HealthFirst Family Care Center

COMMUNITY NEEDS SUMMARY 2018 NOV 1

Overview Needs Data Leads to Goals and Plans.

HealthFirst Family Care Center (HFFCC) takes the process of needs assessment very seriously and conducts them on a regular basis jointly with the other health and human service agencies in the region, as part of our public health network. We combine efforts with other agencies to meet the state requirement to file needs assessments and community benefit reports on an annual basis with the Attorney General's office. The joint needs assessment process provides an overview of the overall target population of the region in which the specifics of the overall needs picture can be refined for specific needs of HealthFirst as a Federally Qualified Health Center (FQHC). The most recent large-scale assessment was completed in the Fall of 2018. The information was gathered utilizing key informant interviews, email-out questionnaires and several community forums that included the general population and patient consumers. The analysis of specific instances of medical conditions from data from the US Census Bureau and the NH Department of Public Health (NH DPH) was reviewed for direction in meeting large population health issues. Additional data was gathered from service providing agencies in the region and from HealthFirst service provision over the past several years.

HealthFirst Family Care Center: Regional community needs assessment 2018 was conducted in multiple parts:

Section I. Analysis of HealthFirst client use data against population health data for the region.

Section II. A regional public health needs assessment jointly with other agencies in the region as part of the work of the Winnipesaukee Public Health Council Regional Assessment. (*See attachment 2*)

Section III. An update to improvements and meeting of objectives from the data gathered jointly with the Winnipesaukee Community Health Improvement Plan (CHIP). (*See attachment 3*)

Section I. Analysis of HealthFirst client use data against population health data for the region.

A. The HealthFirst target population

Encompasses 23 municipalities: Alexandria, Andover, Ashland, Belmont, Bridgewater, Bristol, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Groton, Hebron, Hill, Laconia, Meredith, Moultonborough, New Hampton, Northfield, Salisbury, Sanbornton, Sandwich and Tilton.

Auto-HPSA Update Preview 5 Report1

HEALTHFIRST FAMILY CARE CENTER, INC.

As of April 15, 2019

Primary Care	**Last scored in 2016**	**Update Preview Score 21**	**Current Score 17**
Last scored in 2016	**Update Preview Score 25**	**Dental Health**	**Current Score 24**
Last scored in 2016	**Update Preview Score 19**	**Mental Health**	**Current Score 16**

B. Unique characteristics of the target population that affect access to primary health care, health care utilization and/or health status

The target area for HealthFirst is comprised of a region inclusive of 21 rural towns and two small cities with a total population of 83,867 and a Target population of 25,864. These still represent the towns from our 2016 UDS by Zip code with the most registered clients. The cities include Franklin with a population of just over 8,270 and Laconia of just over 15,492. The small towns range in size from 602 to 7,234 individuals and are very hard to get data by the individual towns. The towns are part of three counties, making the gathering of data for some statistics a difficult task. Reports of most health statistics are by counties; thus, they are reported by town where they are retrievable in this manner and by county where they are not. Total area Population below poverty level show 27% below 200% of poverty levelThe numbers from our two cities are more telling of the true nature of the region Laconia 27.8% and Franklin 35.6%. Our client service population is currently 60% below 200% of poverty level. (Above Data from NH Dept. of Vital statics 2015). The area is characterized by many lakes, rivers and mountains which are part of the attraction to the area for the primary employers which are service industries catering to tourism. The area does not have any significant amount of farming and no migrant seasonal farm workers (report by NH Department of Agriculture). The area does have seasonal workers employed in the tourism industry who remain stable in position in their housing but are seasonally employed in the winter by tourist related industries of winter sports; primarily skiing and snowmobiling, and in the summer months in tourist industries related to the lakes, rivers and mountains, water sports, hiking, hunting and fishing. As is characteristic of many other regions with service industry employment, the large majority of the employers are small or self-employed leading to additional high percentages of uninsured individuals. As can be seen from the map on **Attachment 1,** the region spans an area spread out geographically from East to West, a distance of approximately 85 miles and from North to South a distance of 60 miles. The lakes, rivers and mountains are laced with town maintained Class 5 dirt roads that can make traveling difficult, especially during periods of heavy rain with washouts or in winter months with the large New England snowfalls. During winter, distances to service and access is made more difficult where several of the mountainous regions have passes which are not open in the winter and result in having to circumnavigate the mountains to get to services. A steady process over the past 25 years of out-migration adds additional concerns. There is a growing elderly population in the region putting additional pressure on the healthcare system. The growth and percentage of elderly in the region is disproportionately high compared to the general population of the United States and the state. The race and ethnicity makeup of the region is primarily Caucasian. Less than .1 % are nonwhite. Our client data shows .04% non white with .08% not reporting and 88% reporting White. The area has experienced very small resettlement programs of some refugee populations

