2026 Capital Region and Lakes Region Community Health Needs Assessment















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

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Foundation for Healthy Communities

Capital Region and Lakes Region

Community Health Needs Assessment

2026

Community Input on Health Issues and Priorities,

Selected Service Area Demographics and Health Status Indicators

Your input is valuable!

Please share your comments and questions about our Community Health Needs Assessment and our Community Benefits Action Plan by email:

communitybenefits@crhc.org

The 2026 Capital Region and Lakes Region Community Health Needs Assessment Partnership includes Concord Hospital, Community Action Program Belknap-Merrimack Counties, Capital Area Public Health Network-Granite United Way, Concord Coalition to End Homelessness, Granite VNA, Granite State Independent Living, HealthFirst Family Care Center, Lakes Region Mental Health Center, the Partnership for Public Health, Riverbend Community Mental Health, Overcomers Refugee Services, and the Foundation for Healthy Communities, with technical support from the NH Community Health Institute.

Capital Region and Lakes Region

2026 Community Health Needs Assessment

Executive Summary

During the period November 2025 to August 2026, an assessment of Community Health Needs in the Capital Region and Lakes Region of New Hampshire was completed by Concord Hospital in partnership with Community Action Program Belknap-Merrimack Counties, Capital Area Public Health Network-Granite United Way, Concord Coalition to End Homelessness, Granite VNA, Granite State Independent Living, HealthFirst Family Care Center, Lakes Region Mental Health Center, the Partnership for Public Health, Riverbend Community Mental Health, Overcomers Refugee Services, and the Foundation for Healthy Communities. 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 Concord Hospital and partner organizations.

The geographic area of interest for the assessment was 49 municipalities comprising the primary service area of the Concord Hospital System with a total resident population of 254,860 people. Methods employed in the assessment included:

- surveys of community residents made available through direct mailing, social media, email distribution and website links through multiple channels throughout the region (n=1,880);
- direct email survey of community leaders and service providers representing multiple community sectors (n=143);
- survey of staff of the Concord Hospital health system (n=630);
- 12 discussion groups convened in-person across the region (94 participants); and
- assembly and analysis of available demographic and population health indicators including drivers of health characteristics of the service area communities.

Community engagement and information gathering 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, and 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 graphic on the following page provides a summary of the key findings and priority community health issues identified through this assessment. A more complete summary is included in table format as Appendix 1 at the end of this report.

2026 CAPITAL & LAKES REGION COMMUNITY HEALTH NEEDS ASSESSMENT

SUMMARY OF PRIORITY ISSUES AND FINDINGS FROM COMMUNITY SURVEYS, DISCUSSIONS, AND INDICATORS

Availability of Behavioral Health Services



- Surveys: Adult mental health care is a top challenge (long waits), #1 most difficult service for patient access per hospital staff; ~40% say access is worsening.
- Indicators: Self-harm ER visits are significantly higher than the state average.
- Discussions: Major concerns revolve around staff turnover, stigma, and youth mental health.

Affordability of health care services and insurance



- Surveys: Over 68% say affordability of health care has gotten worse in past few years; out-of-pocket expenses are cited as a top barrier to care.
- Indicators: 6% of residents do not have health insurance; 10%+ uninsured in 6 service area towns.
- Discussions: Affordability of health care, insurance and prescription medications is a major theme.



Resources for healthy, active lifestyles

- Surveys: Top resources people would use more are recreation and fitness programs (31%), and walking and biking paths (27%).
- Indicators: Heart disease mortality is significantly higher in the Lakes Region than the rest of New Hampshire.
- Survey comments: Desire for safe walking routes, affordable fitness options, and resources for stress reduction.

Health care provider access and availability - primary care, urgent and emergency care



- Surveys: ~20% report difficulty accessing primary or specialty care (long waits, not accepting new patients).
- Indicators: Lakes region - highest percentage of residents without a personal provider (~20%) and longest travel times in the state.
- Discussions: Complaints of provider turnover, ED overcrowding, and navigation difficulties.

Adult Dental Care affordability and availability



- Surveys: Most frequently reported as being difficult to access by community residents (30%).
- Indicators: Rate of ED visits for non-traumatic dental conditions significantly higher than the rest of NH.
- Discussions: A topic of comments, though less frequently mentioned than medical and behavioral health needs.



Services for older adults; supports for aging in place

- Surveys: 15% of respondents indicated difficulty getting ‘in-home support services’; 13% had difficulty getting ‘help caring for aging family members’.
- Indicators: Aging population (21% are 65+); 26% of older adults report a recent fall.
- Discussions: Need for home maintenance help, transportation, addressing social isolation. and long term care planning.

Non-Medical Drivers of Health



Housing: #1 priority for leaders (78%). 45% of renters face high cost burdens.



Food: 67% say healthy food is unaffordable. 11% face food insecurity.



Childcare: 16% report access difficulty; high costs, low availability



Financial insecurity: Rising cost of living an overarching concern.

Capital Region and Lakes Region

2026 Community Health Needs Assessment

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A. Community Overview with Selected Service Area Demographics

The total resident population of the Capital Region and Lakes Region is estimated as 254,860 (United States Census Bureau, American Community Survey, 2020-2024); equivalent to about 18% of the total population of New Hampshire. The service area population has increased by approximately 2% or about 5,000 people since the last Community Health Needs Assessment in 2023.

Table 1 on the next page 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 (NH) overall, the service area population has a similar proportion of seniors - (about 21% are 65+ compared to about 20% in NH overall) - while the median age of service area residents is slightly older (about 45 compared to 43 years of age).

A substantial range is observed within the region for the percentage of older adults. About 14% of residents in Weare are aged 65+ compared to 47% of Sandwich residents. A similar, inverse range is observed for the percentage of residents who are under 18 years of age. About 25% of residents in Bow and Windsor are youth under 18 compared to 7% of Sandwich residents.

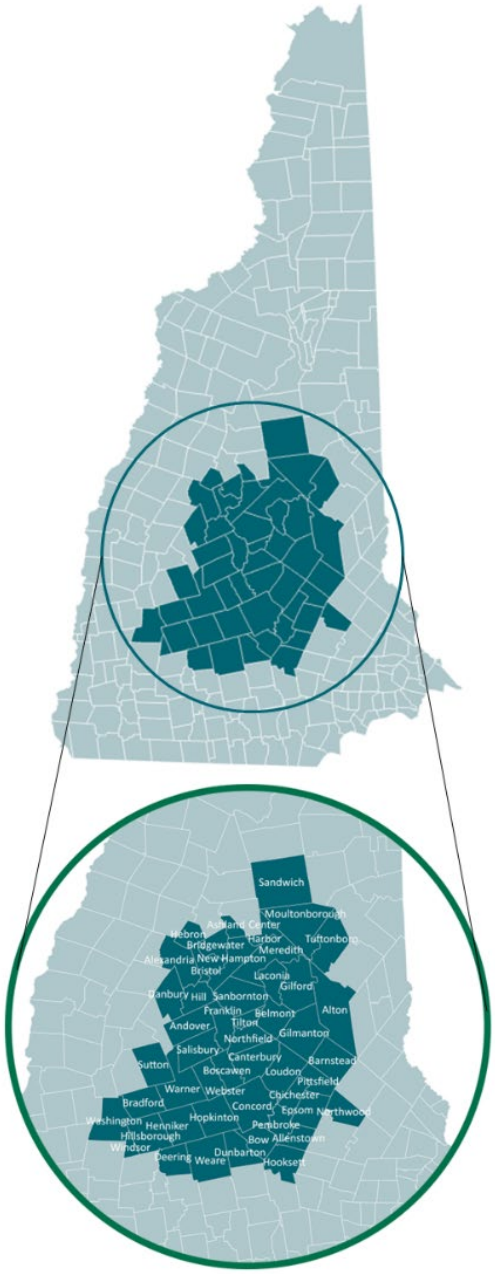


Figure 1: Concord Hospital System Primary Service Area

TABLE 1: Service Area Population by Municipality

Municipality (in alphabetical order)	2024 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Alexandria	1,983	1%	53	14%	25%
Allenstown	4,743	2%	39	20%	16%
Alton	5,994	2%	54	13%	25%
Andover	2,135	1%	46	13%	28%
Ashland	2,183	1%	42	21%	26%
Barnstead	4,994	2%	43	21%	21%
Belmont	7,392	3%	47	18%	22%
Boscawen	4,044	2%	46	18%	25%
Bow	8,335	3%	42	25%	18%
Bradford	1,565	1%	50	21%	26%
Bridgewater	1,169	0%	58	11%	33%
Bristol	3,273	1%	43	24%	23%
Canterbury	2,353	1%	49	17%	23%
Center Harbor	955	0%	60	12%	39%
Chichester	2,745	1%	43	20%	17%
Concord	44,375	17%	41	17%	19%
Danbury	1,451	1%	47	17%	24%
Deering	1,938	1%	49	17%	24%
Dunbarton	3,097	1%	48	20%	20%
Epsom	4,939	2%	47	18%	21%
Franklin	8,799	3%	43	18%	21%
Gilford	7,830	3%	48	21%	22%
Gilmanton	4,026	2%	45	18%	17%
Hebron	883	0%	58	12%	38%
Henniker	6,197	2%	31	15%	17%

Municipality (in alphabetical order)	2024 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Hill	908	0%	49	11%	29%
Hillsborough	5,980	2%	41	17%	16%
Hooksett	15,057	6%	41	17%	17%
Hopkinton	6,037	2%	45	19%	20%
Laconia	17,085	7%	45	18%	23%
Loudon	5,692	2%	50	17%	22%
Meredith	6,758	3%	56	13%	34%
Moultonborough	5,126	2%	58	11%	35%
New Hampton	2,509	1%	52	14%	25%
Northfield	4,971	2%	43	20%	17%
Northwood	4,688	2%	42	18%	22%
Pembroke	7,438	3%	42	24%	16%
Pittsfield	4,105	2%	42	21%	19%
Salisbury	1,609	1%	52	20%	25%
Sanbornton	3,053	1%	42	18%	22%
Sandwich	1,757	1%	64	7%	47%
Sutton	2,239	1%	48	20%	22%
Tilton	4,063	2%	50	16%	26%
Tuftonboro	2,569	1%	52	18%	28%
Warner	2,959	1%	44	17%	20%
Washington	1,208	0%	55	14%	29%
Weare	9,170	4%	46	22%	14%
Webster	2,227	1%	45	23%	19%
Windsor	254	0%	40	25%	16%
Capital & Lakes Region	**254,860**	**100%**	**45**	**18%**	**21%**
New Hampshire	**1,394,868**	**---**	**43**	**18%**	**20%**

Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates.

Table 2 displays additional demographic information for the towns and cities of the Capital and Lakes Region service area. The region overall has slightly lower median household income ($96,997) compared to New Hampshire overall ($99,031). There is also a substantial range within the region on this measure with the highest median household income community (Bow, $172,857) having more than 3 times higher income than the lowest income community (Ashland, $54,607).

Similarly, a substantial range is observed for the percent of people living below the federal poverty level (FPL) with about 1% of Weare residents living below the poverty level compared to about 21% of Ashland residents. Overall, the percent of residents within the service area living below the federal poverty level is similar to NH's overall percentage at about 8% of households. The map following Table 2 displays the distribution of median household income across towns in the service area.

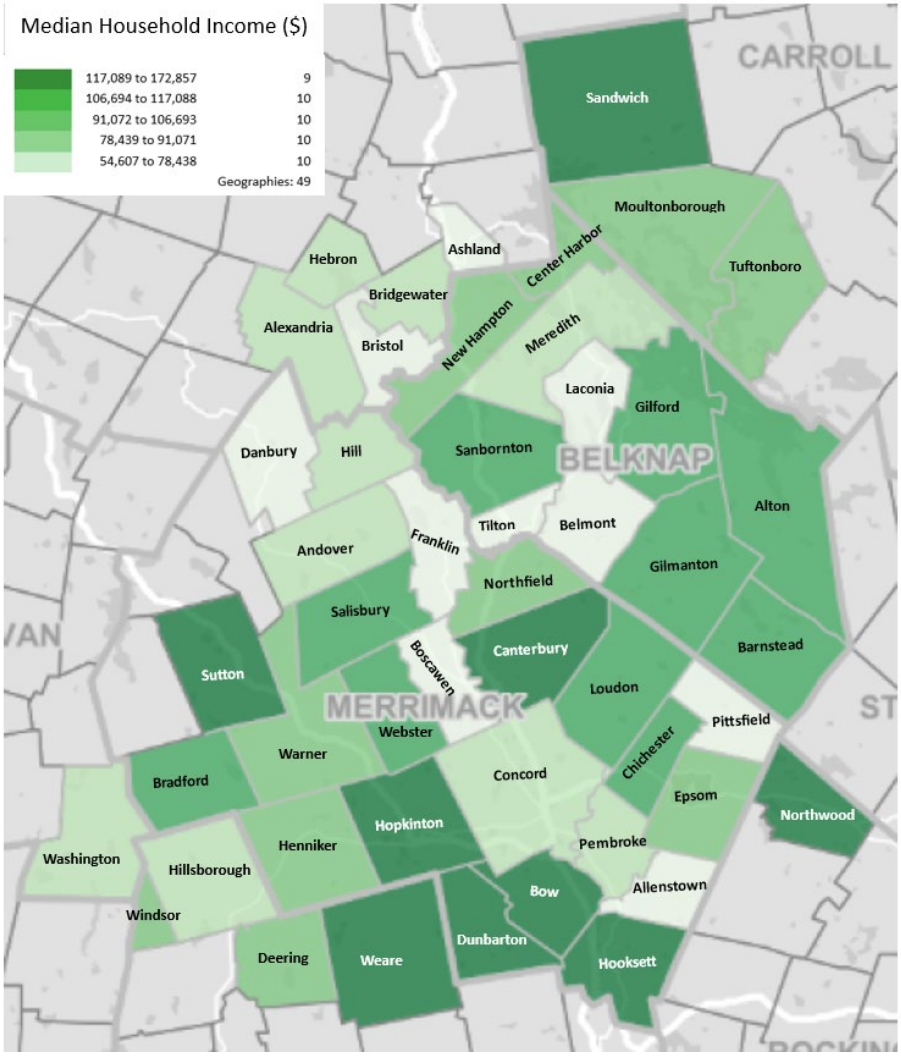
TABLE 2: Selected Demographic and Economic Indicators

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
Bow	$172,857	3%	15%	11%
Sandwich	$140,694	5%	9%	11%
Hopkinton	$137,477	7%	18%	11%
Sutton	$130,313	5%	20%	12%
Northwood	$129,375	7%	28%	11%
Canterbury	$129,333	5%	18%	8%
Dunbarton	$124,348	3%	0%	12%
Weare	$118,271	1%	16%	14%
Hooksett	$117,962	3%	16%	11%
Gilmanton	$117,088	4%	13%	6%
Gilford	$116,635	6%	17%	16%
Sanbornton	$113,750	5%	37%	22%
Alton	$113,715	4%	10%	12%
Barnstead	$111,660	3%	22%	10%
Salisbury	$111,591	7%	20%	14%
Chichester	$109,297	6%	31%	13%
Bradford	$108,015	10%	38%	11%
Webster	$107,171	10%	23%	12%
Loudon	$106,966	4%	6%	15%
Moultonborough	$106,693	2%	45%	17%
Center Harbor	$104,313	2%	11%	21%

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
Windsor	$103,750	11%	15%	6%
Deering	$101,250	14%	17%	18%
Tuftonboro	$100,574	4%	31%	15%
New Hampshire	**$99,031**	**7%**	**27%**	**13%**
Epsom	$97,941	3%	18%	12%
Capital & Lakes Region	**$96,997**	**8%**	**28%**	**15%**
New Hampton	$95,250	13%	19%	22%
Henniker	$95,206	12%	29%	13%
Warner	$94,022	8%	30%	10%
Northfield	$92,917	8%	36%	21%
Hebron	$91,071	15%	39%	16%
Pembroke	$89,519	15%	18%	15%
Washington	$89,453	9%	37%	19%
Alexandria	$89,194	10%	31%	16%
Andover	$88,514	11%	28%	11%
Meredith	$87,019	8%	28%	14%
Concord	$84,902	9%	42%	17%
Hillsborough	$84,495	6%	20%	13%
Bridgewater	$82,361	12%	23%	17%
Hill	$82,125	10%	18%	23%
Bristol	$78,438	10%	40%	13%
Boscawen	$77,328	17%	9%	14%
Pittsfield	$74,318	11%	57%	21%
Laconia	$73,218	13%	48%	17%
Allenstown	$72,500	12%	35%	18%
Danbury	$71,685	12%	36%	17%
Franklin	$71,648	7%	29%	20%
Belmont	$69,063	10%	16%	15%
Tilton	$66,667	13%	57%	15%
Ashland	$54,607	21%	50%	22%

Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates.

Figure 2 – Median Household Income by Town, Capital & Lakes Region



As displayed by Table 3, about 92% of the population of the Capital & Lakes Region identify as 'White' and nearly 5% identify as '2 or more races' according to the U.S. Census Bureau. About 3% of residents identify 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	Asian	Black / African American	American Indian / Alaska Native	Native Hawaiian / Pacific Islander	Other Race	Hispanic or Latino
Capital & Lakes Region	91.6%	4.8%	1.3%	1.2%	0.1%	<0.1%	0.9%	2.8%
New Hampshire	87.9%	6.4%	2.6%	1.5%	0.1%	<0.1%	1.4%	4.7%

Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates.

Drivers of Health: The 2026 Community Health Needs Assessment is based on the understanding that the conditions of communities where we are born, live, age, work, and play can be 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 that health outcomes 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.

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.

