directed by their doctor.

| TABLE 30 |

Area	Ever taken prescription pain relievers, all adults	Ever used pain relievers in higher doses than prescribed, all adults (% of total ever prescribed pain relievers)
Greater Monadnock Public Health Region	25%	Data suppressed, insufficient sample size
New Hampshire	24%	2%

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

According to recent results from the 2021 Youth Risk Behavior Survey (YRBS), 7% of high school students in the Greater Monadnock region reported having ever taken a prescription drug without a doctor's prescription, and about 3% had done so at least once in the 30 days prior to the survey administration. About 7% of high school students reported having ever used inhalants (Table 31).

| TABLE 31 |

Area	High School Students	
	Ever took prescription drugs without a doctor's prescription	Took a prescription drug without a doctor's prescription, in the past 30 days
Greater Monadnock PH Region	7%	3%
New Hampshire	10%	4%

Data Source: Youth Risk Behavior Survey, NH 2021

Marijuana

Results from the 2021 YRBS indicate that about 1 in 6 students self-report having used marijuana in the past 30 days prior to survey administration. About 1 in 7 high school-age youth report having been offered, sold, or given an illegal drug on school property.

| TABLE 32 |

Area	High School Students		
	Currently use marijuana	Tried marijuana for the first time before age 13 years	Were offered, sold, or given an illegal drug on school property
Greater Monadnock Public Health Region	17%	4%	15%
New Hampshire	18%	4%	16%

Data Source: Youth Risk Behavior Survey, NH 2021

Cigarette Smoking / Tobacco Use

Tobacco use is a primary contributor to the leading causes of death, such as lung cancer, respiratory disease, and cardiovascular disease. Smoking during pregnancy also confers significant short-term and long-term risks to the health of an unborn child.

The percent of adults who currently smoke cigarettes in the region is higher than the statewide statistic, although the estimates based on survey samples are not statistically different.

| TABLE 33 |

Area	Percent of High School Students Who Currently Smoke Cigarettes	Percent of Adult Population Who Currently Smokes Cigarettes
Greater Monadnock PH Region	Not available	15%
New Hampshire	4%	10%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023; Youth Risk Behavior Survey, NH 2021

As displayed by Table 34, use of an electronic vapor product among high school age students is substantially more common than cigarette use in New Hampshire.

| TABLE 34 |

Area	Percent of High School Students Who Currently Use an Electronic Vapor Product
Greater Monadnock PH Region	15%
New Hampshire	16%

Youth Risk Behavior Survey, NH 2021

Rural residents have historically had higher rates of smoking during pregnancy than their non-rural counterparts. For example, about 15% of females in the Greater Sullivan County Public Health Region who were pregnant between 2018 and 2022 reported smoking during pregnancy. In contrast, smoking during pregnancy in the Greater Monadnock region is substantially less prevalent (Table 35).

| TABLE 35 |

Area	Percent of Female Population that Reported Smoking During Pregnancy (all ages)
Greater Monadnock PH Region	**7.8%***
New Hampshire	5.9%

Data Sources: NH Vital Records Birth Certificate Data, 2019-2023

**Percent is significantly different and higher than the state percent.*

Smoking during pregnancy has a significant impact on preterm birth and other birth outcomes. In the region and the state, about 13% of births associated with smoking during pregnancy were preterm.

| TABLE 36 |

Area	Percent of births associated with smoking during pregnancy that were preterm
Greater Monadnock Public Health Region	13.0%
New Hampshire	13.4%

Data Source: NH Vital Records Birth Certificate Data, 2019-2023

Prenatal Care

Prenatal care is health care and guidance provided to pregnant individuals before the birth of their baby. Prenatal care is essential for a variety of reasons, including monitoring fetal development, providing nutritional and exercise guidance, screening for complications, providing emotional and mental health support, as well as educational support, and reducing maternal and infant mortality. Regular medical check-ups, screenings, and guidance from healthcare professionals contribute to a healthier pregnancy, a smoother childbirth experience, and better long-term outcomes for both the mother and the baby.