that have added to the diversity of the region to a small degree. Each of these special populations have their own distinguishing cultural characteristics which HF adapted to through additional cultural competency training and the extensive use of medical interpreters through contracts with the Lutheran Social Service Agency and AT&T translation services. These resettlement and service provision efforts were done on a community-wide, team basis with HF working in conjunction with other service agencies.

The predominant language in the region is English with a second language with a very small percentage of French. The area has a substantial history of French-Canadians moving to the region in the late 1800's and many family members following over the years. HF has one fluent French speaker and one Spanish speaker on staff assisting with interpretation with this population. Very small groups of new Americans are settled in the region by Lutheran services agency .

When they join us as clients we use services from Asetia for interpretation and translation.

The predominant cultural differences reported by clients in area surveys indicate a feeling of distinct social class differences. This is seen very readily in the Lakes Region. The large majority of the shoreline homes on the major lakes have been rebuilt over the past twenty years. Originally they were traditionally small, summer-only generational-owned cottages that have been repurchased, torn down and replaced by large, expensive homes built for year-round use. These large replacements are owned and occupied by very wealthy individuals coming from other states, particularly Massachusetts and New York. This is in sharp contrast to the majority of the population which occupies older housing including many triple level wood frame structures with various historic connections to the mill era bringing accompanying problems of lead paint and other environmental concerns and many pre-1950 farm homes. The discrepancy between the haves and have-nots has been noted in many of the surveys done by the various polls and mail-out questionnaires and reported by residents in the area as a cultural discrepancy causing concern to many residents. Additionally as in many other tourist areas, there is a segment of the population, particularly those living around the larger lakes (see Attachment 1): Lake Winnipesaukee, Lake Winnisquam, Squam Lake and Newfound Lake, who migrate south for the winter and live in the Lakes Regions during the warmer months of the year.

These varying characteristics of the population, geography, and socio-economic differences in status, and mortality and morbidity are utilized in designing and developing special programs to expand access to services in the region and are explained in the Service Delivery Section under Response. These differences have led to HF being engaged in community development activity and extensive participation in the development of the public health network that serves the region. The consistent provision of preventive and outreach services is also responsible for the advanced state of our combined efforts. HealthFirst Serves an area of the state that has higher than state average rates of Diabetes and Hypertension and very high rates of Illicit drug use particularly Opioid use. (State of NH Office of Public Health 2016) These special population characteristics are also emphasized in HealthFirst goals and in the agencies Health and Business Plans as they are related to the prevalence, and our choice of Health indicators.

Population Change: The small increases of the population in the area are related to two primary factors. Firstly, continuing housing price increases and housing shortages in the southern part of the state pushing population further north resulting in higher demand of housing in the Twin Rivers and Lakes Region. Secondly, the immigration and naturalization service and several significant social services agencies including Lutheran Social Services have been working to place a small number of immigrant populations in the region.

The very small minority populations produce some need for special services, individual care plans are sensitive to these and thought the use of cultural competency training and Medical interpreters we have special provisions for the small minority groups.

Health Disparities in the area are related to social determinants of health, the most prevalent being income and access to health care.

C. Gaps or duplications in primary health care services currently available in the agencies service area (e.g. provider shortages, role of any other providers who currently serve the target population.

In NH and across the nation, a limited pool of behavioral and medical health primary care providers (PCP) and an increasingly competitive market means fewer candidates, longer recruitment periods, and limited growth capacity. Access to care is limited for both insured and uninsured people because of provider vacancies.