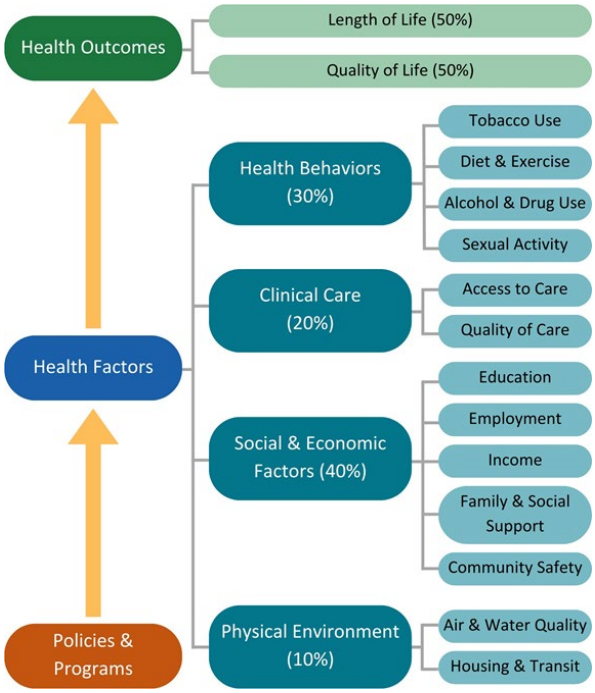


Figure 3: County Health Rankings Model

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 2026 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

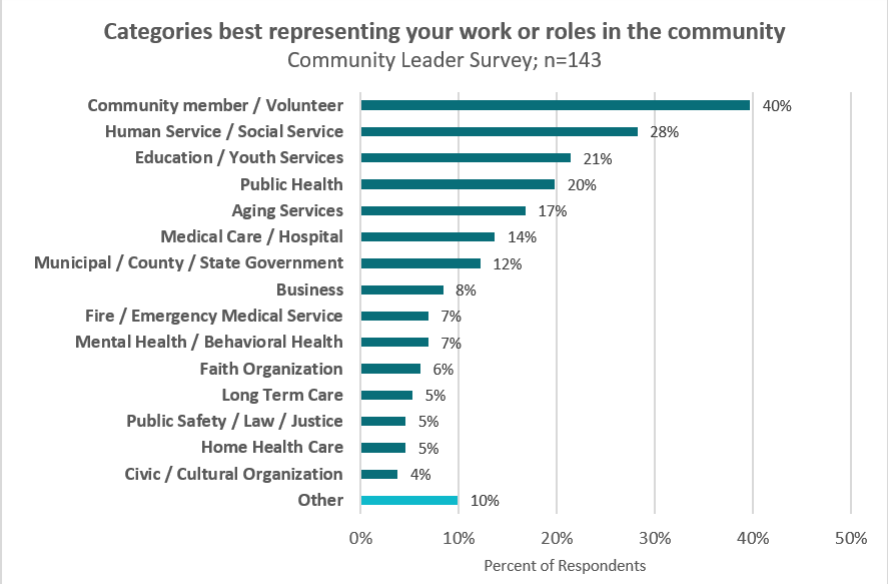
Between February and June 2026, the Community Health Needs Assessment committee fielded three different, but related surveys: one with targeted distribution to community leaders and service providers; one survey broadly disseminated to residents across the region; and one survey of all Concord Hospital System staff members. 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 277 individuals in key positions of formal or informal leadership or community service in agencies, municipalities, business, civic and volunteer organizations across the Capital Region and Lakes Region. The survey distribution list was developed by the Community Health Needs Assessment Steering Committee (see Appendix 2). Understanding that community leaders may be more familiar with some areas than others in the relatively large region, the survey instrument asked respondents to identify 'the areas you primarily serve or are most familiar with'. Of the 277 partners invited to participate in the Community Leader Survey, 143 completed surveys (52% response).

Figure 4 displays the range of community sectors represented by these individuals. Respondents could select more than one sector and more than one geographic area to reflect their community role or work.

Note: Respondents could choose more than one community sector and more than one sub-region.

| Figure 4: Community Sectors Represented in Community Leader Surveys |



Please select the areas you primarily serve or with which you are most familiar.	
Greater Concord area	51% (73 respondents)
Greater Laconia area	46% (65)
Greater Franklin area	29% (42)
Greater Hillsborough area	7% (10)
All of the above	6% (9)
Other area	12% (17)

The community resident survey was distributed electronically through email and social media communication channels, as a pop up on the Concord Hospital website, 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 community meetings and clinics. In addition to English language, online and paper surveys were available in Swahili and Kinyarwanda.

A total of 1,880 people completed the Community Resident Survey representing all 49 towns of the Concord Hospital System primary service area (by zip code, some towns share a common zip code) as well as a other surrounding communities. Table 4 displays the number of respondents by community. The most common locations outside the primary service from which responses were received included Manchester (16 responses), Wolfeboro (10), Thornton (7), Deerfield (6), Newport (6), and Ossipee (5).

| Table 4: Survey Response Totals by Community |

City / Town	# of respondents	% of total*
Concord	330	21%
Laconia	159	10%
Boscawen, Concord-Penacook, Webster (03303)	125	8%
Franklin	78	5%
Tilton, Northfield (03276)	55	3%
Belmont	52	3%
Meredith	46	3%
Allenstown, Pembroke, (Suncook, 03275)	45	3%
Gilford	42	3%
Bow	41	3%
Hopkinton	40	3%
Loudon	40	3%
Hillsborough, Deering, Windsor (03244)	35	2%
Epsom	28	2%
Henniker	23	1%
Pittsfield	21	1%
Gilmanton	21	1%
Sanbornton	20	1%
Canterbury	19	1%
Warner	18	1%
Barnstead	18	1%
Weare	17	1%
Bristol, Alexandria (03222)	16	1%
Moultonborough	15	1%
Alton	15	1%
Bridgewater, (Plymouth, 03264)	14	1%
Center Harbor	12	1%
Chichester	11	1%
Hooksett	10	1%
Northwood	10	1%
Towns with 1 to 9 respondents: Andover, Ashland, Bradford, Danbury, Dunbarton, Hebron, Hill, New Hampton, Salisbury, Sandwich, Sutton, Tuftonboro, Washington	56	4%
Other locations not in the primary service area	145	9%

***Percent of respondents who provided information on the location of their residence. About 16% of respondents did not provide this information.**

Table 5 displays selected characteristics of respondents to the community survey. Compared to the general population, respondents included a higher proportion of females and people ages 65 years or older. Approximately 30% of respondents have household income of less than $50,000, while 22% reported household income of $100,000 or more. About 21% of respondents preferred not to report a household income category.

| Table 5: Demographic Characteristics Community Resident Survey Respondents |

Age < 45 years	Age >= 65 years
22%	47%
Woman	**Black, Indigenous and People of Color**
73%	6%
Household Income < $50K	**Household Income > $100K**
30%	22%
Currently Uninsured	**Currently has Medicaid coverage**
4%	15%

Percentages are of the total respondents who answered the question.

1. Progress on Community Health Priorities and Concerns

Assessments of community health needs are conducted regularly by Concord Hospital and partner organizations. Over the course of these assessments, a relatively consistent pattern has been observed regarding priority issues and concerns identified for health improvement by the community. Among these priorities have been:

- Cost of health care services and 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 housing, transportation, food and child care

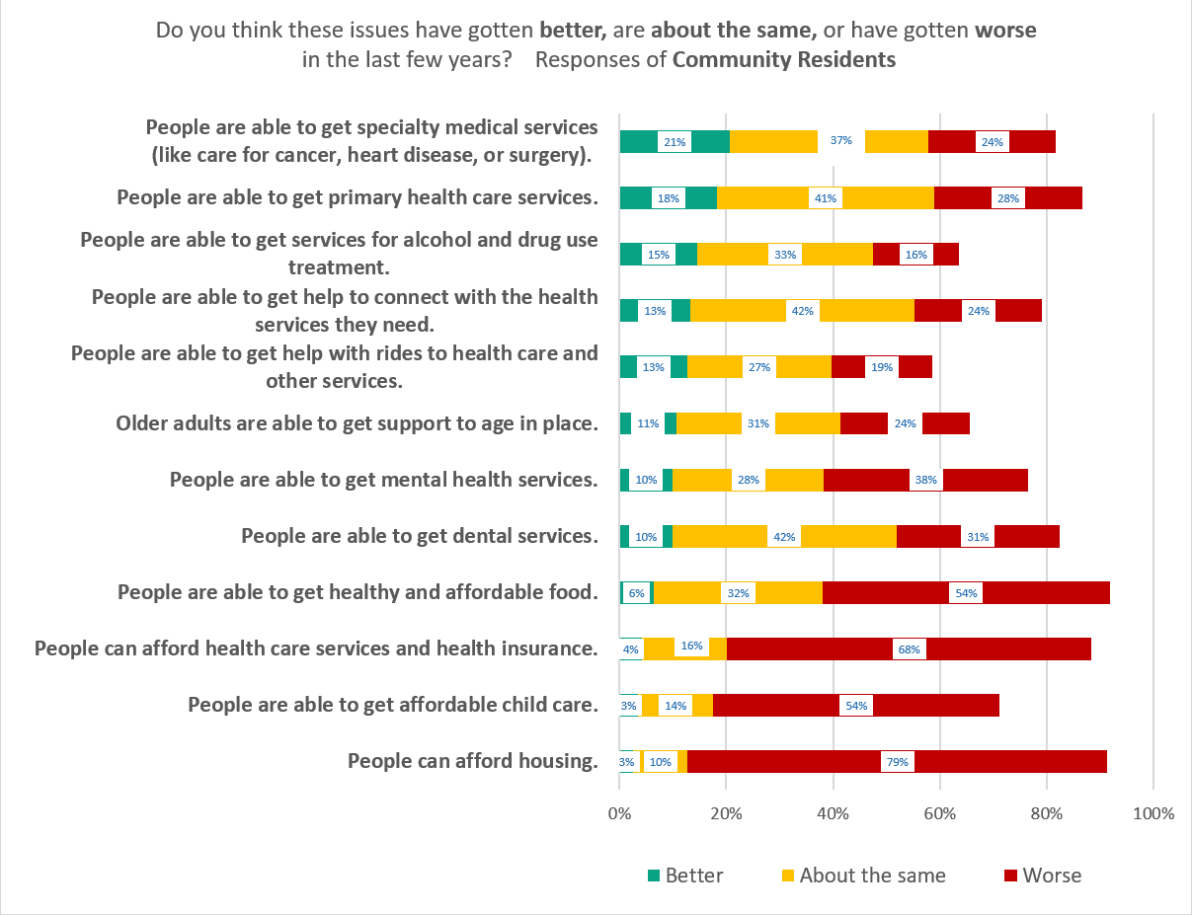
In consideration of this observed consistency over time, the 2026 Community Health Needs Assessment asked respondents to the Community Resident and Community Leader surveys to reflect on a set of statements describing the main priorities and themes identified in the recent past by indicating whether 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 issues listed below are the most important for us to work on. Do you think these issues have gotten better, are about the same, or have gotten worse in the last few years?"*

Figure 5 displays the results for this question set from respondents to the community resident survey. Ability to get specialty medical care services was reported to be 'Better' by 21% of survey 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 18% of respondents and ability to get alcohol and drug treatment was reported 'Better' by about 15% of respondents.

In general, more community residents reported needs have gotten worse than those reporting needs have gotten better in most of the topic areas. In particular, a majority of survey respondents indicated that affordability of health care, child care, and housing have gotten worse over the past few years.

| Figure 5 |



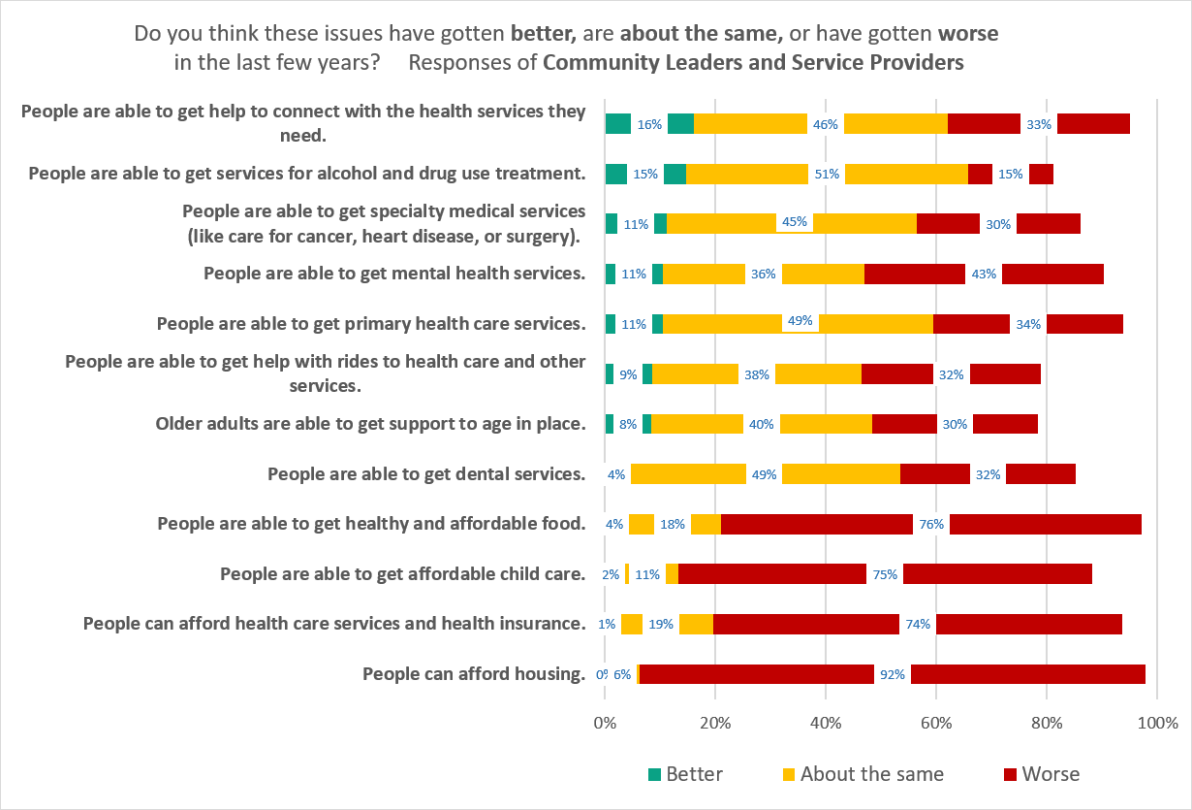
Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the issue is Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

> *"We have a good local hospital with a reasonable physician network, but healthcare is becoming increasingly unaffordable.*
> - *Community Resident Survey Respondent*

Figure 6 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 the community leaders also being more likely to indicate needs overall have gotten worse than better.

Nearly all community leader survey respondents indicated the ability to afford housing has gotten worse and a majority of community leader respondents also indicated that affordability of child care, food, and health care services have gotten worse. Community leaders were most likely to indicate that ability to get help to connect with needed health services has improved (16%, Better). Similar to responses on the community resident survey, other issues most likely to be reported as 'Better' were services for alcohol and drug treatment (15%, Better), medical sub-specialties (11%), mental health (11%), and primary care (11%).

| Figure 6 |



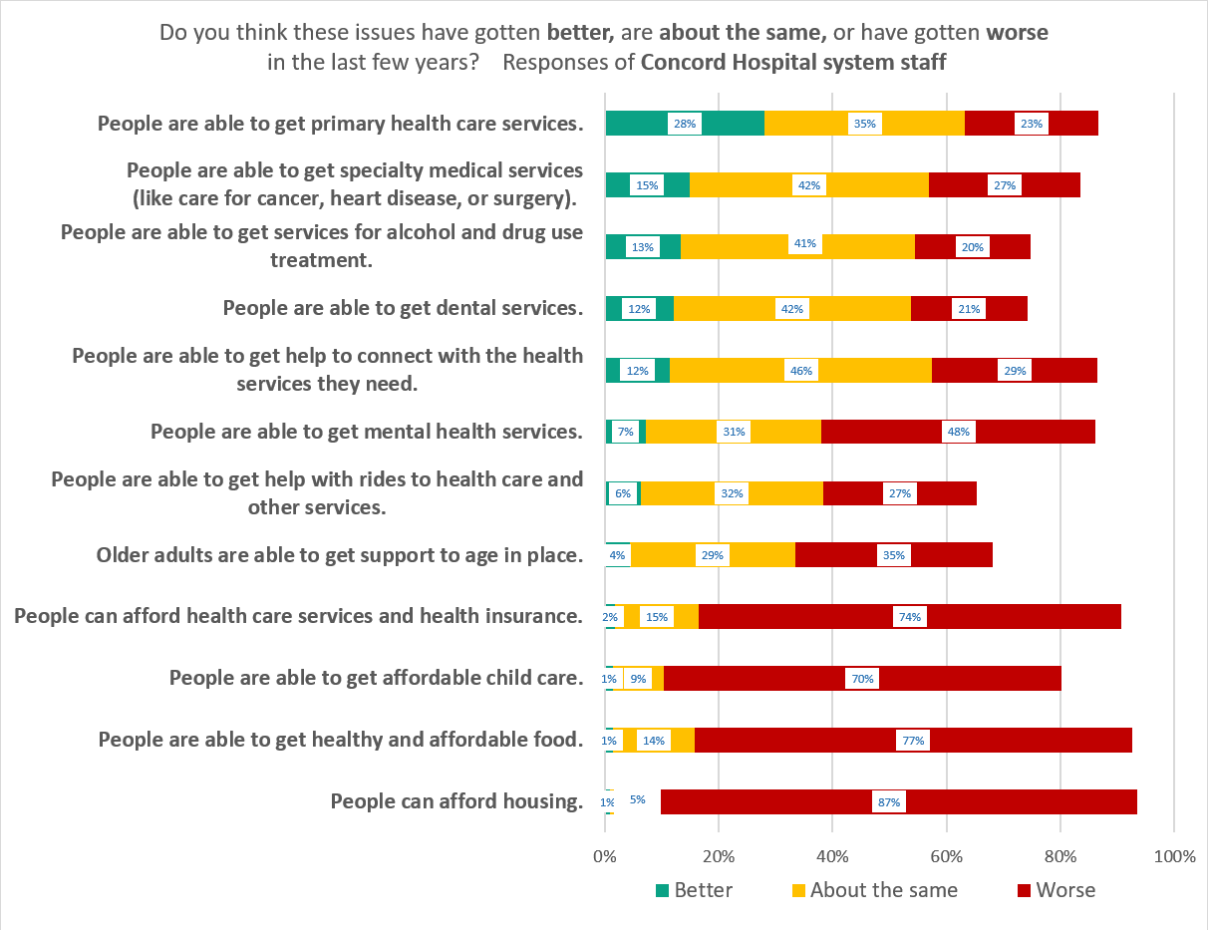
Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents indicating the needs are Better. Totals do not equal 100% because the response choice of "Don't Know" is not displayed.

"Addressing underserved populations in our region requires both increasing service capacity and improving how people access existing supports. Long waitlists, workforce shortages, transportation barriers, and insurance limitations disproportionately impact low-income families, rural residents, children with developmental or behavioral health needs, and older adults living alone."

- *Community Leader, Human Services / Aging Services*

Figure 7 displays the results for the same set of questions from respondents to the survey of Concord Hospital staff members. A similar pattern is again observed with hospital system staff being more likely to indicate the set of issues has gotten worse in the last few years, particularly issues related to affordability. One notable point of variation compared to residents and community leaders is the higher proportion of staff respondents who indicated the ability to get primary health care services has improved (28% selected 'Better').

| Figure 7 |



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.