Table 37 shows the percentage of females who have given birth who received no or late prenatal care. Late prenatal care refers to the initiation of prenatal medical care after the second trimester. Over the five-year period from 2017 to 2021, the percentage of births to females in the Greater Monadnock Public Health Region who received no or late prenatal care (3.2%) was similar to the proportion in New Hampshire overall.

| TABLE 37 |

Area	Percent of Female Population that Received No or Late Prenatal Care
Greater Monadnock PH Region	3.2%
New Hampshire	3.5%

NHDHHS, Office of Rural Health and Primary Care, 2017-2021

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

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

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

| TABLE 38 |

Area	Full-term low birthweight among WIC-enrolled pregnant women	Low and Very Low Birthweight among WIC-enrolled pregnant women, all births
Cheshire County	3.7%	6.8%
New Hampshire	6.4%	9.3%

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

Teen Birth Rate

Teen pregnancy is closely linked to economic prosperity, educational attainment, and overall infant and child well-being. The teen birth rate in the Greater Monadnock Public Health Region is similar to the overall NH state rate.

| TABLE 39|

Area	Teen Birth Rate (per 1,000 female teens)		
	Total (ages 15-19)	Ages 15-17	Ages 18-19
Greater Monadnock Public Health Region	6.0	1.7	10.0
New Hampshire	5.5	1.8	10.7

Data Source: NH Vital Records Birth Certificate Data, 2019 – 2023.

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

Child Safety

Measures of child safety or child abuse and neglect in a community include the rate of child maltreatment victims substantiated by state child protection agencies, as well as the rate of children in temporary, out-of-home placement. As displayed by the table below, the rates of child maltreatment, both screened-in* and substantiated, were higher in Cheshire County than across NH overall in 2020.

| TABLE 40 |

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Screened-in reports of child maltreatment, rate per 1,000 children under age 18	Foster Care Entries, rate per 1,000 children
Cheshire County	8.6	80.4	3.0
New Hampshire	4.7	63.0	2.7

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

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

Childhood Blood Lead Level Testing

Lead is a toxic metal that can have severe and long-lasting effects on children's health and development. Lead exposure can have significant negative effects on neurological and cognitive development. Even low levels of lead exposure have been associated with learning disabilities, attention deficits, and behavioral problems. Early detection and intervention are essential to minimize the potential for long-term cognitive and developmental impairments.

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

| TABLE 46 |

Area	Percent Tested, Ages 0 to 72 months old	% EBLL 3.5µg/dL or higher	% EBLL 5µg/dL or higher
Greater Monadnock Public Health Region	27%	5.8%	1.3%
New Hampshire	27%	5.4%	1.0%

Source: NH DHHS, Division of Public Health Services, Healthy Homes & Lead Poisoning Prevention Program, 2023

In 2023, about one in four children under 6 years of

age had been tested for elevated BLL (Table 46). Of the children tested in the Greater Monadnock Public Health Region, 89 children (5.8%) had elevated BLL of 3.5µg/dL or higher, and 20 children (1.3%) had elevated BLL of 5µg/dL or higher.

4. Health Outcomes

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

Overweight and Obesity

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

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

About 70% of all adults in the region and across the state are considered overweight or obese. Among high school students, a higher percentage of males than females are considered obese.

| TABLE 41 |

Area	Percent of adults who are obese	Percent of adults who are overweight
Greater Monadnock Public Health Region	33%	37%
New Hampshire	33%	36%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023

| TABLE 42 |

Area	High School Students Considered Obese	Female High School Students	Male High School Students
Greater Monadnock PHR	16%	11%	20%
New Hampshire	13%	10%	16%

Data Source: NH Youth Behavior Risk Survey, 2021

Heart Disease and Stroke

Heart disease is the leading cause of death in New Hampshire. Heart disease is closely related to unhealthy weight, high blood pressure, high cholesterol, and substance misuse, including tobacco use.