The area was designated in its eastern end as a medically underserved population for primary care, oral health and mental health due to serious shortages of providers. HealthFirst has been actively engaged in a task force with other agencies in the region to develop a master plan for the increase of behavioral health services in the region and is pleased to report we have, during this past 11 years, truly integrated behavioral health into primary care through special program development initiatives, small local grants and working in conjunction with the local community mental health centers and other providers of behavioral health services. Similarly the addition of medical providers to HealthFirst has eased access to primary health care for many individuals. This just barely touches the surface of the need. Annually HealthFirst reviews our direct client services data and looks at access data.

Wait time to next available appointments for an array of medical and behavioral health services. we review this data in light of our staffing and the availability of referral services and make adjustments as finances allow. For the past four year as a result of this analysis we have been steadily increasing our integrated behavioral health in primary care to meet the demands in the region.

HealthFirst remains the primary agency for providing services to the uninsured. The common sliding fee scale discount mechanism along with the Affordable Care Act Market Place enrolments, that we jointly created across the service delivery system, has opened additional access to small amounts of specialty care with the specialty providers in the region. The difficulty in gathering new providers into the service delivery system has been particularly difficult for HealthFirst as has been the case for many other CHCs around the country. The scarcity of individuals who go into primary health care, the limited but recently improved amounts of money available for loan repayment, the differences in pay scale for primary care physicians vs. specialty physicians, the rural nature of our region and distance from the major metropolitan area of Boston all contribute to significant difficulties in recruiting and hiring new PCPs. During the 2017 calendar year, we were without one full-time primary care physician for eight months due to the untimely Death of our Senior Physician (and Medical Director) in a house fire. We are pleased that we have hired a physician coming out of Pennsylvania and she joined our staff in September, 2017. Additionally, we hired a Medical Director MD who started with us in May of 2018. New Nurse Practitioners are somewhat easier to recruit than primary care physicians. Recent changes in their availability have made recruitment less of a challenge. We are pleased to report that we have added a Nurse Practitioner with no gap until one had been with us for three years and decided to respond to the pleas from the local VA hospital and is now working there. In line with our statagic plan we have also just this week hired an additional APRN to assure access in a time ly basis in our laconia office .

There is one rural health centers West Side Health Care in our area who are affiliated with the local critical access hospital. HealthFirst works closely with them to assure we collectively serve the uninsured in the region. Additionally, there is a new FQHC who started in Plymouth, MidState Health Center (after we were open for ten years), who serves some clients in areas that overlap with us. HealthFirst has discussions with them regularly and are supportive of each other's efforts and working on developing several joint-service delivery programs

The growing numbers of uninsured and elderly population, the scarcity of primary care physicians in the region and other practices in the region being predominately closed to new patients, have all contributed to the HF interest in continued growth, particularly in the westeren end of our service area. While HF has not turned away any individuals, we are carefully reviewing our providers panels and looking at internal efficiencies to serve more clients in the region as other practices continue to close to new patients.

A thorough look at the service area population of 83,867 and survey results from the State Department of Public Health which was done just before the start of the open enrollment period for the market place, indicates there is still a 8.4% uninsured rate in the general population which is down 13.4% prior to the Affordable care act and expanded Medicaid.

Additionally, information from other CHC's that border our region and the RHC indicates additional uninsured that live in our region. This combined with our previously uninsured, equals a total of approximately 8900 previously uninsured are presently being served out of the 11,020 previously uninsured in the region, leaving 2,120 uninsured who did not appear to have a medical home with a PCP just prior to the last open enrollment. It has been noted through a study done by the State of NH Medicaid office, based on data from claims, that our two local hospitals LRGHealthcare and Franklin Regional have ER use that was considerably higher than expected for hospitals of their size. The service statistics from the ER clearly indicate that a larger than normal number of individuals were coming to the ER with acute medical conditions which could alternately be serviced by a CHC or PCP from a community practice. The majority of these individuals are uninsured. Through the 1115 waive Integrated Deliver Network (IDN) program HealthFirst has employed two full-time Care Coordinators who are a part of regional teams who have lowered the ER rate in the past year by 41% .