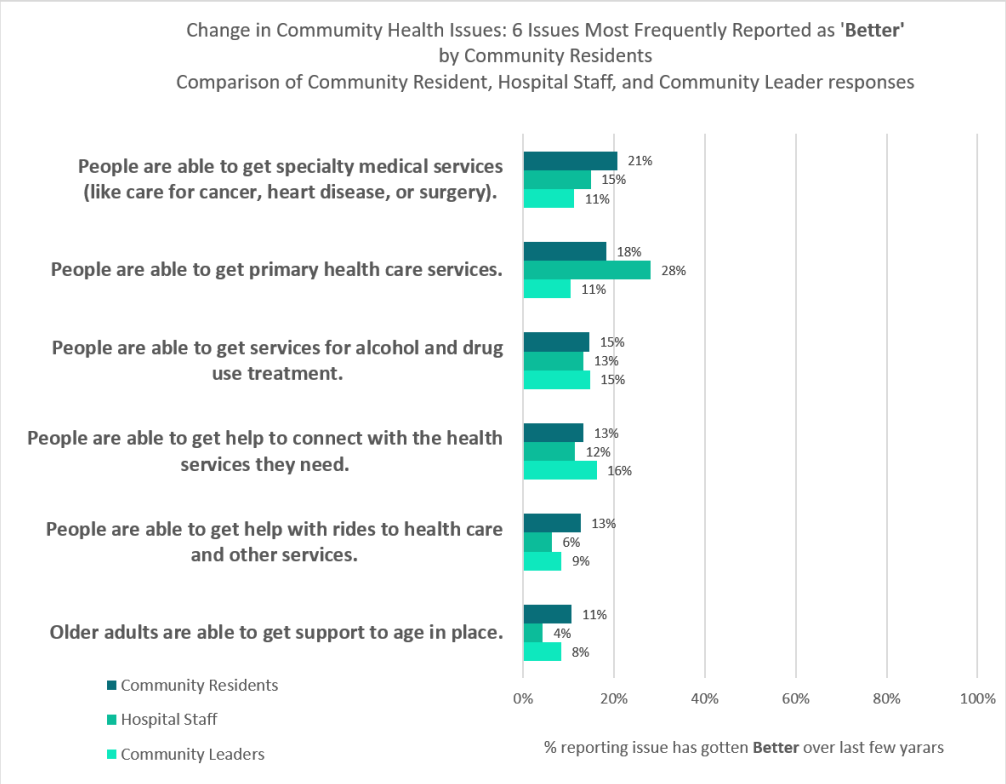
"Nearly every health challenge links back to access to care, behavioral health, chronic disease management, maternal health, and preventive services. Ultimately, it comes back to having enough trained professionals available in the communities that need them. Rural New Hampshire is experiencing provider shortages, an aging workforce, and increasing demand for services."

- *Concord Hospital Staff Member*

The next two charts display side-by-side comparisons of community resident, hospital staff, and community leader responses. Figure 8 shows just the top 6 issues that were most frequently selected by community residents as having gotten ‘Better. Figure 9 on the next page shows the remaining 6 issues that were most frequently selected as having gotten ‘Worse’.

In general, there is a high degree of consistency between the two response groups: agreement with regard to 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 better or worse (e.g., issues of affordability are at the top including housing, child care, and health care). Community residents were somewhat more likely to report improvement in ability to get specialty medical services while hospital staff were somewhat more likely to report improvement in ability to get primary health care.

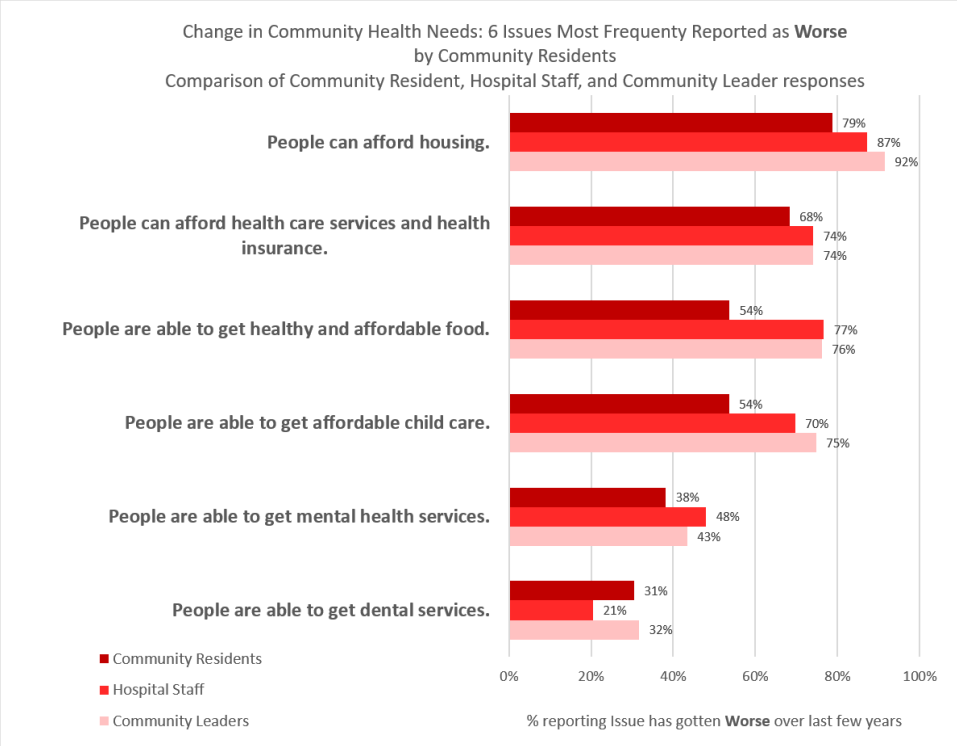
| Figure 8 |



“If I could change one thing, it would be to make it much easier for people and families to navigate care as needs become more complex. Too often, support exists, but it's fragmented and difficult to access. A more coordinated, easy-to-understand system where people know who to call, what services are available, and how to get help would reduce stress and allow individuals to focus more on their health and well-being rather than trying to manage the system itself.”

- *Community Resident Survey Respondent*

| Figure 9 |



"Even with two full-time incomes, it's hard to keep up with the cost of living and housing. People are very frustrated. Gas, housing and food is so hard to afford now a days.

- *Community Resident Survey Respondent*

"No matter day or night, it seems the emergency room is overwhelming, over loaded and under staffed. It needs to change."

- *Community Leader, Local Government*

"There is a significant issue with timely and appropriate access to Emergency Medicine in the Concord Hospital system as a whole. The distinct lack of inpatient beds either due to lack of staff or lack of urgency to hire and staff inpatient floors is causing a significant strain on Emergency Medicine access, placing strain on providers, staff, and resources. This is resulting in delayed time to definitive medical care resulting in worse overall medical outcomes."

- *Concord Hospital Staff Member*

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?"* More than 850 comments were received in response to this question. The most common topic areas included:

1. **Non-medical Drivers of Health** including Housing affordability and homelessness, food security, cost of living, basic needs, and employment.
2. **Access to Care & Workforce Shortages** including provider availability, specialist and primary care wait times, clinic operations, staffing shortages and wage strains.
3. **Healthcare Affordability & Insurance** including high cost of medical services, health insurance coverage, medication affordability, and systemic economic impacts on patients.
4. **Behavioral Health Care Services** including availability of behavioral health care, addiction treatment, and substance use disorder services.
5. **Aging, Senior Care, & Geriatrics** including support services for the elderly, dementia care, long-term planning, and aging-in-place resources.
6. **Emergency Department (ED) & Hospital Capacity Strains** including ED overcrowding and wait time, urgent care capacity, and inpatient bed availability.



7. **Transportation & Regional Access Barriers** including lack of transit options to medical appointments, rural healthcare access, and regional infrastructure challenges.
8. **Youth, Childcare, & Family Support** including child care access, school-based health services, perinatal and pediatric care, and building protective factors for youth.
9. **Wellness, Prevention, & Chronic Disease Management** including nutrition education, promoting healthy lifestyles, community outreach, and alternative care delivery models.
10. **Health Equity & Social Connection** including reducing social isolation, improving diversity and inclusion, and supporting marginalized populations.

> *"We need to get more systems in place so people can age at home longer and feel safe about it. More in home services are needed."*
>
> *- Community Leader, Fire / EMS*

2. Characteristics of a Healthy Community

The Community Resident survey included a series of fourteen statements that can describe essential 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.

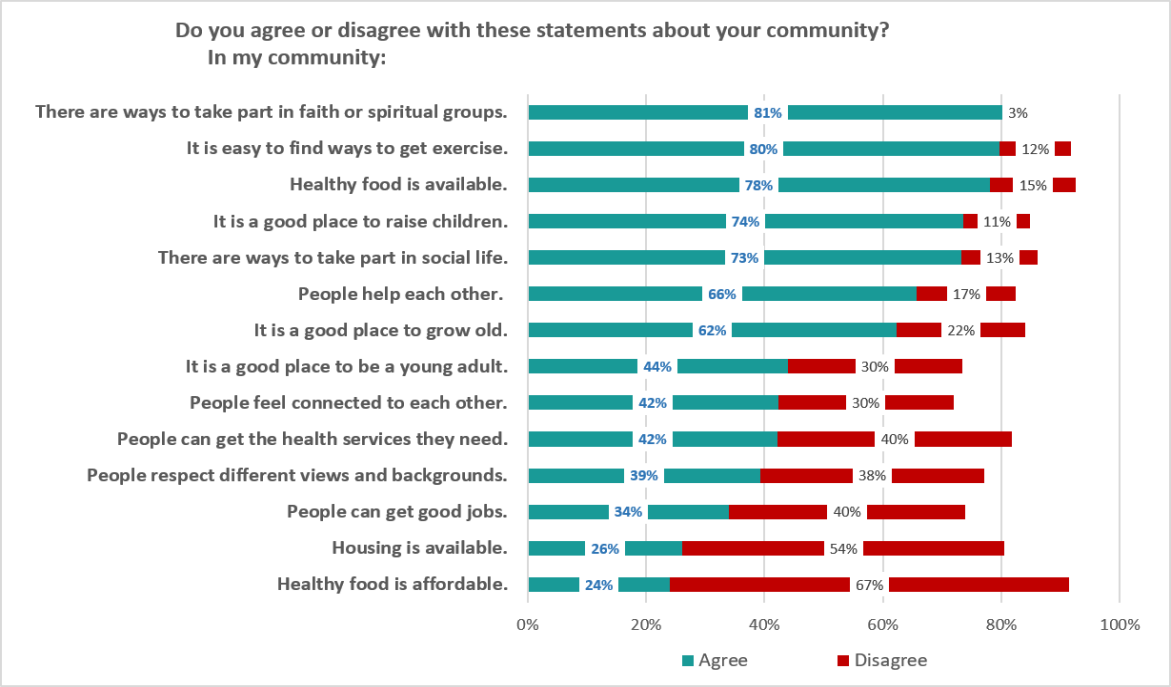
Figure 10 displays the results for this set of questions. Community residents overall were most likely to agree that 'in my community':

- There are ways to take part in faith or spiritual groups (81% of survey respondents agree).
- It is easy to find safe ways to get exercise (80% agree).
- Healthy food is available (78% agree).

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

- Healthy food is affordable (67% disagree)
- Housing is available (54% disagree)
- People can get good jobs (40% disagree).

| Figure 10 |

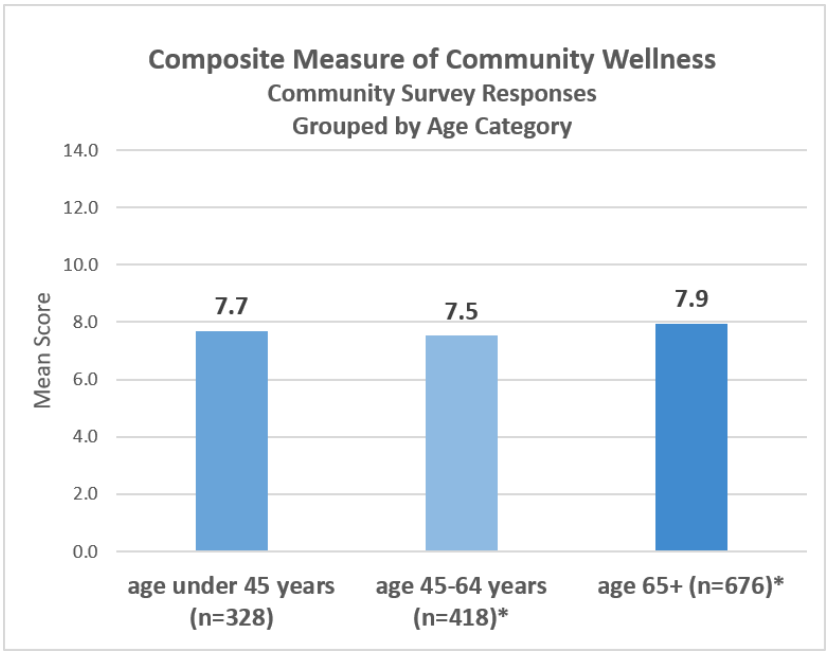


Note: Statements are re-ordered from the original survey instrument. Items are listed in order of highest to lowest percentage of respondents who Agree with each statement. Totals do not equal 100% because the response choice of "Don't Know/Not Sure" is not displayed.

Further analysis of this set of questions was conducted by calculating a composite measure of 'community wellness'. 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 analysis by certain respondent characteristics as follows.

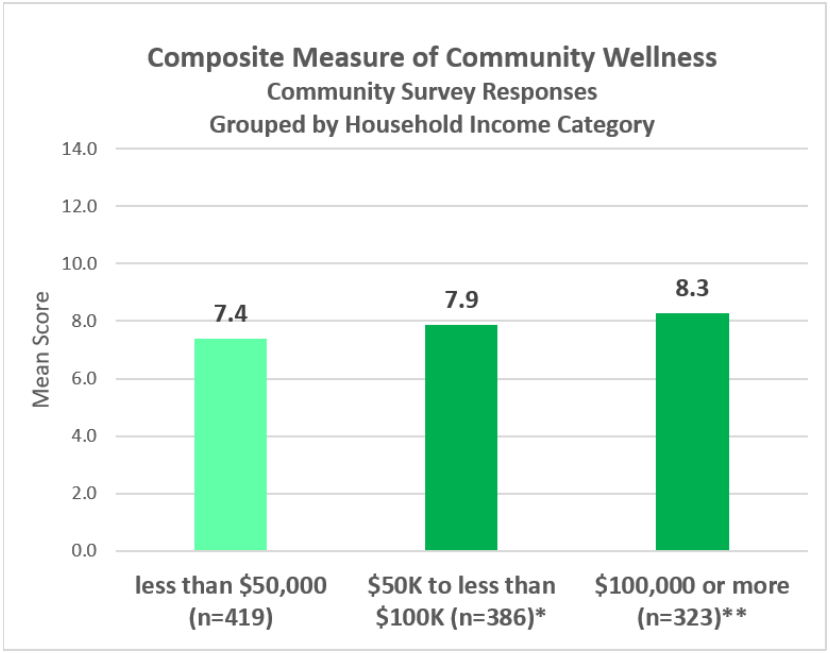
1. Figure 11 displays the results for perceptions of Community Wellness by age category. Older adults (age 65+) were somewhat more likely to report higher community wellness scores. Although not a numerically large difference from other age categories, the difference in group score compared to adults ages 45-64 is statistically significant (*p<.05).

| Figure 11 |



2. Figure 12 displays the results for the same composite measure of Community Wellness by income category. Overall, respondents with household income less than $50,000 were more likely to report lower scores on the measure of Community Wellness. The difference in scores is significantly different from each of the higher income categories (*p<.05; **p<.001).

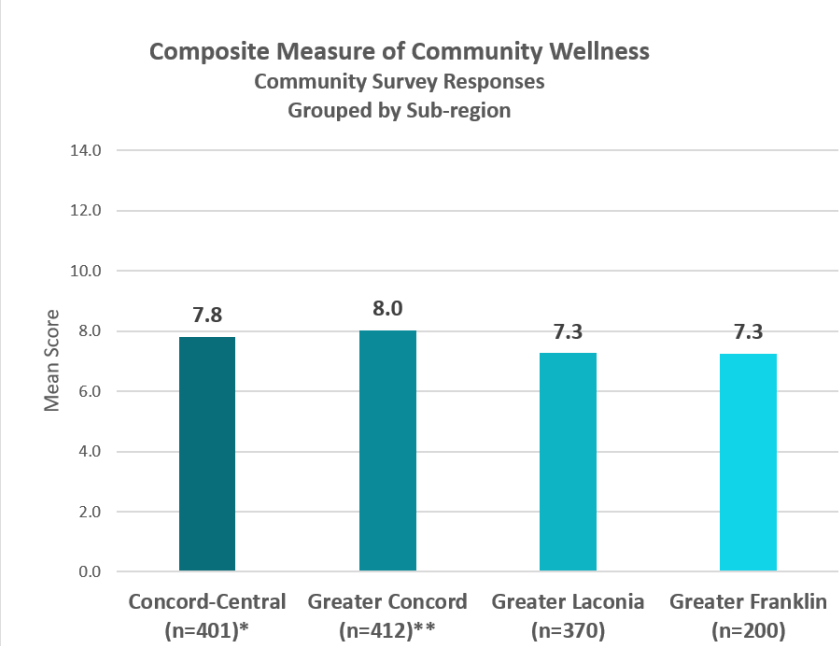
| Figure 12 |



3. A third perspective on the measure of Community Wellness was developed by grouping responses into four sets of communities within the Capital & Lakes Region according to their proximity to the three main Concord Hospital campuses. The community groups can be described as: 1) communities within 15 minutes travel time to the main Concord Hospital campus (Concord-Central); 2) other communities in the service area of the Concord Hospital system that are closest to the main Concord campus (Greater Concord); 3) communities that are closest to the Laconia campus (Greater Laconia); and 4) communities closest to the Franklin campus (Greater Franklin). The towns / cities included in each group are listed below Figure 13, which displays the composite Community Wellness score for each group.