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

| TABLE 43 |

Area	Percent of adults told by a health professional that they have high blood pressure	Percent of adults who had their blood cholesterol checked within the past 5 years
Greater Monadnock Public Health Region	35%	90%
New Hampshire	33%	90%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023

Table 44 displays the rate of hospitalizations for congestive heart failure (CHF), often a consequence and end-stage of various heart diseases. Approximately 75% of persons with CHF have antecedent hypertension. The rate of hospital inpatient discharges for acute myocardial infarction (commonly called a heart attack) was significantly higher in the Greater Monadnock Public Health Region compared to the rest of New Hampshire over the period 2017 to 2021.

| TABLE 44 |

Area	CHF hospitalizations (inpatient) age-adjusted rate per 100,000	Heart attack hospitalizations (inpatient) age-adjusted per 100,000
Greater Monadnock Public Health Region	2.7	**174.6***
New Hampshire	4.2	152.5

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

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

Heart Disease and Stroke Mortality: Heart disease is the leading cause of mortality in New Hampshire and the second leading cause in the Greater Monadnock Public Health Region. Coronary heart disease, a narrowing of the small blood vessels that supply blood and oxygen to the heart, is the largest component of heart disease mortality.

Cerebrovascular disease (stroke), which happens when blood flow to a part of the brain stops, is the fifth leading cause of death in New Hampshire.

| TABLE 45 |

Area	Heart Disease (all) Mortality (per 100,000 people, age-adjusted)	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Greater Monadnock Public Health Region	145.8	88.4	29.8
New Hampshire	148.5	84.1	30.1

Source: NH Vital Records Death Certificate Data, 2019 – 2023.

Diabetes

Diabetes is an increasingly prevalent chronic health condition that puts individuals at risk for further health complications, but is also amenable to control through diet, physical activity, and adequate clinical care.

Diabetes Prevalence: This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. The proportion of people with a diabetes diagnosis increases substantially with age. The estimated prevalence of diabetes among adults in the service area is similar to the overall NH rate, where nearly 10% of adults report being diagnosed with diabetes.

| TABLE 46 |

Area	Percent of Adults Diagnosed with Diabetes
Greater Monadnock Public Health Region	8.1%
New Hampshire	9.8%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023;

Diabetes-Related Hospitalization: Complications of diabetes, such as cardiovascular disease, kidney failure, amputations, and ketoacidosis, frequently require hospitalization. The table below shows the age-adjusted rates of inpatient hospitalizations between 2017 and 2021 for diabetes-related conditions. The rate of diabetes-related hospitalizations in the Greater Monadnock Public Health Region was significantly lower than the overall rate across New Hampshire.

| TABLE 47 |

Area	Diabetes-Related Hospital Discharges; age-adjusted rate per 100,000
Greater Monadnock Public Health Region	**1,398***
New Hampshire	1,553

Data Sources: NH Uniform Healthcare Facility Discharge Dataset, 2017-2021;
**Rate is significantly different and lower than the state rate.*

Diabetes-related Mortality: The rate of death due to Diabetes Mellitus in the service area has been somewhat lower in recent years compared to overall state rates, although the observed differences are not statistically significant.

| TABLE 48 |

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Greater Monadnock Public Health Region	21.4
New Hampshire	20.0

Source: NH Vital Records Death Certificate Data, 2019 – 2023

Cancer

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

Cancer Screening: Table 49 displays screening rates for several of the most common forms of cancer, including colorectal cancer, breast cancer, cervical cancer, and prostate cancer.

| TABLE 49 |

Cancer Screening Type	Greater Monadnock PHR	New Hampshire
Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2022)	63%	67%
Females ages 50-74 who had a Mammogram in the past 2 years (2022)	76%	81%
Females ages 21-65 who have had a pap test in the past 3 years (2020)+	Not available	78%
Males age 40+ who had a PSA test in the past 2 years (2020)+	Not available	31%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2022, +CDC, 2020

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

Cancer Incidence: The table below shows cancer incidence rates for the cancer types that account for the majority of new cancer cases (incidence). Cancer incidence overall and rates by site are similar in the Greater Monadnock region compared to NH statewide rates.