Given our current staffing pattern we are projecting that we can serve approximately 500 more individuals than present by the end of this reporting period ending September 2019 period. This service to the uninsured remains one of the major unmet needs in the region and continues to drive the Board of Directors (BOD) and staff of HealthFirst to work with all the other healthcare providers in the system to try to find additional funding to expand services and access to care for the uninsured. These numbers have also led to HealthFirst and LRGHealthcare into looking at, and developing under the safe harbor rules, a method of ER alternatives and care coordination across the service delivery system. This program started jointly in October, 2016. It identifies individuals at the community who are high users of the ER and, or hospital walk-in care who do not have a PCP, and have minor acute needs that could alternately be triaged and differed for treatment to HF, or at the RHC practice in the area. Clients who make this informed decision benefit from a shorter wait time for service, and may decide to make the health center or RHC their PCP. This ER alternative educates clients from other PCPs to refer them back on the spot to their PCPs for service; thus, saving valuable resources and making for better continuity of care.

Oral health provision is in scarce supply with a very small dental professional presence. HealthFirst has worked in conjunction with local dental providers and LRGHealthcare over the past several years and has made small improvements in the availability and access of oral health services. This was accomplished through the joint development, with LRGHealthcare Dental Resource Center, with a grant from the local

endowment for health, and several other small local grants, and Oral health Service capacity expansion grant in 2016. HealthFirst also operates a small children's outreach preventative dental program with state grants. LRGHealthcare hospitals and primary care practices are the majority of other PCPs in the region. They indicate that their practices are predominately full to acceptance of new patients

D. New Hampshire Environment - SFY 2018

There is concern that changes to the contracting for companies on the Exchange may have negative financial and clinical implications for the community Health centers in New Hampshire.

Successful efforts, with increasing enrollment in the Affordable Care Act and Expanded Medicaid, have had a positive impact which makes for a better ending fiscal year for HealthFirst.

Through our joint efforts with other agencies in the region and several grants we have received, we have achieved a very high percentage, compared to national averages of new individuals enrolled in the Affordable Care Act (in the past year insuring over 40% of the total eligible target population in our region). Similar results have developed in the Expanded Medicaid program in New Hampshire, started in September 2014 and already achieving a very high percentage of eligible enrolled. These efforts combined are greatly improving access to healthcare. We worked jointly with local community hospitals, elderly service providers and resources centers on a joint action plan to increase awareness and enrollment in health insurance under the Affordable Care Act and Expanded Medicaid.

The last eight years have shown a slow but steady recovery in the economy of the area. Unfortunately, many people who lost good paying jobs in the manufacturing sector saw those facilities close, never to return; therefore, taking jobs in our growing service economy sectors where wages are less, the company medical benefits are greatly reduced or not present.

There are no particular changes to the special populations. Immigration and resettlement to the area was way down to under 36 individuals in the last three years combined. The % of elderly in the population continues to grow and is reflected in our growing elderly client sub-population and Medicare payments.

The continually changing payment structure and funding sources continue to create a challenging environment in which to operate New Hampshire's health centers. The end result is that community health centers are extremely cautious about developing new services and do extensive analysis of cost, versus benefits, in terms of client outcomes before attempting any program changes.

The opioid crisis has led to an expansion of the agencies Behavioral Health and Medication assisted treatment programs.

The past five years of turmoil in state budgets are now behind us but has left the staff and Board with a new resolve to have a larger percentage of our funding relying on fees paid by insurance rather than state grants, which continue to be erratic.