   Overall, survey respondents from the communities of Greater Concord had the highest score for Community Wellness; and the Greater Concord score was significantly higher than scores for the Greater Laconia and Greater Franklin areas (**p<.01). The Community Wellness score for the Concord-Central group was similar to the Greater Concord group, while also higher than the Laconia or Franklin sub-regions (*p<.05).

| Figure 13 |



"I live in a rural area with a lot of senior citizens. Transportation to medical and social events would greatly improve the mental and physical health of the communities.
- Community Resident Survey Respondent

Concord Central: Concord, Bow, Hopkinton

Greater Concord: Allenstown, Barnstead, Boscawen, Bradford, Canterbury, Chichester, Deering, Dunbarton, Epsom, Henniker, Hillsboro, Hooksett, Loudon, Northwood, Pembroke, Penacook (zip 03303), Pittsfield, Sutton, Washington, Warner, Weare, Webster, Windsor

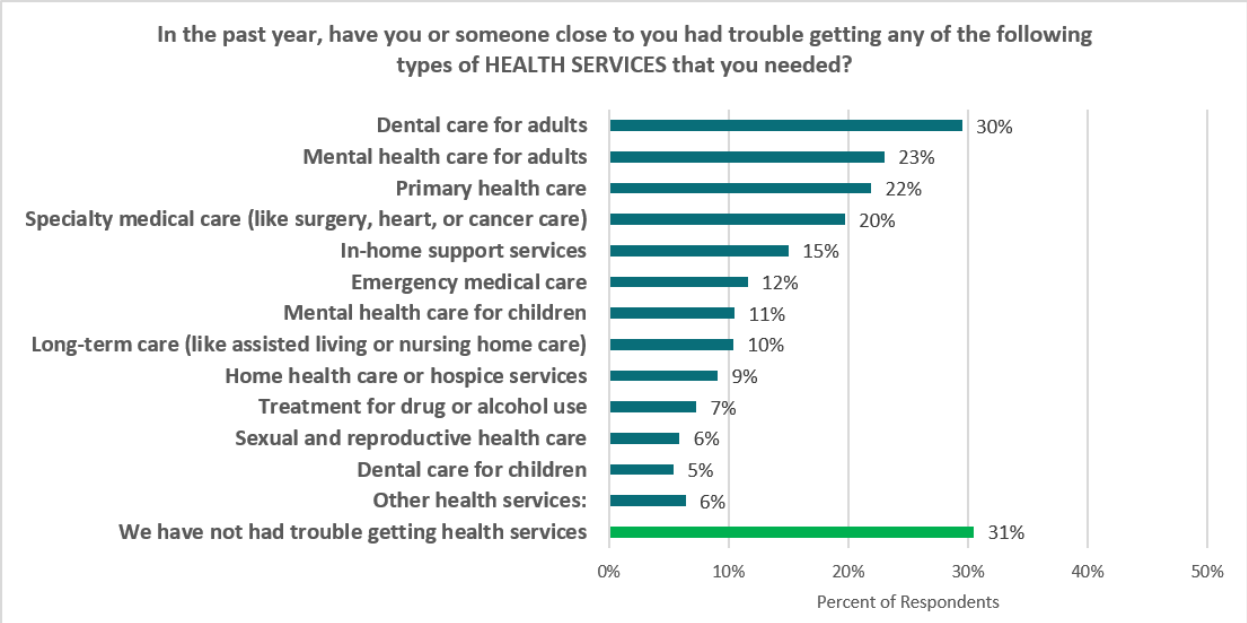
Greater Laconia: Alton, Ashland, Belmont, Center Harbor, Gilford, Gilmanton, Laconia, Meredith, Moultonborough, New Hampton, Sandwich, Tuftonboro

Greater Franklin: Alexandria, Andover, Bridgewater, Bristol, Danbury, Franklin, Hebron, Hill, Northfield, Salisbury, Sanbornton, Tilton

3. Barriers to Services

Respondents to the Community Resident survey were presented with a list of 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 30% of respondents reported difficulty getting 'Dental care for adults' and 23% had difficulty getting 'Mental health care for adults'. Other health services cited most frequently for access difficulties included Primary health care (22% of survey respondents), 'Specialty medical care' (20%), and 'In-home support services' (15%).

| Figure 14 |



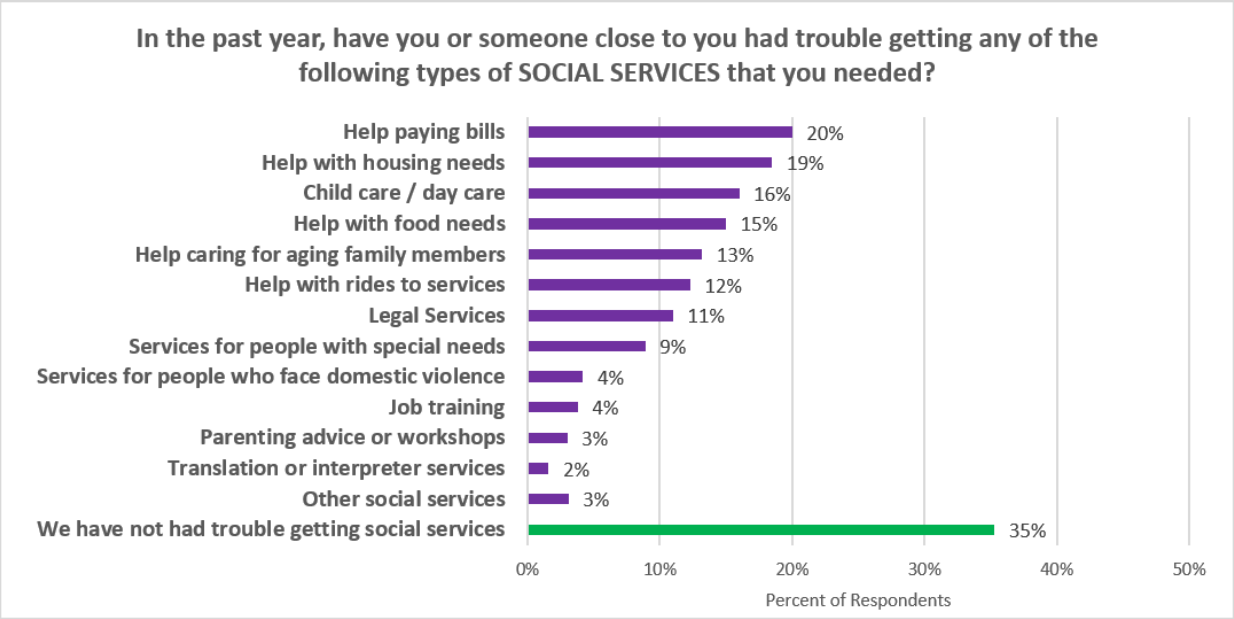
"Without insurance dental care is almost out of the question for people on fixed income."
- Community Leader, Public Health

"Having more mental health providers . . . . would be huge. I have tried 5 different locations that I had been told would have available providers, and if they did, they didn't take my insurance. If they took my insurance, they didn't have any availability."
- Community Resident Survey Respondent

"The waits for primary care are ridiculous. . . . People shouldn't be at urgent care because they can't see their doctor or the ER wait is 10 hours. Calling your doctor should reach your doctor's office, not a centralized call center that doesn't know you."
- 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 15, about 20% of respondents indicated difficulty getting 'Help paying bills' and 19% had difficulty getting 'Help with housing needs' over the past year. Other more frequently cited social services for access difficulty included getting 'Child care / Day care' (16%), 'Help with food needs' (15%), and 'Help caring for aging family members (13%).

| Figure 15 |



"We need better education for our aging population and their families about their options for care when they are unable to fully care for themselves. Often, people think that their insurance will cover long term care when it is needed and that is rarely the case."

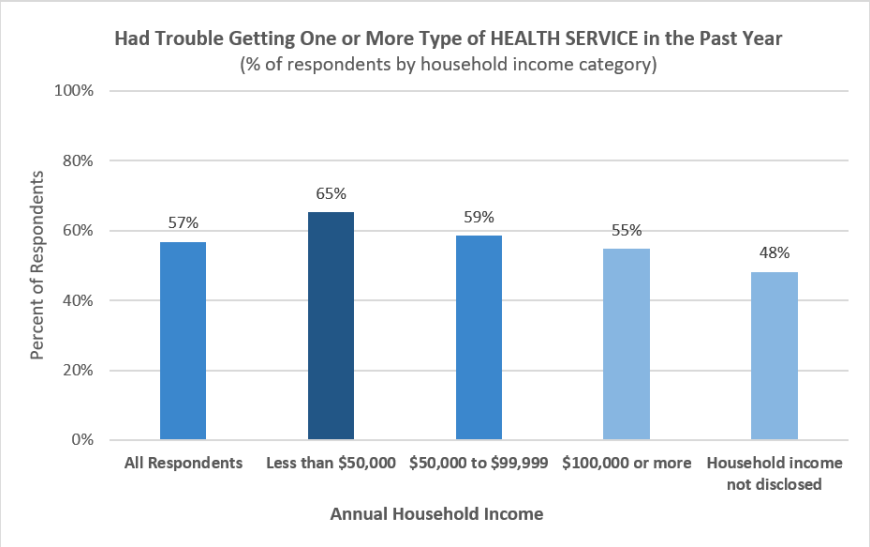
- *Concord Hospital Staff Member*

"While the community offers good resources, there needs to be stronger support for people and families navigating aging, chronic illness, and end-of-life care. Caregiving can quickly become overwhelming, and it's not always clear where to turn or how to coordinate help. . . . The resources are often there, but not everyone knows how to access them or feels comfortable doing so. Strengthening both support systems and personal engagement would make a real difference."

- *Community Resident Survey Respondent*

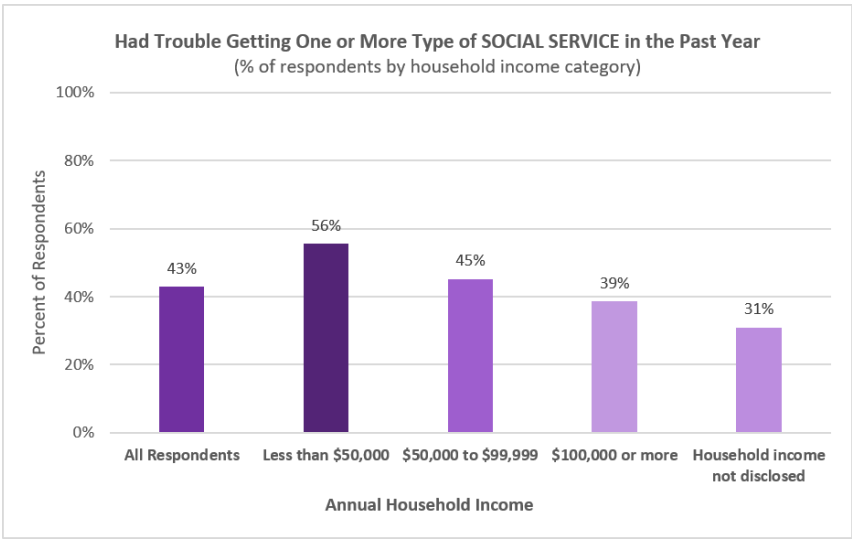
In general, survey respondents were more likely to report difficulty accessing health services than social services, which may in part be a function of different proportions of the population overall attempting to access certain health or social services over the course of a year. About 57% of all survey respondents reported having difficulty accessing at least one type of health service. Figure 16 displays the percentage of survey respondents reporting any access difficulty by income category. Survey respondents reporting household income less than $50,000 were significantly more likely to report difficulty accessing at least one type of health service (65%) compared to respondents with higher household income (p<.05).

| Figure 16 |



As displayed by Figure 17, about 43% of all survey respondents reported having difficulty accessing at least one type of social service. As with health services, respondents with household incomes less than $50,000 were significantly somewhat more likely to report difficulty accessing at least one type of social service (56%) compared to respondents with higher income (p<.001).

| Figure 17 |



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, issues of cost and insurance were the top reasons cited for difficulty accessing Dental Care for Adults. In contrast, "Wait time too long" was the top reason cited for difficulty accessing Mental Health Care, Primary Health Care, and Specialty Medical Care.

| 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)

DENTAL CARE FOR ADULTS (n=482, 30% of respondents)	**MENTAL HEALTH CARE FOR ADULTS** (n=376, 23% of respondents)	**PRIMARY HEALTH CARE** (n=367, 22% of respondents)	**SPECIALTY MEDICAL CARE** (n=328, 20% of respondents)
65% of respondents who indicated difficulty accessing Dental Care for Adults also selected **"Cost too much"** as a reason	**52%** of respondents who indicated difficulty accessing Mental Health Care for Adults also selected **"Wait time too long"** as a reason	**56%** of respondents who indicated difficulty accessing Primary Health Care also selected **"Wait time too long"** as a reason	**63%** of respondents who indicated difficulty accessing Specialty Medical Care also selected **"Wait time too long "** as a reason
No insurance or not enough insurance (61%)	**Cost too much (43%)**	**Not accepting new patients (46%)**	**Cost too much (39%)**
Not accepting new patients (32%)	**No insurance or not enough insurance (42%)**	**No insurance or not enough insurance (41%)**	**Service not available (37%)**
Wait time too long (29%)	**Not accepting new patients (40%)**	**Cost too much (38%)**	**Not accepting new patients (36%)**
Service not available (25%)	**Service not available (39%)**	**Service not available (28%)**	**No insurance or not enough insurance (30%)**
Did not know where to go or who to call (16%)	**Did not know where to go or who to call (26%)**	**Had no way to get there (18%)**	**Did not know where to go or who to call (18%)**

Other survey options included: Not open when I could go, 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).

"Access to dental care even with insurance is quite literally unattainable, if you need more than just regular cleanings."

- Community Resident Survey Respondent

"Many people in the community struggle to find counseling, crisis support, or substance use treatment because of long wait times, lack of providers, or cost.

- Community Resident Survey Respondent

"PCPs (are lacking). No one is accepting patients. If you do get in for an appointment it is rushed and concerns are not addressed. "

- Community Leader, Social Services

Survey respondents who reported difficulty accessing **social services** were asked a similar follow-up question for each type of service selected. As displayed by Table 7, 'Did not know where to go or who to call' was the most frequently selected reason for difficulty getting 'Help Paying Bills'. For other top social services indicated for access difficulties, "Cost too much" was the most common reason. Waitlists and lack of service availability were also frequently selected reasons for difficulty accessing 'Help with Housing Needs' and 'Child Care / Day Care'.

| 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 PAYING BILLS (n=319, 20% of respondents)	**HELP WITH HOUSING NEEDS** (n=295, 19% of respondents)	**CHILD CARE / DAY CARE** (n=259, 16% of respondents)	**HELP WITH FOOD NEEDS** (n=238, 15% of respondents)
40% of respondents who indicated difficulty getting Help Paying Bills also selected **"Did not know where to go or who to call"** as a reason	**59%** of respondents who indicated difficulty getting Help with Housing Needs also selected **"Cost too much"** as a reason	**77%** of respondents who indicated difficulty getting Child Care / Day Care also selected **"Cost too much"** as a reason	**46%** of respondents who indicated difficulty getting Help with Food Needs also selected **"Cost too much"** as a reason
Service not available (37%)	**Wait time / Waitlist too long (52%)**	**Service not available (65%)**	**Did not know where to go or who to call (26%)**
Cost too much (31%)	**Service not available (31%)**	**Wait time / Waitlist too long (43%)**	**Service not available (24%)**
Wait time / Waitlist too long (19%)	**Did not know where to go or who to call (27%)**	**Not accepting new clients (32%)**	**Had no way to get there (23%)**
Shame or stigma (18%)	**Not accepting new clients (20%)**	**Not open when I could go (12%)**	**Not open when I could go (22%)**

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)

"Housing is wildly expensive and local jobs generally don't pay enough, especially for younger folks. Vacation housing is overtaking our area and locals are getting priced out.

- Community Resident Survey Respondent

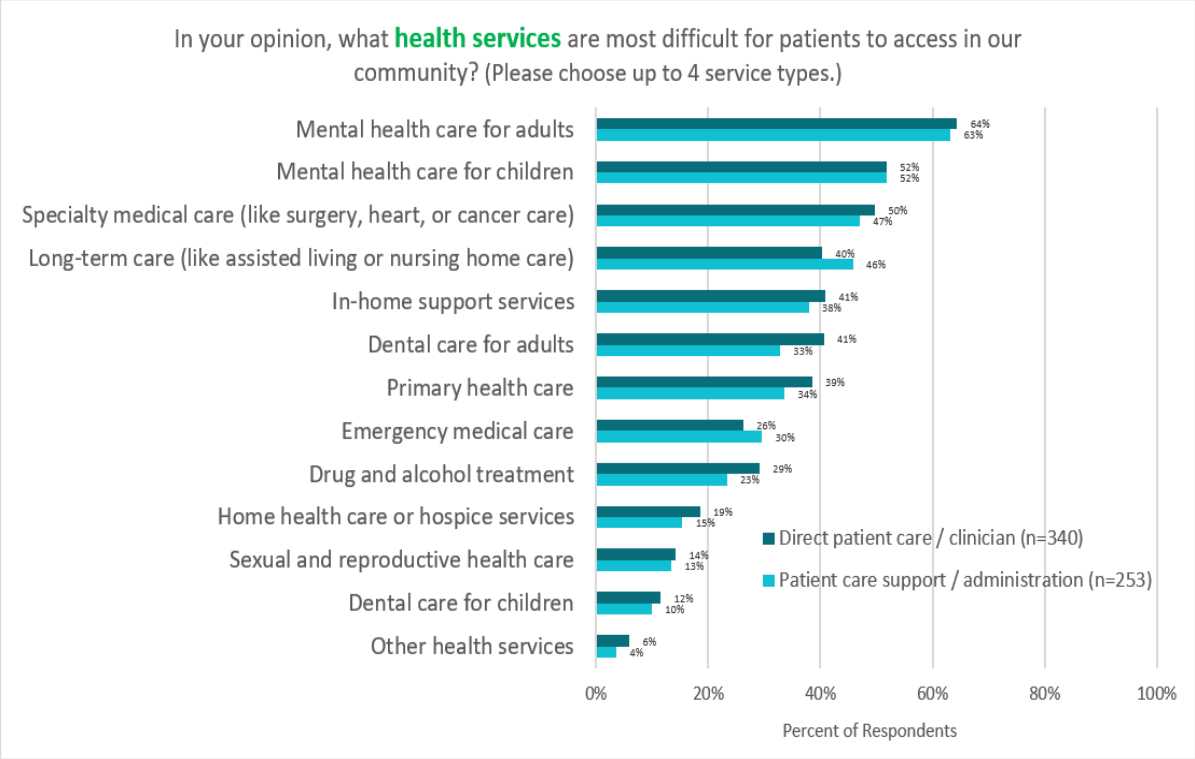
"Health care access needs to be addressed. Health insurance is unaffordable and is sinking middle class families."

- Community Resident Survey Respondent

Concord Hospital system staff were asked a variation on the questions about difficulty accessing specific services. The survey included the same list of health service types from which staff were asked to choose the top 4 services that are most difficult for patients to access.