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| TABLE 50 |

Cancer Incidence by Type per 100,000 people, age-adjusted rate		
Cancer Type	**Greater Monadnock Public Health Region**	**New Hampshire**
Overall cancer incidence (All Invasive Cancers)	480	474
Cancer Incidence by Type		
Breast (Female)	141	139
Prostate (male)	120	117
Lung and Bronchus	58	59
Melanoma of Skin	33	30
Colorectal	38	34
Uterus (female)	28	30
Bladder	25	26
Non-Hodgkin Lymphoma	18	20
Kidney and Renal Pelvis	16	17
Leukemia	15	14
Ovary	13	10
Pancreas	13	14
Oral Cavity and Pharynx	12	13
Thyroid	11	13

Data Source: NH State Cancer Registry, 2017-2021

Cancer Mortality: The table below shows the overall cancer mortality rate and the cancer mortality rate for types that account for the majority of cancer deaths. The overall mortality rate from all cancers has decreased steadily over the past several decades. For example, the rate of all cancer deaths in NH has decreased from about 195 per 100,000 people in 2001 to a rate of about 141 per 100,000 in 2023.

Cancer mortality overall and rates by cause are similar in the Greater Monadnock region compared to NH statewide rates.

| TABLE 51 |

Cancer Mortality per 100,000 people, age-adjusted		
Cancer Type	**Greater Monadnock Public Health Region**	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	148	143
Cancer Mortality by Type		
Lung and bronchus	32	32
Breast (female)	23	18
Prostate (male)	22	19
Colorectal	11	11
Pancreas	11	12
Uterus	6	5
Ovary	6	6
Liver and Intrahepatic Bile Duct	6	5
Leukemia	5	5
Esophagus	5	4
Non-Hodgkin's Lymphoma	5	5

Data Source: NH State Cancer Registry, 2019 – 2023

Asthma

Asthma is a chronic lung disease that inflames and narrows the airways. Asthma causes recurring periods of wheezing, chest tightness, shortness of breath, and coughing. Asthma is an increasingly prevalent condition that can be exacerbated by poor environmental conditions. In 2023, about 10% of adults responding to the Behavioral Risk Factor Survey from the Greater Monadnock Public Health Region reported they currently have asthma.

| TABLE 52 |

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Greater Monadnock Public Health Region	Not available	10%
New Hampshire	10%	12%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2023

Asthma-Related Hospitalizations: The table below displays rates of emergency department visits and inpatient hospitalizations for complications of asthma. The rate of emergency department visits for asthma-related diagnoses is significantly lower in the Greater Monadnock region compared to the state overall. The rate of inpatient hospitalizations is also notably lower in the region, although the difference from the state rate is not statistically significant.

| TABLE 53 |

Area	Asthma Emergency Department Visits, age-adjusted rate per 100,000	Asthma Inpatient Hospitalizations age-adjusted rate per 100,000
Greater Monadnock Public Health Region	**256***	22
New Hampshire	290	28

NH Uniform Healthcare Facility Discharge Dataset, 2017

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

Intentional and Unintentional Injury

Accidents and unintentional injury are the third leading cause of death in the region and in the state. In recent years, the epidemic of opioid and other substance misuse has been a substantial underlying cause of accidental and intentional injury and death.

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

The table below reports the total unintentional injury mortality rate, which is the number of deaths that result from accidental injuries per 100,000 people. This measure includes injuries from causes such as motor vehicle accidents, falls, drowning, and unintentional drug overdose.

| TABLE 54 |

Area	Unintentional (accidental) Injury Mortality, all causes Age-adjusted rate per 100,000
Greater Monadnock Public Health Region	56
New Hampshire	60

Data Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom 2019-2023

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

| TABLE 55 |

Area	Percent of people age 65+ who report having experienced a fall in the past 12 months	Fall-related ED visits per 100.000 people age 65 and older
Greater Monadnock Public Health Region	30%	6,794
New Hampshire	27%	6,818

Data Sources: NH BRFSS, 2023. NH Hospital Discharge Data Set for NH Residents, 2017-2021