Section II. A regional public health needs assessment jointly with other agencies in the region as part of the work of the Winnipesaukee Public Health Council Regional Assessment. *(See attachment 2)*

Winnipesaukee Public health Council Community data gathering

7 Community Discussions (Focus Groups)

7 Online Surveys (Survey Monkeys)
2 In Person Surveys
17 Drop Box Locations at several town halls and libraries
242 Total respondents

Most Important Health Issues

Alcohol and Drug Abuse	74.38%
Mental Health Care	52.48%
Mental Illness (Depression, Anxiety, etc.)	50.83%
Health Care For Seniors	33.88%
Primary Health Care	25.62%

Most Important Safety Issues

Child abuse or neglect	51.65%	125
Crime	46.69%	113
Domestic violence or partner abuse	43.39%	105
Being prepared for an emergency	35.54%	86
Safety of public place (parks, streets, etc.)	33.88%	82

Most Important Issues to Promote Healthy Individuals and Families

Affordable housing	64.05%
Making a living wage	63.22%
Employment opportunities locally	52.89%
Education in the public schools	47.93%
Job training opportunities	44.21%
Adult education and learning opportunities	40.91%
Recreation opportunities	31.40%
Arts and cultural events	19.83%
Literacy	15.29%

Which resources should be available in the community

Drug and alcohol abuse treatment	51.79%
Drug and alcohol abuse prevention activities	49.11%
Mental health counseling	48.66%
Public transportation	48.21%
Job training	41.96%

Where resources should be focused

Substance abuse recovery programs	64.88%
Public transportation	45.45%
Job development	42.15%
Support for older adults	37.60%
Affordability of food	33.47%
Ability to get housing assistance	31.40%
Children's programs and support	31.40%
Ability to get quality child care	27.27%
Parenting support	26.03%
Services for persons with disabilities	23.14%
Preparing for emergencies	17.77%
Affordability of clothing	9.09%

Section III. An update to improvements and meeting of objectives from the data gathered jointly with the Winnipesaukee CHIP Community Health Improvement Plan. *(See attachment 3)*

A. Community Health Improvement Plan progress report 2018

The Winnipesaukee Public Health Council (of which HealthFirst is an active member and our CEO is currently Co-Chair, conducts a needs assessment for the region every three years.

This needs assessment feeds the development and monitoring of the Winnipesaukee Regional Health Improvement Plan and the HealthFirst Strategic Plan (CHIP).

The original Community Health Improvement Plan (see attachment 4) for the Winnipesaukee Public Health Region was created in 2015. We are now at the halfway point of the plan and we are evaluating the progress that we have made towards the goals we set in our eight priority areas. Unfortunately, the original community health improvement plan was not designed with the idea that goal progress could be tracked on an annual basis. Many of the original baselines have not been updated by their sources so the process of evaluating progress made was difficult. In addition, the original sources for some of the baselines weren't appropriate or relevant to the measures that we wanted to track.

Priority Area 1 –

According to data from the Small Area Health Insurance Estimates conducted in 2016, 8.1% of people in Belknap County and 7.1% of people in Merrimack County do not have health insurance. Using these numbers as well as the town population estimates from the New Hampshire Office of Strategic Initiatives, we can estimate that the uninsured rate within the Winnipesaukee Public Health Region is approximately 7.9%. This means that approximately 92.1% of the Winnipesaukee Public Health Region is insured which meets the goal that we set forward in the original CHIP.

For the original baseline related to the percent of our population with a primary care provider, a question was used from the 2012 Behavioral Risk Factor Surveillance System pertaining to healthcare accessibility. I believe this question was used because it was one of the few years that there was a large enough sample size of respondents from the Laconia metropolitan area to be significant. However, this question does not really address the percentage of people in our public health region who have a PCP. New Hampshire as whole has not improved on this measure during the same time period.

Ratio of population to PCP is 1440:1 for Belknap County and 900:1 for Merrimack County as of 2015.

Priority Area 2 –

2017 Data from County Health Rankings suggest that Belknap County has the best ratio of population to mental health providers in the state of New Hampshire at 220:1. Merrimack County has the 3rd best ratio at 310:1. This suggests an immense improvement in this priority area which was measured at 801:1 in 2010.

Priority Area 3 –

Overdose death rates as of 2017 remain high in the Belknap health region. The 4.47 overdose deaths per 10,000 population trails only the Hillsborough region. Fentanyl remains the most lethal and toxic drug to public health. This is most commonly combined with cocaine.

The trends in Narcan Administration indicate a spike during summer months, particularly July. Belknap averaged 1.48 per 10,000 Narcan incidents during the month of July. This trend has been consistent since 2015 and looks like the same pattern in 2018.