The top health services cited as being difficult for patients to access were mental health care for adults, mental health care for children, medical specialty care, and long-term care (Table 17). Overall, there was a high degree of alignment between the responses of clinical patient care staff and patient care support staff.[2]

| Figure 17 |

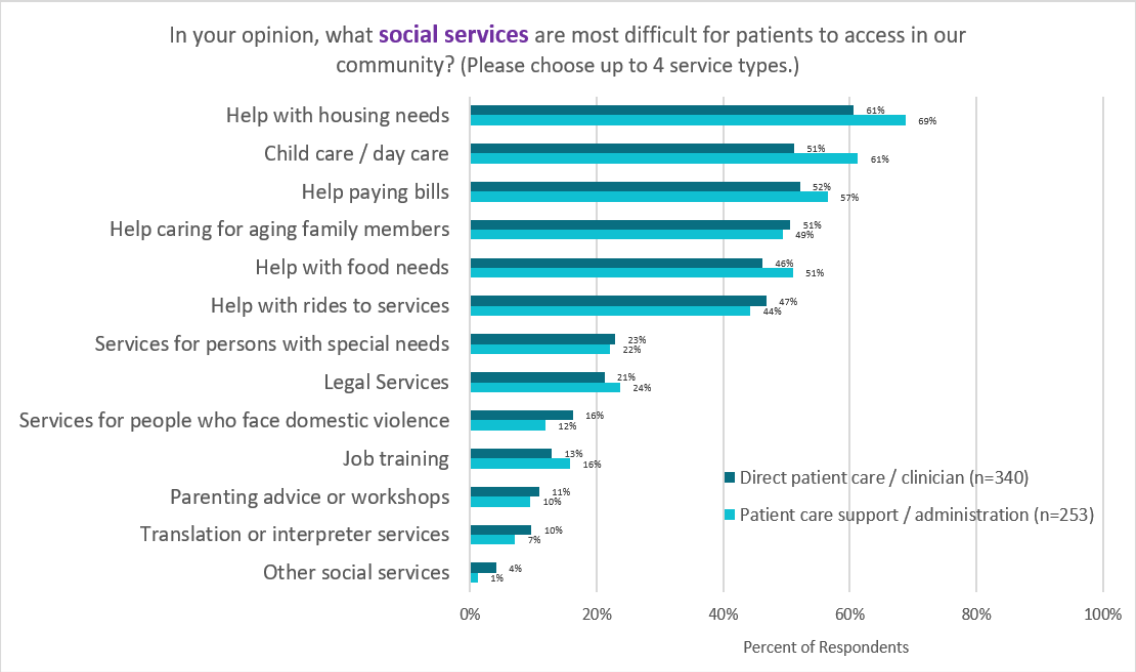


"More access to Mental Health support would be very beneficial. I see this as our biggest challenge here in Concord. I have heard of people having to wait months for mental health services. To me this is not acceptable since the need is often someone in crisis and then they end up in the emergency department."
- Concord Hospital Staff Member

[2] At the end of the staff survey, respondents were asked to indicate the category - "Direct patient care / clinician" or "Patient care support / administration" - best representing their work with Concord Hospital.

Figure 18 displays the responses on a similar question about social services that are most difficult to access by Concord Hospital patients. Again, there was overall agreement between clinicians and patient support personnel, as well as general alignment with the responses of community residents on social services most difficult for patients to access. Help with housing needs, child care / day care, and help paying bills were selected most frequently overall; followed closely by help caring for aging family members, help with food needs, and help with rides to services.

| Figure 18 |

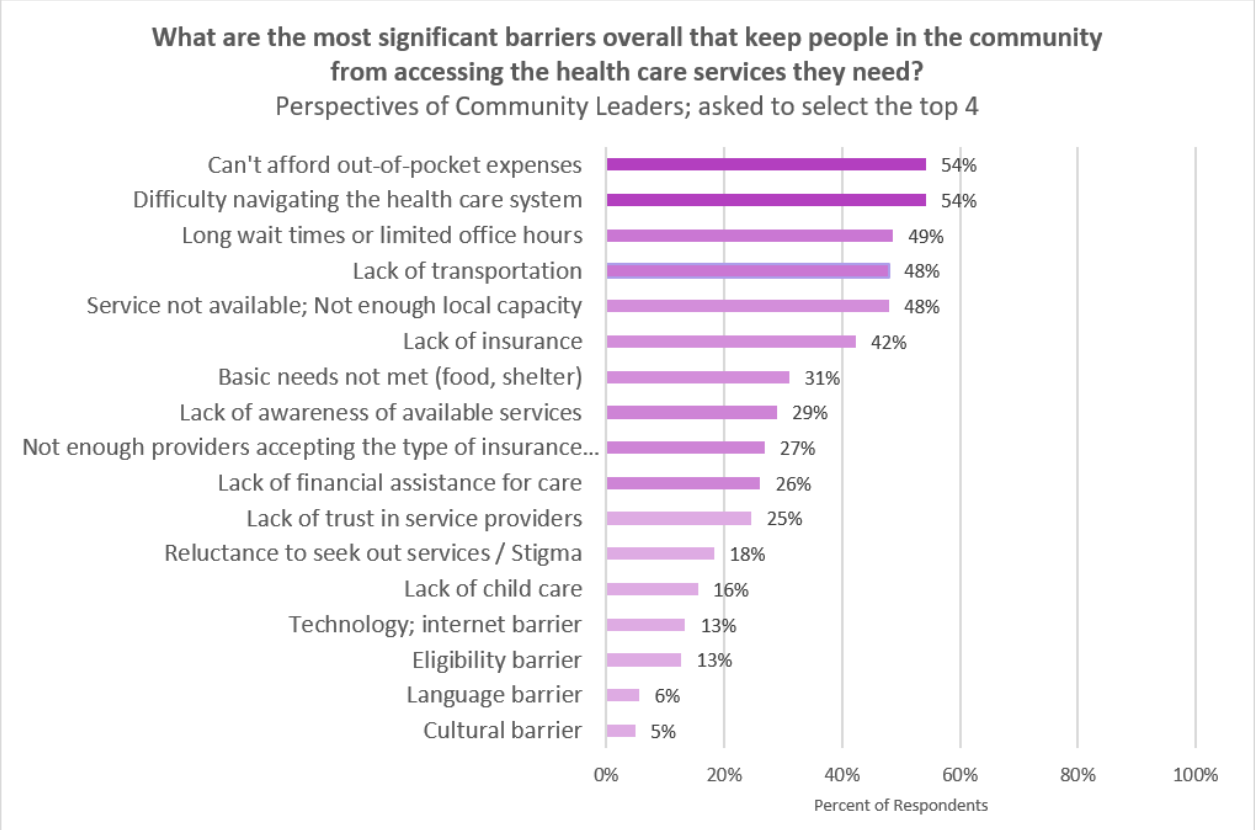


"The waitlists for available daycare are very long, often requiring parents to put their unborn children on the waitlist just to stand a chance to get them enrolled in time. Once enrolled, thousands of dollars per child are spent monthly for daycare. It is a big burden that often has no other options."

- *Concord Hospital Staff Member*

For another perspective on barriers to care, 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 17 potential barriers (and a write-in option) from which respondents were asked to select the top 4 barriers to health care access. The top issues identified by this group were 'Can't afford out-of-pocket expenses' (54% of community leaders chose this barrier) and 'Difficulty navigating the health care system' (also 54%). The next most frequently identified barriers were 'Long wait times or limited office hours' (49%), 'Lack of transportation' (48%), and 'Service not available; Not enough local capacity' (48%).

| Figure 19 |



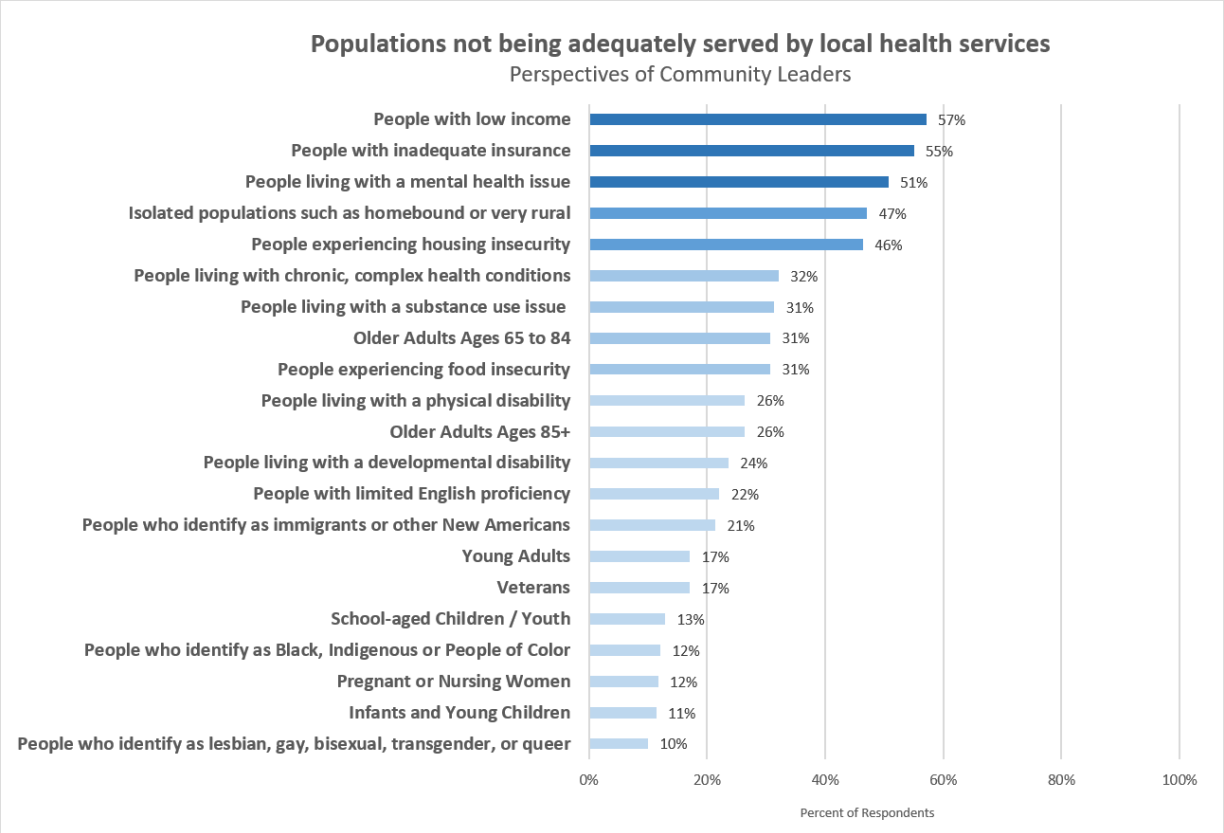
"While Concord has a higher concentration of providers relative to surrounding towns, access remains uneven, and capacity challenges are more pronounced in smaller communities . . . where transportation barriers further compound access limitations. Overall, the issue is less about the total absence of services and more about insufficient capacity to meet demand, long waitlists, workforce shortages, and geographic disparities in access.

- *Community Leader, Human Services*

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 being underserved (Figure 20) were people with low income, people with inadequate insurance, people living with a mental health issue, isolated populations such as homebound or very rural, and people experiencing housing insecurity.

In a related question, Community Leaders were asked to identify in an open comment box '*particular types of health providers, specialties or services that are needed in the community due to insufficient capacity or availability'*. The most frequently mentioned services were: mental health care (22 comments) including mental health services for youth in particular; a need for additional primary care provider capacity (22 comments); dental care including dental practices accepting Medicaid in particular (12 comments); and dermatology services (10 comments).

| Figure 20 |

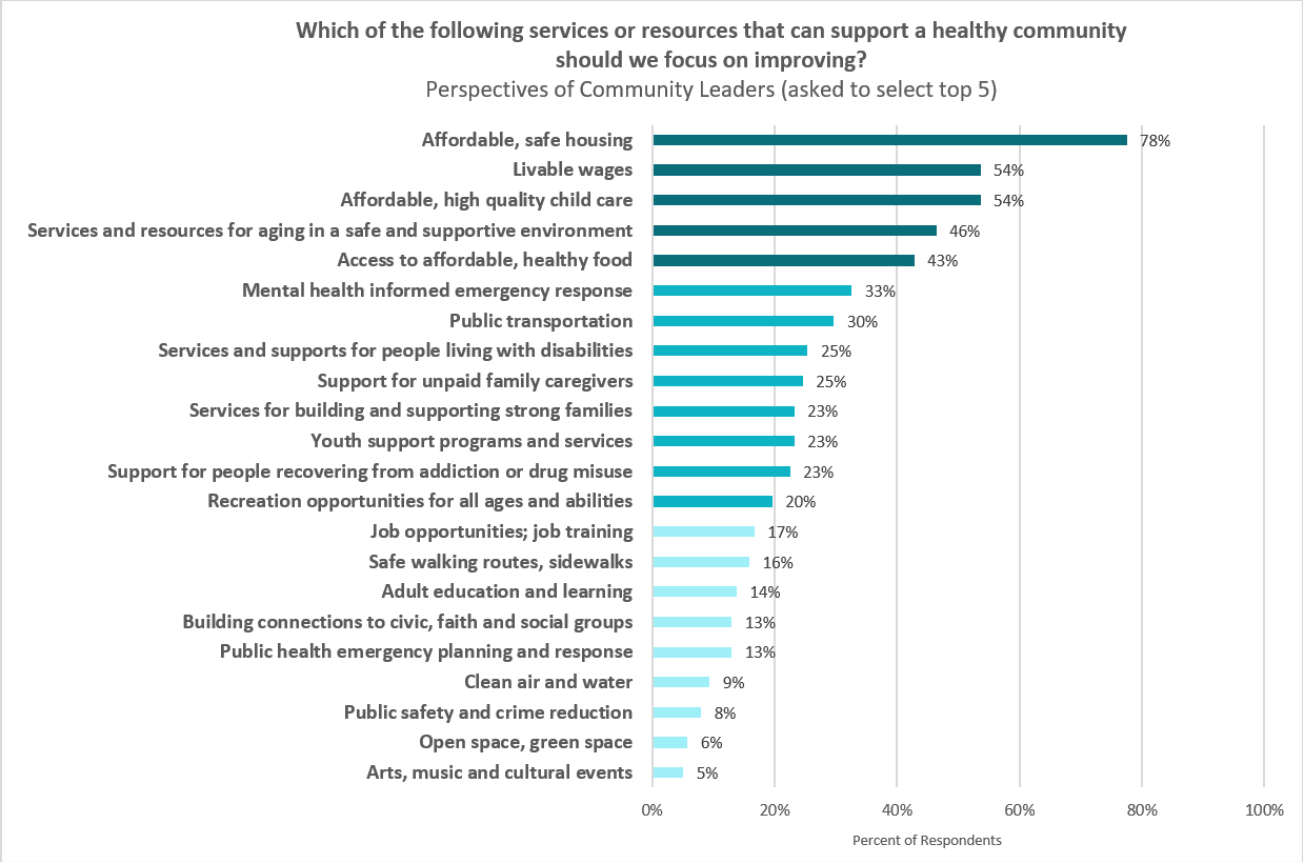


There is a shortage of healthcare providers in our area. When you need an appointment for a healthcare concern, it takes too long. You have to be a very strong advocate for yourself or a loved one to get attention. Not everyone is able to do so. - Community Resident Survey Respondent

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 22 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 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; and Welcoming Community. Survey respondents could select any of the individual topics from across the different topic groups.

| Figure 21 |

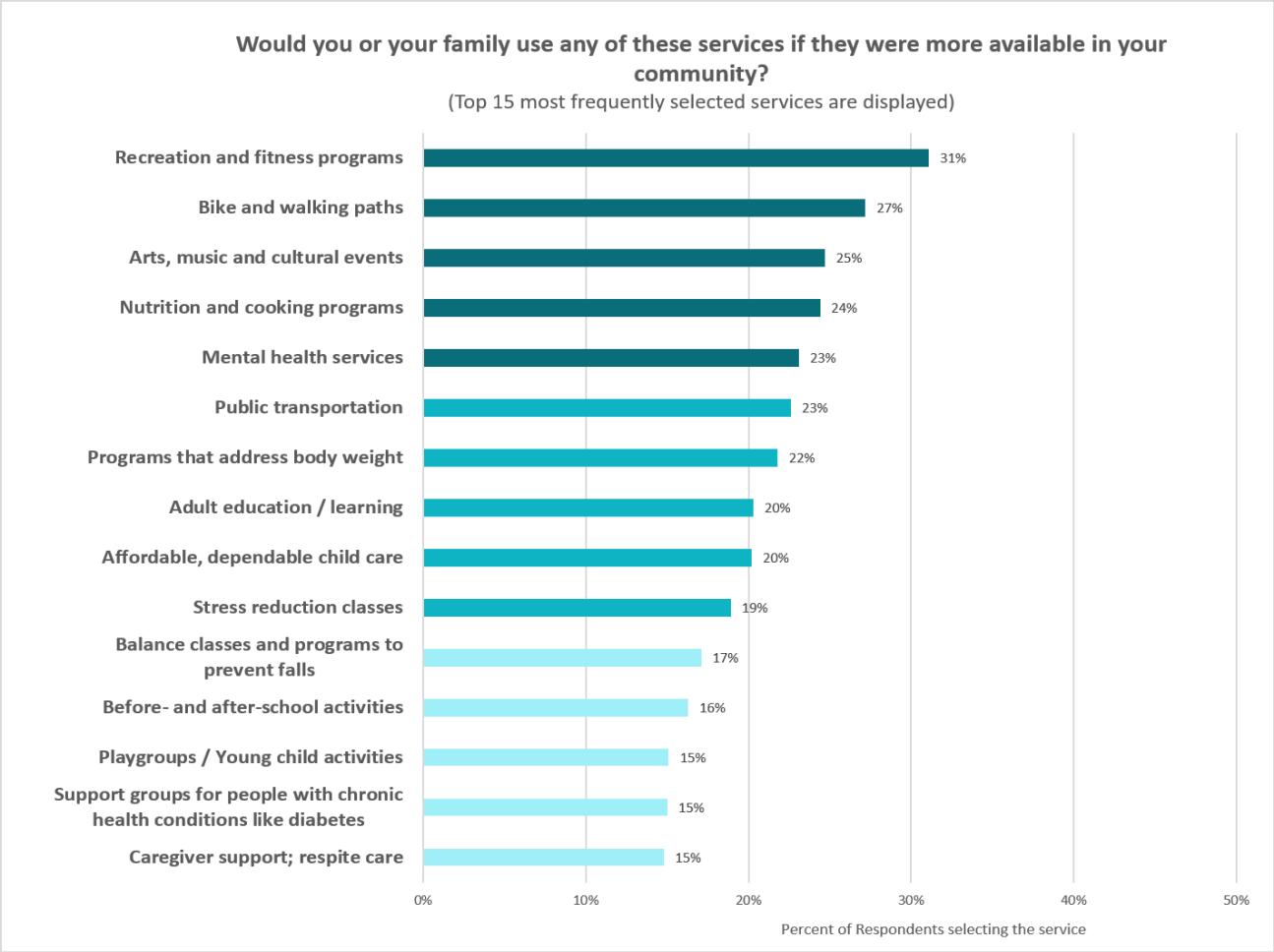


As displayed by Figure 21, 'Affordable, safe housing' was by far the most frequently selected resource, identified by 78% of respondents as an area the community should focus on to support community health improvement. Other top focus areas are 'Livable Wages', 'Affordable, high quality child care', 'Services and resources for aging in a safe and supportive environment', and 'Access to affordable, healthy food'.