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

| TABLE 56 |

Area	Opioid Overdose ED visits; Age-adjusted rate per 100,000 population	Opioid Overdose Hospitalizations (inpatient) age-adjusted per 100,000 population
Greater Monadnock Public Health Region	**96.1***	**17.0***
New Hampshire	135.1	24.1

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

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

Among respondents to the 2024 Monadnock Community Survey, 23% would 'probably not' or 'definitely not' know where to go to 'get help If they or a loved one had an issue with mental health; and 28% would probably or definitely not know where to go to 'get help if they or a loved one were struggling with substance use'.

Drug Overdose Mortality: Over 90% of all accidental and undetermined drug overdose deaths involve opioids. Table 57 displays the rate of opioid overdose mortality in recent years. Over the 5-year period from 2019 to 2023, the rate of opioid overdose deaths in the Greater Monadnock Public Health Region was notably lower than the overall NH rate, although the difference is not statistically significant.

| TABLE 57 |

Area	Opioid Overdose Deaths, age-adjusted per 100,000	Alcohol-related overdose deaths, age-adjusted per 100,000
Greater Monadnock PH Region	23.1	5.2
New Hampshire	28.4	4.6

Data Source: NH Division of Vital Records Death Certificate Data, 2019 to 2023;

The table also displays the rate of alcohol-related overdose deaths in NH over the same time frame (defined as ICD-10 codes: X45, Y15, T51.0, T51.1, T51.9 (alcohol

poisoning), X65 (suicide by and exposure to alcohol), and R78.0 (excessive blood level of alcohol) as the underlying cause.

Self-Harm-Related Emergency Department Visits and Hospitalization: Table 58 displays rates of emergency department (ED) visits for injury recorded as intentional, including self-intentional poisonings due to drugs, alcohol, or other toxic substances. The table also includes rates for inpatient hospitalizations by sex between 2017 and 2021. The rate of ED visits involving self-inflicted harm among females in the Monadnock region was significantly higher than the state rate over this period of time, while the inpatient hospitalization rate among females and males was significantly lower. Overall, rates of ED visits and hospitalizations related to self-harm are significantly higher among females than males in the region and across the state.

| TABLE 58 |

Sex	Area	Suicide or self-harm-related hospital visits (ED), age-adjusted rate per 100,000 people	Suicide or self-harm-related hospitalizations (inpatient), age-adjusted rate per 100,000 people
Male	Greater Monadnock PHR	115	**31***
	New Hampshire	131	43
Female	Greater Monadnock PHR	**271**+**	**50*+**
	New Hampshire	238+	65+
All Sexes	Greater Monadnock PHR	192	**40***
	New Hampshire	183	54

Data Source: NH Hospital Discharge Data Set (HDDS) for NH Residents, 2017 to 2021;
**Rate is significantly different and lower than the state rate; **Rate is significantly different and higher than the state rate*
+Female rate is significantly different and higher than the male rate.

Suicide Mortality: This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 people. Suicide rates can be an indicator of access to mental health care and other community supports. The suicide mortality rate is significantly higher for males than for females in the region and across New Hampshire.

| TABLE 59 |

Area	Suicide Mortality, age-adjusted rate per 100,000		
	Total	Female	Male+
Greater Monadnock Public Health Region	19.2	9.1	29.3
New Hampshire	15.7	6.3	25.3

Data Sources: NH Vital Records Death Certificate Data 2019 to 2023;
+Rate among males is significantly different and higher than among females.