Narcan is proven to save lives, but there is little evidence it helps to improve public health.

Data suggests that a pattern of increased use of Narcan begins in May, peaking in July. In 2018, Belknap had the highest Emergency related visits due to opioid abuse of any public health region at 6.22 per 10,000 population.

Emergency Department visits increased statewide by 4% from June to July. Again, July is a month to monitor. This may be a time to make a point of emphasis on emergency preparedness.
The age group with the largest number of opioid related Emergency Department visits was 30-39 with 37% of all opioid related Emergency Department visits for July across the state.

The data statewide says treatment favors no gender. 52% male, 48% female. For Belknap, the data suggests there is no drug that poses a greater threat to public health security than opioids at this time. By far most hospital admissions are related to heroin and fentanyl.

Priority Area 6 –

Obesity among third graders: Most of the baseline data hasn't been updated since the baselines were taken so we have been going to different sources to see if we can find updates. New Hampshire Healthy Smiles

survey was conducted in 2009 and 2014. Has not been updated since. Obesity among third graders and high school students was respectively 12.6% and 12.2% for the whole state in 2015. https://wisdom.dhhs.nh.gov/wisdom/#Topic_C592D4F396C546058649E106C802DB89_Anon

According to the 2016 National Survey of Child's Health, the obesity rate for children 10-17 was 8.5% in New Hampshire compared to 16.1% nationally. Overweight rate for NH was 15.3%. New Hampshire is the fifth least overweight state for children between the ages of 10 and 17 years old in the nation. http://childhealthdata.org/browse/survey/results?q=4576&r=1&r2=31

Unfortunately, this survey data isn't broken down by county but if we use the decrease of 3.5%-4.1% across the state as a representation of the county, it seems to be a pretty significant decrease. The CDC reported no significant change in WIC participant obesity for NH between 2010 and 2014. https://www.cdc.gov/obesity/downloads/wic-science-in-brief.pdf

Breastfeeding: The breastfeeding baseline is not explicitly mentioned. The statistics referenced in the press release don't make sense. https://www.dhhs.nh.gov/dphs/nhp/documents/bfdatabrief2011.pdf Unfortunately, New Hampshire is the only state in New England that hasn't yet met the HP2020 goals for initiating breastfeeding (81.9%) as of 2016. State-wide, the rate of initiation is 79.6% and breastfeeding at 6 months is at 54.8%. https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf

This suggests a regression if anything for this particular objective.

Priority Area 7 –

State-wide behavioral health risk factor assessment shows that 82% of households surveyed say they believe we are prepared for handling regional public health emergencies.

Priority Area 8 –

Merrimack County improved between 2012 and 2016 in both poverty rate and median household income. https://www.census.gov/datatools/demo/saipe/saipe.html?s_appName=saipe&map_yearSelector=2016&map_geoSelector=aa_c&s_state=33&s_county=33001,33013&menu=trends&s_inclStTot=y&s_USStOnly=n&s_measures=mhi_snc

Belknap County initially improved between 2012 and 2016 in both poverty rate and median household income but regressed significantly in 2016 back to 10%, erasing two years of progress. https://www.census.gov/datatools/demo/saipe/saipe.html?s_appName=saipe&map_yearSelector=2016&map_geoSelector=aa_c&s_state=33&s_county=33001,33013&menu=trends&s_inclStTot=y&s_USStOnly=n