5. Interest in Specific Community Health Programs or Services

Community members were asked a variation on the question about community services or resources to support health and wellness. 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 30 topics organized into 6 overall conceptual groups: 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 22). Other services most frequently mentioned were Bike and walking paths; Arts, music and cultural events; and Nutrition and cooking programs.

| Figure 22 |



Other services not displayed: Dental services (14%), Legal Services (13%), Family counseling (12%), Summer lunch programs for youth (12%), Home safety assessment (10%), Adult daycare (10%), School-based mental health services (9%), Job training (9%), Parent support groups or workshops (9%), Stop smoking / vaping programs (9%), Help managing medications (8%), Drug and alcohol prevention programs (7%), Medical services (7%), Drug and alcohol treatment (6%), Addiction recovery supports (5%).

Table 8 displays the top services or resources of interest by age group. In general, survey respondents under age 45 selected multiple services more frequently compared to older age groups. For example, 'Recreation and Fitness programs' was the most frequently selected resource in each age group with the percentage of respondents under 45 more than twice as likely than those age 65 and older to select that option. For the older age group, 'Balance classes and programs to prevent falls' was the second most frequently selected resource. 'Affordable, dependable child care' was the top service selected by people with children in their household.

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

Age 18-44 (n=330)		Age 45-64 (n=430)		Age 65+ (n=715)		Households with children (n=428)	
Recreation and fitness programs	57%	Recreation and fitness programs	41%	Recreation and fitness programs	25%	Affordable, dependable child care	43%
Affordable, dependable child care	53%	Bike and walking paths	34%	Balance classes and programs to prevent falls	24%	Before- and after-school activities	36%
Playgroups / Young child activities	43%	Nutrition and cooking programs	33%	Bike and walking paths	22%	Recreation and fitness programs	35%
Before- and after-school activities	42%	Mental health services	30%	Arts, music and cultural events	20%	Playgroups / Young child activities	34%
Mental health services	41%	Programs that address body weight	30%	Public transportation	20%	Arts, music and cultural events	30%
Arts, music and cultural events	39%	Arts, music and cultural events	28%	Nutrition and cooking programs	18%	Bike and walking paths	29%
Nutrition and cooking programs	38%	Public transportation	27%	Programs that address body weight	18%	Mental health services	29%
Bike and walking paths	37%	Adult learning / education	26%	Adult learning / education	17%	Nutrition and cooking programs	29%
Stress reduction classes	32%	Stress reduction classes	24%	Mental health services	14%	Programs that address body weight	26%

Table 9 displays results for the same question on services or resources people would use if more available by groups of cities and towns within the Concord Hospital system service area. The sub-regional groups are the same as for the question on characteristics of community wellness described on page 19. The most frequently selected topics are similar across town groups with 'Recreation and Fitness Programs' and 'Bike and walking paths' near the top. The second most frequently selected resource by residents of the Greater Laconia area was 'Arts, music and cultural events'. For residents of Greater Franklin, 'Mental health services' was the second most likely resource selected.

Table 9: Top Services or Resources People Would Use by Service Area Sub-region

Concord Central (n=395)		Greater Concord (n=417)		Greater Laconia (n=362)		Greater Franklin (n=192)	
Bike and walking paths	38%	Recreation and fitness programs	31%	Recreation and fitness programs	33%	Recreation and fitness programs	31%
Recreation and fitness programs	37%	Bike and walking paths	28%	Arts, music and cultural events	27%	Mental health services	24%
Arts, music and cultural events	34%	Programs that address body weight	25%	Nutrition and cooking programs	26%	Bike and walking paths	23%
Nutrition and cooking programs	32%	Nutrition and cooking programs	25%	Public transportation	25%	Public transportation	22%
Mental health services	28%	Arts, music and cultural events	24%	Bike and walking paths	25%	Stress reduction classes	21%
Public transportation	27%	Mental health services	23%	Programs that address body weight	23%	Nutrition and cooking programs	20%
Adult learning / education	27%	Public transportation	20%	Mental health services	22%	Programs that address body weight	19%
Affordable, dependable child care	27%	Adult learning / education	20%	Stress reduction classes	20%	Affordable, dependable child care	19%
Programs that address body weight	24%	Stress reduction classes	19%	Affordable, dependable child care	20%	Playgroups / Young child activities	18%

I live in (a more rural town). We have (an agency) for childcare and (an agency) supporting families and older adults. These are great programs. What we don't have is accessible public transportation because we are so rural. Makes growing old and perhaps not being able to drive a challenge."

- Community Resident Survey Respondent

The 2026 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 1,174 survey respondents provided written responses to this question (including 89 respondents to the community leader survey, 331 hospital system staff respondents, and 754 responses from community residents). Table 9 provides a summary of the combined responses by theme and response frequency.

| TABLE 9 |
"If you could change one thing you believe would improve health and wellness in your community, what would you change?

Health care provider availability including primary care and urgent care; ED overcrowding, wait times; delivery system improvements including appointment availability and assistance navigating the health care system	**258 comments (22% of total)**
Affordability of health care including prescriptions, low cost or subsidized services; health insurance costs; health care payment reform	**195 (17%)**
Affordable housing; resources for people who are unhoused	**100 (9%)**
Caring community, culture; community diversity and acceptance; facilities and opportunities for social interaction; reducing social isolation	**94 (8%)**
Availability of mental health services in general and for youth in particular; mental health awareness	**70 (6%)**
Resources and activities for supporting healthy youth and families including health education and wellness programs; available and affordable child care	**60 (5%)**
Senior services, supports and activities; concerns of aging; caregiver support; assisted living	**58 (5%)**
Improved transportation services, public transportation; medical transportation	**51 (4%)**
Cost of living, financial insecurity, basic needs; livable wages; taxes	**45 (4%)**
Improved resources, programs or environment for physical activity, active living; affordable recreation and fitness; safe biking and walking routes	**44 (4%)**
Improved awareness, communication and coordination of available services and resources	**36 (3%)**
Affordability and availability of Dental Services	**35 (3%)**
Affordability of healthy foods; Improved resources or environment for healthy eating, nutrition	**34 (3%)**
Substance misuse prevention, treatment and recovery; community impact of drug use	**25 (2%)**
More funding, support for public health programs and community services	**16 (1%)**
Political Climate, Better Representation and Leadership	**15 (1%)**
Community safety; physical infrastructure and handicap accessibility	**14 (1%)**
Other comments; no changes, comments of appreciation	**24 (2%)**

C. Community Health Discussion Themes and Priorities

The Community Health Needs Assessment Steering Committee worked with community partners to convene 12 discussion groups between May 2026 and July 2026. The discussion groups intentionally sought to engage people with lived experience and perspectives on dimensions of community health such as housing insecurity, behavioral health, and concerns of aging.

Each discussion group was facilitated by a community-based partner using a common facilitation guide. While conversations flowed naturally according to the interests and concerns of each group, each group was asked to consider a core set of questions including:

- What do people worry about most when it comes to taking care of their health or their family's health?
- Are the issues and priorities identified by the previous needs assessment still the most important? Are there other new or emerging priorities?
- Have people observed improvements in the past few years on priority community health issues?
- What could healthcare and public health organizations be doing better or differently to have a positive impact?

In total, 94 people participated in the community discussions across the following groups:

- Reverence House Men's Sober Living, 10 participants
- Merrimack County Recovery Court (long term addiction recovery), 5 participants
- Riverbend IOP program (addiction treatment), 1 participant
- Lakes Region Mental Health Passage House (group residence), 8 participants
- Lakes Region Mental Health (group counseling), 6 participants
- Isaiah 61 Café (support services for unhoused people), 8 participants
- Winni Hotel (temporary housing for unhoused adults), 7 participants
- Concord Coalition to End Homelessness (permanent supportive housing), 8 participants
- Laconia Housing Authority (subsidized housing and supports), 7 Participants
- Overcomers Refugee Support Services, 10 participants
- TRIP Senior Center, 6 participants
- White Birch Senior Center, Healthy Living Program, 8 participants

The following pages summarize common themes among the discussion groups including cross-cutting systemic barriers, highlights concerns specific to certain sectors and concludes with recommendations from discussion participants for local healthcare and public health organizations.

1. Primary Concerns Regarding Health

Discussion group participants were asked, "*What do the people you know worry about most when it comes to taking care of their health or their family's health?*" Across all groups, discussion of this question tended to focus on basic needs and structural barriers to achieving wellness. Participants also expressed concerns regarding their ability to access, afford, and navigate the healthcare system.

Shared Themes and Concerns

- **Necessity of Stable Housing:** Stable housing was widely recognized as a foundational prerequisite for health. Participants noted that individuals struggling with housing instability are focused on immediate needs, making proactive healthcare management difficult, while renters expressed anxiety over loss of housing tied to rising costs and medical debt.
- **Transportation as a Chronic Barrier:** Lack of transportation resources was described as a serious limitation for making health care appointments and other activities of daily living, particularly in more rural communities. Existing transportation resources are described as unreliable. Participants shared experiences of medical transport services leaving them stranded, treating them as burdens, or causing missed appointments.
- **Financial Strain and Eligibility 'Cliffs':** Healthcare is viewed by community members as increasingly unaffordable. Participants highlighted the burden of high deductibles, co-pays, and lost wages resulting from time taken off for appointments. Income eligibility thresholds for financial assistance are seen as sources of stress, disincentivizing financial advancement, and unfairness in terms of penalizing people who do not meet eligibility criteria but struggle to afford the cost of health care and insurance.

> *"With current prices, cost of healthcare is a luxury."*
> - *Discussion Group Participant*

- **Lack of Provider Capacity and Delays in Accessing Care:** Long wait times for appointments were a source of concern across all demographics. Lack of primary care availability and long delays in scheduling referrals forces some individuals to rely on urgent care, which is also described as insufficiently available in terms of capacity and geographic distribution, or emergency departments, which are described as overcrowded with non-emergent conditions.

> *"We still can't afford insurance and income is too low to pay hospital bills if you get sick. So we just stay home and get sick."*
> - *Discussion Group Participant*

- **System Navigation and Information Deficits:** An issue observed across groups is the challenge of navigating the system of health and human services and knowing what services and programs are

> *"Why have a doctor when I can't even get in to see them for months."*
> - *Discussion Group Participant*

available. Participants noted that localized community hubs of information, such as senior centers or dedicated case managers, are helpful but leave those disconnected from these hubs vulnerable.

> *"Getting in with a PCP or specialist is still a challenge... Have to have a referral and jump through hoops to get the referral for insurance coverage."*
> - *Discussion Group Participant*

Population-Specific Concerns

People with Behavioral Health Care Experience

- **'Window of Readiness':** Participants described months-long wait times for care, which can lead to critical missed opportunities for health improvement and recovery. Participants cautioned that, when an individual is ready to seek help, systemic delays can contribute to loss of motivation or a change of mind.
- **Diagnostic Overshadowing:** Participants expressed fear that their legitimate physical medical symptoms are minimized or ignored by providers who attribute all complaints to their behavioral health diagnoses.

> *"Now that I am housed my health has improved."*
> - *Discussion Group Participant*

Unhoused and Recently Housed People

- **Basic Survival and Hygiene Needs:** Individuals experiencing homelessness emphasized the daily struggle of maintaining basic needs, such as access to drinking water, hygiene facilities, and safe restrooms.
- **Technology and Communication:** A specific challenge is keeping mobile phones charged to communicate with healthcare providers, prompting a recommendation for publicly accessible solar-powered charging benches.
- **Stigma and Navigation Support:** Participants expressed concerns about systemic stigma and judgmental treatment, particularly in emergency departments. Discussion also emphasized that successfully navigating the healthcare system is nearly impossible without the assistance of a dedicated case manager.

New Americans

- **Fear of Eviction:** Medical debt is tied to the fear of eviction. Participants expressed anxiety over receiving bills they cannot read or understand, fearing that questioning these bills or waiting for translation could lead to the loss of their housing.

> *"Sometimes I am told I have to pay a bill but don't know what it is for. But I don't know who to ask and I worry about being evicted."*
> - *Discussion Group Participant*

- **Trust and Navigation Barriers:** There is a perceived lack of information on which providers to trust, coupled with skepticism regarding whether health care providers can assist with broader non-medical drivers of health such as housing issues.

Seniors and Family Caregivers

- **Isolation and Physical Vulnerability:** Older adults voiced concerns regarding social isolation and physical vulnerability. A specific worry is the risk of falling while at home alone and unable to reach out for assistance.
- **Caregiver Fatigue:** Family caregivers, particularly those caring for partners with impaired memory conditions, worry about their own declining energy levels and what will happen to their loved ones if they can no longer provide care.

2. Continuing Priorities and Emerging Issues

Discussion groups were asked to consider a list of high-priority health issues identified in previous community health needs assessments. Groups were then asked to comment on whether those issues remain high priorities for focusing improvement efforts, as well as to identify any new or escalating concerns.

Validation of Past Priorities

There was nearly unanimous consensus across all groups that previously identified health priorities remain critical, unresolved issues for the community. Participants explicitly validated:

- continued urgency of addressing the high cost of healthcare,
- lack of availability of primary and specialty care,
- gaps in mental health and substance use disorder services,
- insufficient support resources for aging-in-place, and
- the overarching impact of non-medical drivers of health like housing, food, and transportation.

Some participants also commented that conditions in these areas have deteriorated rather than improved in recent years. While participants confirmed that previously identified priorities remain the community's most critical unmet needs overall, new economic and social pressures have emerged to compound these issues.

> *"Why are we still talking about the same issues years later? What has been done to make a change?"*
> - *Discussion Group Participant*

Escalating or Emerging Concerns

- **Youth Mental Health:** The perception of an escalation of youth mental health needs linked to social media and isolation, such as youth anxiety, depression, and early substance exposure, was identified as a rapidly growing area of concern.
- **The 'Digital Divide':** Increased reliance on electronic communication, such as patient portals, smartphone check-ins, and automated phone systems, emerged as a new issue. This

development is of particular concern to individuals without reliable access to technology and older adults who may be less comfortable using technology.

- **Burden of Bureaucracy:** Participants described exhaustion associated with having to navigate complex administrative systems. Eligibility determination, restrictive insurance caps on treatment duration (such as addiction treatment), and complicated specialist referral processes were identified as escalating barriers to receiving care.

> *"Specialist access requires PCP referrals, adding further delays . . . Insurance companies, not doctors, are driving care decisions."*
> - *Discussion Group Participant*

- **Workforce Turnover and Continuity of Care:** While general workforce shortages are a known issue, participants emphasized the frequent turnover of staff, particularly within primary care and behavioral health, as a pressing issue. Participants observed that needing to repeat medical or trauma histories to a 'revolving door' of new staff prevents establishment of trust necessary for effective treatment and recovery.

> *"Specialists are few and far between in our area. And a lot of doctors nowadays don't spend enough time with patients. We feel rushed."*
> - *Discussion Group Participant*

- **Cost of Living and Inflation:** The sharp rise in the cost of living over the past several years, outpacing wages and fixed incomes, is perceived to have exacerbated health disparities. The high cost of food, child care, utilities, and property taxes were all described as jeopardizing financial stability for some individuals and families. Participants noted that the increased cost of living is forcing people to make choices between meeting basic needs and health care maintenance.

Population-Specific Concerns

People with Behavioral Health Care Experience

- **Systemic Flaws in Treatment Infrastructure:** Participants offered a critique of the current addiction treatment model, describing it as a system that funds infrastructure while ignoring the root causes of addiction. They expressed frustration with a cycle they believe prioritizes revenue generation over true recovery.

- **Need for Weekend and Extended Care:** Noting that medical and behavioral health crises do not adhere to standard business hours, participants emphasized the critical need for fully staffed weekend healthcare access and extended treatment durations that are not prematurely cut short by insurance limitations.

Unhoused and Recently Housed People

- **Stigma and Discrimination:** A prominent concern raised in some discussion groups is the perception of systemic stigma within healthcare settings. Participants reported feeling judged based on their appearance or housing status, which is believed to result in longer wait times and medical or mental health crises being dismissed or minimized.

> *"Providers need to understand what is actually available... unhoused individuals are often stereotyped and not taken seriously, resulting in recommendations they have no structural ability to follow."*
> - *Discussion Group Participant*

- **People Over Systems:** A recurring sentiment was the belief that community systems should place greater emphasis on supporting individuals rather than focusing primarily on administrative requirements, funding constraints, or organizational priorities.

New Americans

- **Cultural Differences and Youth Substance Use:** An important concern among new immigrants and refugees is the perception of an American youth drinking culture and its destructive impact on families. A sense of powerlessness was described regarding a conflict between child discipline practices and fears of law enforcement intervention, highlighting a need for culturally attuned parenting support.

> *"They were OK before they came here and now they are not OK because of substance use. And there is no help."*
> - *Discussion Group Participant*

Seniors and Family Caregivers

- **Costs of Aging in Place:** While services for older adults including in-home supports for aging in place was validated as an ongoing priority, seniors highlighted that crucial tools required for safe independent living - such as medical alert systems, incontinence supplies, and home modifications - are often entirely out of pocket and unaffordable for those on fixed incomes.

> *"The Life lines are essential to remaining in your home independently, but they are costly and I can't afford it."*
> - *Discussion Group Participant*

3. Observed Improvements and 'Bright Spots'

When asked if they had noticed any improvements in community health issues over the past few years, the general sentiment across most focus group participants was that broad systemic challenges remain largely unresolved.

Lack of Systemic Improvement

- **Persistent Macro-Level Barriers:** Participants emphasized that macro-level barriers such as the cost of healthcare, transportation reliability, housing affordability, and primary care access have not improved, and in many cases, have worsened.
- **Systemic Failures Undermining Good Work:** While many participants expressed appreciation for the dedication and sincerity of individual frontline workers, they noted that systemic failures undermine community progress and improvement. High staff turnover, severe underfunding, and facility closures were cited as structural issues that hinder the effectiveness of dedicated community providers and services.