Leading Causes of Death

Malignant neoplasms (cancer) are the leading cause of death in the Greater Monadnock region, followed by diseases of the heart (e.g., congestive heart failure, coronary heart disease, heart attack) over the five-year period from 2019 to 2023. Cancer and heart disease account for more deaths than the next 10 causes of death combined. Accidents and unintentional injury are the third leading cause of death in the region and the state.

| TABLE 61 |

Cause of Death	Greater Monadnock Public Health Region	New Hampshire
Malignant neoplasms	147.9	143.6
Heart diseases	145.8	148.5
Accidents / Unintentional Injury	56.2	60.2
Cerebrovascular diseases	34.1	30.1
Chronic lower respiratory disease	32.6	36.2
Alzheimer's disease	30.5	25.7
COVID-19	24.1	28.8
Diabetes mellitus	21.4	20.0
Intentional self-harm (suicide)	18.9	15.6
Chronic liver disease	18.9	12.5
Parkinson's disease	13.7	10.7

Source: NH Vital Records Death Certificate Data, 2019 – 2023

Infant Mortality

Infant mortality rate - the number of deaths of infants under the age of one year per 1,000 live births - is a significant indicator of the health and wellbeing of a population, including maternal health, community nutrition and wellness, accessibility and quality of health care services, health inequalities, and access to social support systems. New Hampshire has historically had low infant mortality rates relative to the nation.

| TABLE 60 |

Area	Infant Mortality Rate per 1,000 Live Births
Greater Monadnock Public Health Region	4.0
New Hampshire	3.6

Data Source: NH Vital Records Birth Certificate Data, 2019-2023

Life Expectancy at Birth

Life expectancy at birth is a commonly used measure of the overall health of people in a particular location or with demographic characteristics in common. The measure estimates an average number of years a person is expected to live and can be influenced by many factors, including access to quality health care and public health services, economic development, as well as personal factors such as occupation and biological sex. Over the last century, life expectancy has increased substantially due to widespread improvements in sanitation and access to clean water, adequacy of food and nutrition, advances in the prevention of infectious disease, and other advances in medicine and clinical care, particularly with respect to infant and maternal mortality. In the current age, women generally have a higher life expectancy than men.

| TABLE 62. Life Expectancy at Birth (years) and by Sex |

Area	Life expectancy	Male	Female
Cheshire County	79.2	76.5	81.9
New Hampshire	79.5	77.0	82.1

Sources: NH Vital Records, death data, 2016 – 2020; National Center for Health Statistics, 2019 - 2021

Premature Mortality

An overall measure of the burden of preventable injury and disease is premature mortality. The indicator below expresses premature mortality as the total years of potential life lost before age 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost. Cheshire County had a higher rate of premature mortality than New Hampshire overall during the period 2019 to 2021.

| TABLE 63 |

Area	Years of Potential Life Lost before age 75, age-adjusted rate per 100,000
Cheshire County	7,142**
New Hampshire	6,622

Data source: National Center for Health Statistics via County Health Rankings; 2020-2022
***Rate is significantly different and higher than the state rate.*

Summary

The 2025 Community Health Needs Assessment provides a comprehensive overview of health needs and priorities in the Greater Monadnock region. Through analysis of community input from multiple methods and channels, and assembly of demographic data and health indicators, the assessment highlights key health challenges and priorities for health improvement. The report identifies high-priority health issues such as health care availability and capacity challenges, cost of care concerns, behavioral health needs, and disparities in access to services. Additionally, the assessment includes information on broad drivers of health, including socioeconomic factors that influence community well-being. This assessment will hopefully serve as a useful resource for planning program and service improvements, for guiding targeted interventions, and for strengthening collaborative partnerships to improve overall health and wellness in the communities served by Cheshire Medical Center and partner organizations across the region.

What is being done well in the community to support good health and quality of life?

"A lot of agencies and resources for people of all ages who need support with a variety of basic needs. Many groups exist for collaboration and shared effort. Lots of activities for children and teens. Strong agencies that serve different purposes and all make an impact on those who benefit from the services."
- Community Leader, Family Support

"I would like to see the program we were striving for a few years ago called 'Vision 2020' reinstated . . . . It's very obvious that our community as a whole could benefit from more nutrition and exercise guidance.
- Community Resident Survey Respondent

What is being done well in the community to support good health and quality of life?

"Healthy Monadnock Alliance. Strong collaborations between the hospital and our community - nonprofits, businesses, individuals. The hospital's broad view of social determinants of health and commitment to partnering across the region for solutions."
- Community Leader, Human Services