Attachment 1: Map of HealthFirst Service Area

Attachment 2: Additional results from community surveys

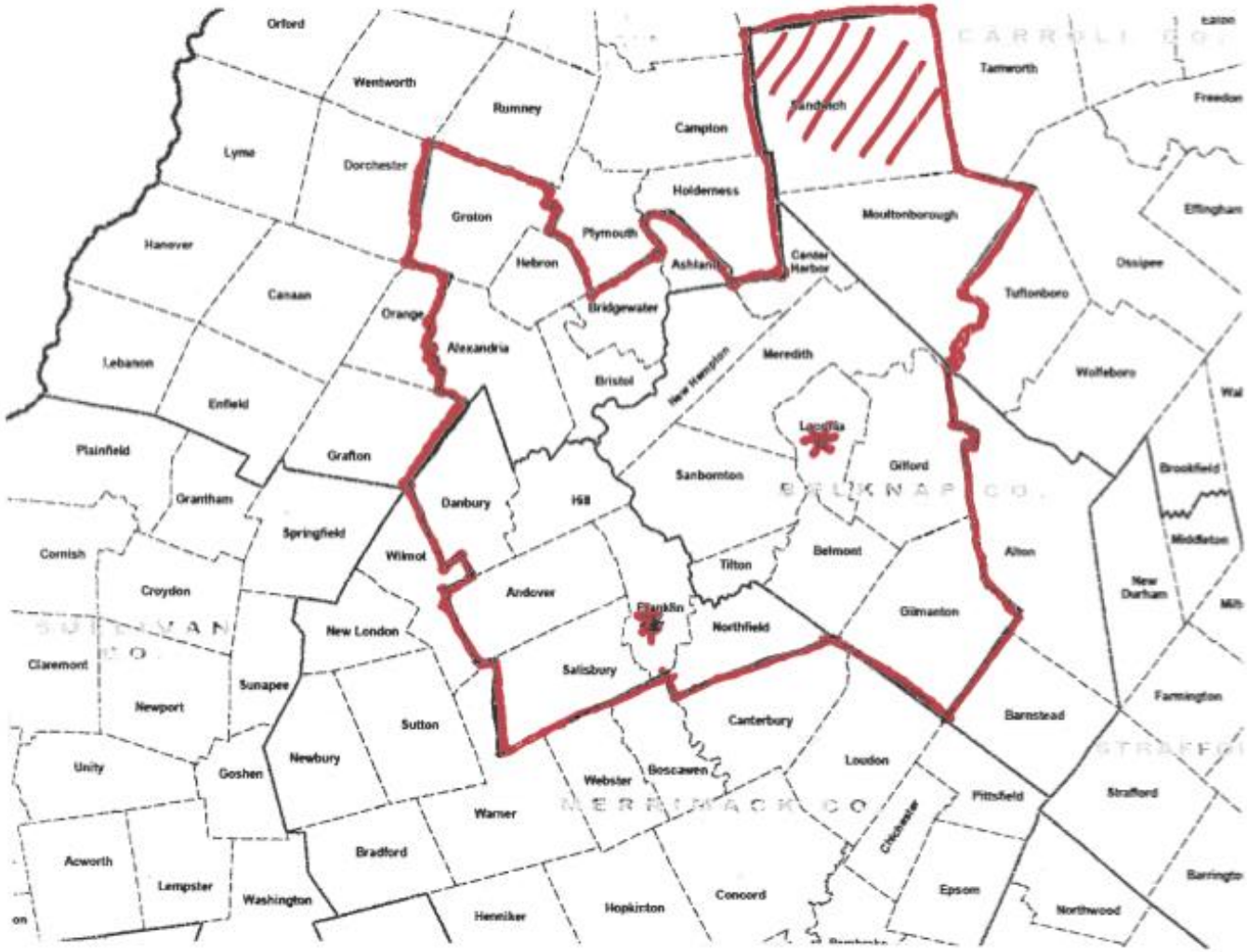
A. Social and Human Services to promote healthy individuals and family, where do you feel our community should focus its resources? (Check five)

Substance abuse recovery 64.88%

B. Have you had trouble getting services or assistance in the past year?

Dental – health professionals	39%
Social/human service agencies	30%
Medical professionals	28%
Mental health professionals	25%
Routine health care	25%
Drug and alcohol services	25%

Attachment 4: Community Health Improvement Plan (CHIP_wphc 9.16.pdf)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Hanover
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Hebron
Ashland
Center Harbor
Tuftonboro
Canaan
Orange
Bridgewater
Alexandria
Bristol
Meredith
Wolfeboro
Lebanon
Enfield
New Hampton
Laconia
Plainfield
Grafton
Sanbornton
Gilford
Grantham
Danbury
Hill
Springfield
Cornish
Wilmot
Tilton
Belmont
Alton
Croydon
Andover
Franklin
Gilmanton
New London
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