> *"(There are) good people in the community doing the work despite systemic failures. To be clear (our) criticism is directed at systems and structures, not the individuals working within them."*
> - *Discussion Group Participant*

Programmatic Bright Spots and Frontline Dedication

- **Mobile and Co-Located Services:** Despite broader systemic criticisms, participants highlighted specific programmatic improvements, particularly the expansion of Community Health Workers and mobile health initiatives like Winnipesaukee Mobile Health. These models were praised for successfully bringing essential care directly to vulnerable populations.
- **Expansions in Peer Support and Access Points:** Participants praised specific community resources, such as "The Doorway," for improving initial access to SUD treatment. There was also positive recognition of expanded peer support networks and local coalitions that offer meaningful, non-judgmental assistance.
- **Quality of Local Care:** While accessing care is perceived as being difficult, participants noted that once they successfully navigate the system, the actual quality of care provided by local health care and community service organizations is excellent.

Population-Specific Observations

People with Behavioral Health Care Experience

- **Targeted Access Improvements:** Participants praised specific entry points and models of care, noting that "The Doorway" program has improved timely access to SUD treatment. They also highlighted the benefits of integrated care, such as having medication-assisted treatment (MAT) and psychiatric providers located within the same organization.

- **Contrasting Systemic Decline:** Conversely, some groups reported a decline in the broader treatment infrastructure. They cited the recent closure of a state-funded SUD treatment facility, the elimination of respite beds, and ongoing challenges with staff turnover.

Unhoused and Recently Housed People

- **The Stabilizing Power of Housing:** Participants living in permanent supportive housing reported significant improvements in their overall health and stability. They specifically cited the benefits of having dedicated residential staff and case managers to assist with care coordination, transportation, and daily life skills.
- **'Meeting People Where They Are':** Unhoused individuals praised organizations that provide accessible services, such as mental health, meals, and support services, co-located at trusted community hubs.

Seniors and Family Caregivers

- **Mixed Experiences with Home Supports:** There was a notable split among senior groups regarding aging-in-place services. While some reported positive improvements, seeing more staff and agencies actively assisting in the home, other seniors felt there had been no improvements in recent years.

> *"We see a lot more people being helped in home which is nice. Aging in place seems to have more support now more than ever."*
> - *Discussion Group Participant*

> *"It seems like the system is prompting doctors to make a visiting nurse available after certain procedures, but when you actually need supports to help you, help isn't available."*
> *- Discussion Group Participant*

4. Focus on Behavioral Health

The 2026 Community Health Needs Assessment discussion groups included a specific focus on issues associated with behavioral health care. Participants were asked to identify the most pressing behavioral health concerns in the community, encompassing both mental health and substance use conditions, and to provide specific recommendations for programs, services, or systemic improvements.

Most Pressing Behavioral Health Concerns

- **Prevalence of Complex Conditions:** Across the discussion groups, substance use disorders (SUD), anxiety, depression, and trauma were identified as the most critical and pressing behavioral health concerns.
- **The Impact of Chronic Stress and Non-Medical Drivers of Health:** Participants consistently emphasized that behavioral health crises are heavily driven and exacerbated by the chronic, compounding stress of financial hardship, housing instability, and social isolation.
- **System Capacity and Continuity of Care:** Participants described significant access barriers across the behavioral health system, including long wait times and a lack of local services. High staff

turnover at existing mental health centers was cited as a major barrier. Participants noted that lack of continuity in provider visits prevents patients from building the trust necessary for effective therapeutic relationships.

- **Over-Medicalization vs. Person-Centered Care:** Participants expressed frustration that healthcare providers frequently prioritize prescribing medication before adequately exploring other treatment options, leaving patients feeling unheard, misunderstood, and excluded from their own treatment planning.

> *"We used to have a program that would come to where we live once per month. In one year, we had 3 different staff for that program because the staff kept leaving the agency."*
> - *Discussion Group Participant*

Recommendations for Programs and Services

- **Integrated, Dual-Diagnosis Care:** A primary recommendation across several groups was to stop treating mental health and substance use disorders in silos. Participants advocated for dual-diagnosis programs that address both issues simultaneously in one location, noting that removing the substances often reveals underlying trauma that must be treated concurrently.

> *"Dual diagnosis is huge. It is a lot more common. When you remove the drugs there is a lot more than just the use"*
> - *Discussion Group Participant*

- **Expanded Entry Points:** To address prohibitive waitlists, participants recommended expanding walk-in behavioral health clinics, same-day appointments and open-access scheduling.
- **Insurance and Administrative Reform:** Participants called for increased insurance coverage for longer-term treatment and recovery support, noting that current duration limitations hinder true recovery. Simplifying administrative requirements for maintaining outpatient and sober-living program participation was also suggested.
- **Embedded Social Workers and Peer Support:** Groups advocated for embedding social workers in non-traditional settings, such as on police forces to follow up on traumatic events and increasing their presence in hospital emergency departments. Expanded peer support programs and community health worker initiatives were also recommended.

Population-Specific Observations

Youth and Families

- **Invest in Prevention:** Participants emphasized the value of early intervention, viewing mental health investment at a young age as a form of prevention, and suggested that more extracurricular activities for youth could provide community, purpose, and a protective buffer against substance use and mental health decline.

- **Gaps in Family Support:** There is a perceived lack of services for family counseling, parenting education, and resources for kinship caregivers. A specific issue noted was that DCYF supervised visitation locations are too distant, creating serious logistical barriers for families.

Seniors and Family Caregivers

- **Social Isolation:** For older adults, behavioral health concerns can manifest as profound loneliness, grief, and emotional distress.
- **Use of Telehealth:** While telehealth was praised by some as a convenient tool that removes transportation barriers for counseling services, it was also described as a potential obstacle for older adults who are not comfortable setting up or navigating platforms for virtual conferencing.

> *"I think it's an issue for seniors because a lot of seniors are not conversant in setting up a zoom, joining a zoom, navigating all of that. . . . I can do it. But I know my mother can't do it."*
> - *Discussion Group Participant*

- **Community-Based Outreach:** Seniors recommended establishing drop-in office hours for social workers at local senior centers. They also praised proactive wellness check programs, such as the police department's "Good Morning Henniker" daily calls, as effective ways to combat isolation and ensure safety.

People with Behavioral Health Care Experience

- **Sober Housing and Building Community:** There is a need for more affordable, high-quality sober living options. Participants highlighted that local zoning laws present a barrier to establishing recovery homes in more residential areas. To support long-term wellness, participants recommended implementing incentive-based recovery programs, such as subsidized gym memberships or e-bikes, to encourage physical activity and build community.
- **Veterans Services:** Participants noted that VA behavioral health services are important but are not consistently understood or easily accessed, indicating a need for improved coordination and navigation of Veteran-specific benefits.

Unhoused and Recently Housed People

- **Safe Spaces and Sanitation:** Unhoused individuals emphasized the need for designated safe spots equipped with basic sanitation to reduce marginalization and promote community safety.
- **Peer Support for Transitions:** Formerly unhoused individuals highlighted a need for specialized peer support specifically designed for people who are no longer homeless, as navigating the transition into housed life presents its own unique behavioral health challenges.

> *"(There needs to be) safe spots for the unhoused and the community as well. Just because you kicked them out of an area does not mean they are housed . . . . they don't magically get housed just because they have to leave an area."*
> *- Discussion Group Participant*

5. Recommendations for Healthcare and Public Health Organizations

Discussion participants were asked what healthcare and public health organizations could be doing better or differently to have a positive impact on the community. Recommendations ranged from systemic overhauls to specific, localized interventions, but emphasized that the issues discussed must be addressed holistically, not in isolation.

Interconnectedness of Healthcare and Non-medical Drivers of Health

Multiple groups used their final comments to underscore that healthcare cannot be treated in a vacuum. Participants emphasized that housing, transportation, financial stability, and healthcare access are deeply intertwined; addressing one area without the others will fail to produce meaningful, long-term improvements in community health.

Person-Centered Care

- **Time and Empathy:** A common request across discussion groups was for healthcare providers to be able to spend more time with patients, actively listen, and avoid rushing through appointments.
- **Stigma Reduction:** Participants recommended expanding training for healthcare professionals, especially in emergency departments, to reduce systemic stigma surrounding homelessness, mental health, and substance use.

> *"If my child has something minor, I will wait until the weekend to go the walk-in clinic. It's easier to get in and I will actually be listened to. It is nearly impossible to get in to our PCP."*
> *- Discussion Group Participant*

Communication and Resource Navigation

- **System Navigators:** Participants broadly advocated for expanding the use of community health workers, social workers, and peer navigators to help patients advocate for themselves and navigate complex medical, insurance, and social service systems.
- **Centralized Resource Directories:** Several groups recommended creation of a centralized, easily accessible community resource manual or directory. Noting that "people don't know what they don't know," participants suggested distributing this information through various channels, including local businesses, newspapers, press releases, and community centers.

Access and Availability

- **Alternative Access and Hours:** To address prohibitive wait times, groups recommended expanding walk-in services, same-day appointments, open-access scheduling, and ensuring better healthcare access during evening and weekend hours.

- **Investing in the Staff:** Participants commented that to improve overall care, organizations must provide better compensation and support for frontline workers to improve staff retention and continuity of care.

> *"Take care of the people doing the good work."*
> *- Discussion Group Participant*

- **Expanded Services:** Recommendations included expanding available specialty services (specific services mentioned were cancer treatment, obstetrics/maternity, dental, and vision care) and advocating for policies that treat housing and transportation as essential healthcare interventions.

Population-Specific Observations

Seniors and Family Caregivers

- **Physical Accessibility:** Seniors offered specific recommendations for healthcare facilities, such as implementing valet parking at the hospital (cited as especially crucial during winter months to prevent falls) and providing scheduled medical shuttles similar to those used by assisted living facilities.

> *"Concord Hospital needs valet parking. There's no place to park, or parking is too far away. Especially in the winter, I couldn't walk that far with the ice."*
> *- Discussion Group Participant*

- **Community Support Programs:** To combat isolation and physical vulnerability, older adults recommended establishing community "buddy" or senior companion programs. They also suggested creating local "handyman" services to help with household tasks, such as changing smoke detector batteries or lightbulbs, to safely support aging in place.
- **Overcoming Pride:** A cultural nuance was raised regarding the "Yankee" hesitancy to ask for help. Seniors noted that it would be helpful for organizations to proactively reach out with services because many older adults are too proud, fearful, or hesitant to ask for assistance themselves.

New Americans

- **Repetition and "Nudging":** New Americans highlighted that health information often needs to be shared multiple times and in various formats before it is fully understood and adopted. It was recommended that providers always act with a "caring heart" and gently "nudge" people toward healthier behaviors in culturally sensitive ways.

Individuals in Recovery

- **Incentive-Based Recovery:** Participants recommended innovative, incentive-based recovery programs to encourage physical activity and support sobriety, such as providing subsidized gym memberships.

- **Transitional Housing:** There was a call for more support and investment in transitional housing and quality sober living options for individuals leaving treatment.

Unhoused Populations

- **Strengthening Community Collaboration**: Participants advocated for improved coordination among healthcare providers, behavioral health agencies, law enforcement, community organizations, and homeless service providers. It was suggested that stronger communication and collaboration could improve service delivery, increase awareness of available resources, and better address individual needs.

> *"They have been unhoused for 5 years and now they are doing great. Their lives are now just different. To see them housed, tent not in a trash bag. They are good and safe. They have the joy of having a place."*
> *- Discussion Group Participant*

An over-arching request from the discussion groups is for more collective action, urging healthcare systems, municipalities, and nonprofit organizations to break down silos, share resources, and work toward solutions together. As one participant commented: *"If multiple spaces, organizations are seeing the same problems, why aren't we all working together to solve them?*

D. Community Health Status Indicators

This section of the 2026 Community Health Needs Assessment report provides information on key data indicators 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 specific to the 49 town service area identified as the Capital & Lakes Region service area.

In some instances, data are only available at the county level or the Public Health Network (PHN) region level. County level data is presented for Belknap County (11 municipalities, 100% of the county total) and Merrimack County (24 municipalities, 89% of the county total). The remaining communities of the Capital & Lakes Region service area span 5 of NH's 10 counties (5 towns in Grafton County, 4 in Hillsborough County, 3 in Carroll County, and 1 each in Rockingham and Sullivan counties) such that most municipalities comprising those counties are not part of the Concord Hospital service area. Thus, statistics describing those counties do not particularly reflect the population served by the Concord Hospital system.

Similarly, for data available at the regional PHN level, this assessment will include statistics describing the Capital Area and Winnipesaukee PHNs. Of the 49 municipalities in the Concord Hospital system primary service area, 25 are included in the Capital Area PHN and 16 are in the Winnipesaukee PHN (also referred to as the Lakes Region). Together the Capital Area and Winnipesaukee regions contain 89% of the service area population. The remaining 8 towns are distributed across 4 other PHNs (Central NH; Carroll County, Greater Manchester, and Greater Sullivan).

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 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 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.

According to the 2024 American Community Survey, the population of the Capital & Lakes Region service area has a slightly higher percentage of people age 65 and older compared to New Hampshire overall. The service area map below the table on the next page displays the percentages of the age 65 and older population by town. A general pattern can be observed where towns in the northern

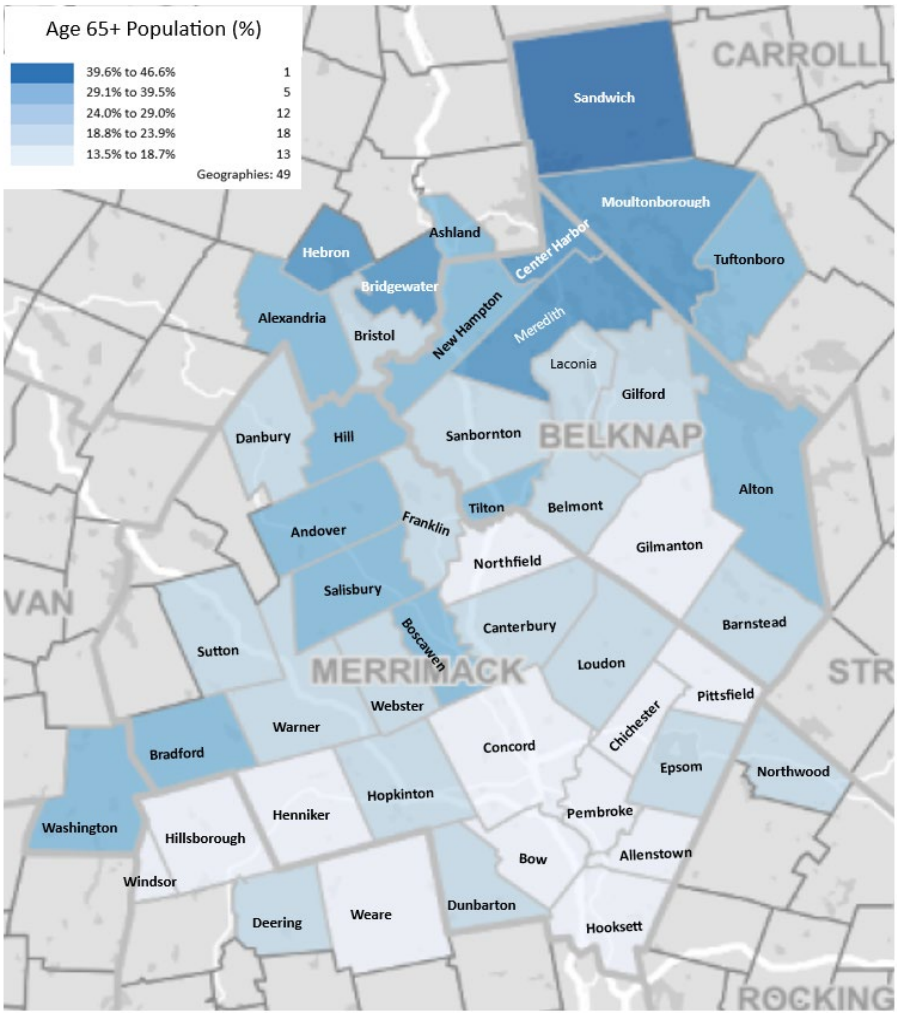
and western parts of the service area have a relatively higher proportion of residents age 65 and older. Between 2021 and 2024, the population of the service area grew by about 2.0%; a slightly faster pace than New Hampshire population growth overall.

| TABLE 10 |

Indicators	Capital & Lakes Region	New Hampshire
Total Population	254,860	1,387,834
Age under 5 years	4.3%	4.5%
Age 5 to 17 years	13.8%	13.7%
Age 65 and older	21.2%	20.1%
Age 85 and older	2.0%	2.0%
Change in population (2021 to 2024)	+2.0%	+1.7%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2020 - 2024

Figure 23: Percent of Service Area Population 65 years of age and older



Disability Status

The proportion of people with a disability is associated with a populations age profile. 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 Capital & Lakes Region who report having at least one disability - about 15% - is higher than in New Hampshire overall.

| TABLE 11 |

Total Population (Noninstitutionalized) with a Disability		
Age Group (in years)	**Capital & Lakes Region**	New Hampshire
Age <18 with a disability	5.9%	5.1%
Age 18-64 with a disability	12.6%	10.9%
Age 65+ with a disability	29.1%	28.5%
Total population (%) with a disability	14.8%	13.3%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2020 – 2024

Education

Educational attainment is also considered a key driver of health status. One reason education level is associated with health status is 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 aged 25 and older who have earned at least a high school diploma (Table 12) is similar to New Hampshire overall. The percent of the population with a bachelor's degree or higher is also similar to the statewide statistic.

| TABLE 12 |

Percent of Population Aged 25+	Capital & Lakes Region	New Hampshire
High School Diploma (or Equivalent) and Higher	94%	94%
Some College or Associate's Degree	29%	27%
Bachelor's Degree or Higher	39%	41%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2020 – 2024

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.

Some information describing household income and poverty status was included in the first overview section of this report. Table 13 displays the percent of people in the service area living in households with income below the Federal Poverty Level (FPL) including the percent of children under age 18 and the percent of adults 65+ years living in households with income below the FPL. For context, the Federal Poverty Level for an individual in 2024 was $15,060 and for a family of four was $31,200.

About 9% of households with children in the region - equivalent to about 4,000 households - are estimated to have income below the poverty level. About 8% of households in the region with people aged 65+ - also equivalent to about 4,000 households - are estimated to have income below the poverty level.

| TABLE 13 |

Percent of people in households with income below the Federal Poverty Level (FPL)		
Population Group	**Capital & Lakes Region**	**New Hampshire**
All people with household income below the FPL	7.9%	7.2%
Children (under 18) in households with income below the FPL	9.1%	7.9%
Adults 65+ years in households with income below the FPL	7.7%	7.7%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010 – 2024

Language

Limited ability 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 471 households in the service area (0.5%) are considered limited-English speaking households. A limited English speaking household is defined as one in which no member

| TABLE 14 |

Indicator	Capital & Lakes Region	New Hampshire
Limited English Speaking Households (%)	0.5%	1.2%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2020 – 2024

14 years old or older either speaks only English or speaks a non-English language and speaks English very well. Concord has the largest proportion of limited English speaking households, approximately 1.2% or 230 households, in the service area.

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 less 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.

| TABLE 15 |

Percent of Households with High Cost Burden or Substandard Housing	Capital & Lakes Region	New Hampshire
Housing Costs >30% of Household Income (%)	24.8%	24.8%
Rental Costs >30% of Household Income (%)	45.3%	48.2%
Occupied Housing Units Lacking Complete Plumbing Facilities (%)	0.5%	0.5%
Occupied Housing Units Lacking Complete Kitchen Facilities (%)	0.5%	0.7%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2020 – 2024

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 – equivalent to about 500 households - that have characteristics of sub-standard housing such as lacking complete plumbing facilities or complete kitchen facilities.

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. Of particular note, the use of lead paint and asbestos-containing insulation was banned in 1978. In the Capital and Lakes Region, more than half (52%) of housing units were built before 1980, a percentage similar to New Hampshire overall (about 51%).[3]

Transportation

Individuals with limited transportation options also have limited employment options, greater difficulty accessing services, and more challenges to leading independent, healthy lives. About 3% of households in the service area report having no vehicle available, a percentage somewhat lower than in New Hampshire overall. Salem has the highest estimate among service area towns for households with no vehicle available (3.9%).

| TABLE 16 – Vehicle Availability|

Area	Percent of Households with No Vehicle Available
Capital & Lakes Region	4.0%
New Hampshire	4.6%

Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates.

[3] Data Source: U.S. Census Bureau, 2012-2024 American Community Survey 5-Year Estimates.

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 17 displays town level estimates of the proportion of residents in the Capital & Lakes 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 (5%). There is a notable range in the region from 16% without health insurance in Danbury to about 2% in Bow, Gilmanton, Andover, Northwood, and Epsom. A wide range is also observed for the percentage of residents with Medicaid coverage from 3% in Gilmanton to about 31% in Bristol. The map following the table (Figure 24) displays the percent of residents with Medicaid coverage by municipality.

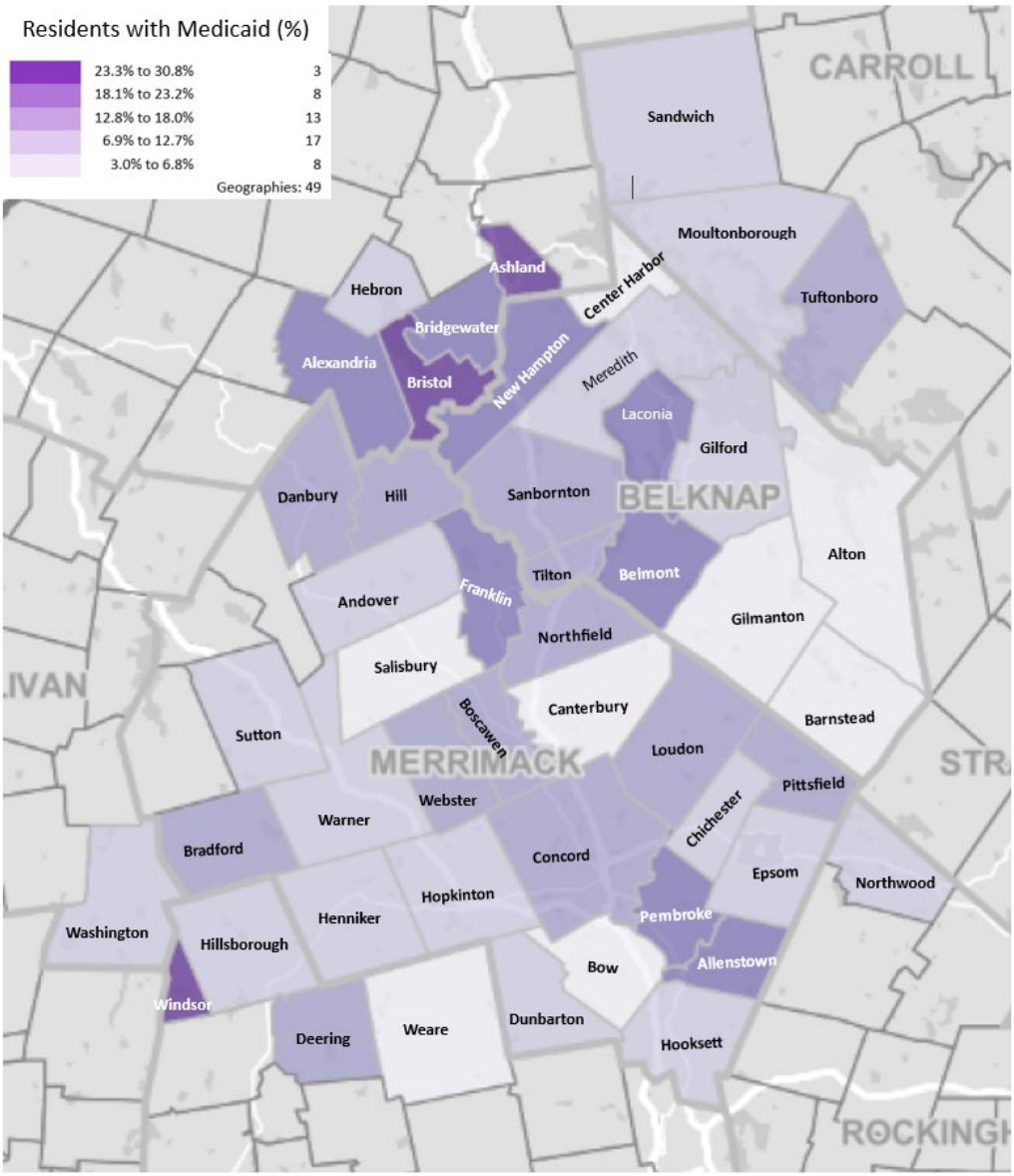
| TABLE 17: Health Insurance Coverage Estimates |

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*
Danbury	16%	24%	18%	4%
Hebron	11%	40%	12%	1%
Pittsfield	11%	23%	14%	5%
Webster	10%	19%	16%	1%
Hillsborough	10%	19%	12%	3%
Meredith	10%	32%	11%	3%
Belmont	9%	24%	19%	4%
Alexandria	9%	24%	19%	3%
Center Harbor	8%	40%	4%	2%
Warner	8%	20%	11%	2%
Tuftonboro	8%	31%	16%	5%
Bridgewater	8%	34%	22%	4%
Washington	7%	28%	13%	4%
Moultonborough	7%	36%	9%	5%
Allenstown	7%	22%	20%	3%
Laconia	6%	23%	23%	2%
Weare	6%	15%	6%	4%
New Hampton	6%	26%	23%	6%

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*
Sanbornton	6%	22%	14%	2%
Hooksett	6%	19%	12%	4%
Gilford	6%	21%	9%	4%
Concord	6%	22%	18%	2%
Bristol	6%	24%	31%	3%
Sutton	6%	21%	8%	3%
Hill	6%	30%	15%	4%
Capital & Lakes Region	**6%**	**23%**	**14%**	**3%**
Loudon	6%	26%	16%	2%
New Hampshire	**5%**	**21%**	**13%**	**2%**
Windsor	5%	20%	29%	3%
Boscawen	5%	24%	17%	3%
Sandwich	5%	47%	8%	4%
Ashland	5%	30%	27%	3%
Deering	5%	27%	18%	3%
Northfield	5%	20%	16%	4%
Franklin	4%	25%	21%	4%
Salisbury	4%	27%	6%	3%
Chichester	4%	17%	12%	5%
Dunbarton	4%	21%	10%	2%
Canterbury	4%	23%	7%	2%
Tilton	4%	25%	17%	3%
Henniker	4%	18%	8%	1%
Pembroke	4%	18%	20%	2%
Bradford	3%	26%	17%	2%
Barnstead	3%	22%	5%	3%
Hopkinton	3%	19%	11%	2%
Alton	3%	26%	7%	2%
Bow	2%	17%	6%	2%
Gilmanton	2%	17%	3%	2%
Andover	2%	29%	10%	3%
Northwood	2%	21%	11%	2%
Epsom	2%	21%	10%	3%

Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates.

| Figure 24. Percent of Residents with Medicaid Coverage, Capital & Lakes Region |



Estimates for Medicaid Coverage by town range from 3% in Gilmanton to 31% in Bristol.

Delayed or Avoided Care Due to Cost

This indicator reports the percentage of adults aged 18 and older who self-report that they have delayed or avoided a healthcare visit in the past year because of cost. A higher rate on this measure is reflective of limitations of household income or health insurance benefits inhibiting access to care. While data are not currently available at the regional level, it is likely that the percentage of residents who needed to see a doctor in the past 12 months but could not afford it is in a similar range.

| TABLE 18 |

Area	Percent of Population Who Could Not See a Doctor because of Cost
Capital & Lakes Region	NA
New Hampshire	8.6%

Data Source: CDC, Behavioral Risk Factor Surveillance System 2024; Data not available for the Concord or Laconia Micropolitan Statistical Areas. The survey question is: "Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it?"

The New Hampshire Consumer Healthcare Experience State Survey[4] conducted in 2024 by Altarum in collaboration with New Futures found that 20% of respondents "avoided going to the doctor or having a procedure done altogether due to cost" in the previous 12 months.

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 providers, dentists and mental health professionals. The Winnipesaukee Public Health Region has the second lowest ratio (fewer providers per total population) of primary care physicians among NH's 13 public health regions after the Greater Sullivan County region.

| TABLE 19 |

Area	Primary Care Provider FTEs per 100K Population*	General Dentist FTEs per 100K Population*	Ratio of Population to Mental Health Providers**
Capital Area Public Health Region	99.4	37.9	
Winnipesaukee Public Health Region	72.1	33.0	
Belknap County			185:1
Merrimack County			185:1
New Hampshire	97.5	37.1	250:1

**NHDPHS, Rural Health and Primary Care Section, Annual Report on the New Hampshire Health Care Workforce, 2024 (2022 data)*

***Data Source: CMS, National Provider Identification via County Health Rankings, 2024*

[4] 2024 New Hampshire Consumer Healthcare Experience State Survey accessed at https://new-futures.org/chess

Table 20 displays the percentage of NH adults who self-reported not having a primary care physician (PCP). In 2022, the Winnipesaukee Public Health Region had the highest percentage of residents (18+) without a personal doctor/health care provider in the state, at 20.2%.

| TABLE 20 |

Area	Percent of Population (18+) Without a PCP
Capital Area Public Health Region	8.6%
Winnipesaukee Public Health Region	**20.2%**
New Hampshire	12.3%

Data Source: NHDPHS, Rural Health and Primary Care Section, 2022

Table 21 displays primary care utilization as the annual rate of medical primary care visits per person. The NH State Office of Rural Health (SORH) classifies Public Health Network regions throughout the state as rural (7 regions including Winnipesaukee) or non-rural (6 regions including Capital Area). Of the 49 towns included in the primary service area, 24 towns are categorized as non-rural (49%) and 25 are categorized as rural (51%).

| TABLE 21 |

Area	Medical Primary Care Visits per person, annual count
Capital Area Public Health Region	1.71
Winnipesaukee Public Health Region	1.27
New Hampshire - Rural	1.64
New Hampshire - Non-Rural	2.06

**NH Comprehensive Healthcare Information System via NHDPHS, Rural Health and Primary Care Section, 2026 (2023 data)*

Travel Time or Distance

One measure of access to primary care is travel time to health care visits. As displayed by Table 22, more than one-third of primary care visits in the Capital Area and Lakes Region require one-way travel time greater than 30 minutes. The Winnipesaukee region has the highest statistic on this measure of any region in the state, and the Capital Area has the second highest percentage of primary care visits with one-way travel times greater than 30 minutes.

| TABLE 22 |

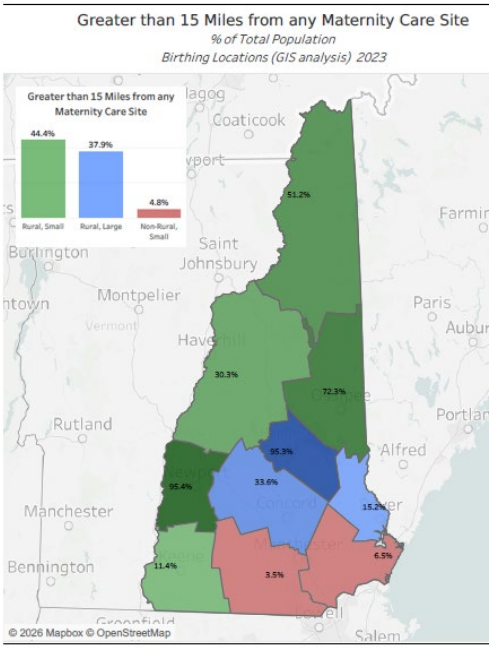
Area	Percentage of primary medical care visits with travel times greater than 30 minutes, one way
Capital Area Public Health Region	34.0%
Winnipesaukee Public Health Region	39.4%
All Non-Rural New Hampshire	19.2%
All Rural New Hampshire	28.5%

NHDPHS, Rural Health and Primary Care Section, Annual Report on the New Hampshire Health Care Workforce, 2024 (2023 data)

The number of hospitals providing obstetric services has been in decline in New Hampshire and across the country. The loss of hospital-based obstetric services is associated with increases in out-of-hospital births and pre-term births, which may contribute to poor maternal and infant outcomes.[5] About 95% of the population of Belknap County lives greater than 15 miles to the nearest hospital providing birthing services, tied with Sullivan County for the highest percentage in the state.

| Table 23 |

Area	Greater than 15 Miles to Nearest Birthing Center, % of total population
Belknap County	95%
Merrimack County	34%
All Rural New Hampshire	41%
All Non-Rural New Hampshire	5%



Data Source: New England Rural Health Association, Rural Data Analysis Dashboard, 2023. Belknap and Merrimack are classified as rural, large counties.

[5] 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 rate of preventable hospital stays for Medicare enrollee residents of Belknap and Merrimack counties was similar to the statewide rate in 2022.

| Table 24 |

Area	Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees
Belknap County	2,101
Merrimack County	2,215
New Hampshire	2,348

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

Prevention quality indicators (PQIs) are a similar measure of acute (e.g., bacterial pneumonia, urinary tract infection) and chronic (e.g., diabetes, COPD, asthma) inpatient admissions that may have been avoided with proper access to primary care. The NH State Office of Rural Health reports PQI rates for inpatient admissions of adults (ages 18+) for Public Health Regions. Overall, the PQIs for the Capital Area and Winnipesaukee Public Health Regions rates are somewhat higher than the overall state rate for rural PHN regions, although the acute composite rates are notably lower.

| Table 25 |

Preventive Quality Indicators: Inpatient Admissions (age-adjusted per 100,000, NH adults 18+)			
Area	**Overall Composite**	**Acute Composite**	**Chronic Composite**
Capital Area Public Health Region	744.4	157.3	587.1
Winnipesaukee Public Health Region	675.5	139.5	536.0
All Non-Rural New Hampshire	895.1	230.4	664.7
All Rural New Hampshire	661.6	170.8	490.8

Data Source: NHDHHS, Office of Rural Health and Primary Care, 2020-2022 data

Dental Care Utilization (Adult)

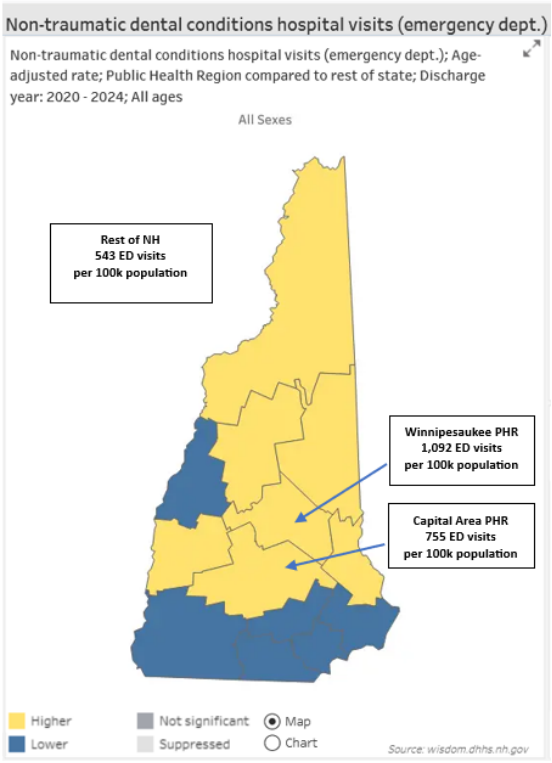
This indicator reports the percentage of adults aged 18 and older who self-report they have visited a dentist, dental hygienist, or dental clinic within the past year. Nearly one-third of adults in the region report not having had a dental visit in the past year.

| Table 26 |

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

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

Emergency department visits for non-traumatic dental conditions provides 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 Capital Area and Lakes Region experiences significantly more hospital emergency department dental visits for non-traumatic reasons (i.e., not resulting from an acute injury) compared to the rest of New Hampshire. The rate in the Winnipesaukee Public Health Region is twice the rate for the rest of the state.



| Table 27 |

Area	Emergency Department visits for non-traumatic dental condition; Age-adjusted rate per 100,000
Capital Area Public Health Region	**755***
Winnipesaukee Public Health Region	**1,092***
All other New Hampshire	543

*Data Source: NH Hospital Discharge Data, 2020-2024 *Regional rate is significantly different and higher 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 11% of households in the Capital & Lakes Region experienced food insecurity in the past year (2024 data) defined as the percentage of households unable to provide adequate food for one or more household members due to lack of resources.

| TABLE 28 |

Area	Percent of Households Experiencing Food Insecurity
Belknap County	10.6%
Merrimack County	11.0%
New Hampshire	11.2%

Data Source: Feeding America, Map the Meal Gap, 2024

Table 29 shows the percent of households receiving support through the Supplemental Nutrition Assistance Program (SNAP). About 7% of households in the Capital & Lakes Region receive SNAP support. Among these households about 43% have children under 18 in the household and about 47% have at least one household member aged 60 years or older.

| TABLE 29 |

Area	Percent of All Households Receiving SNAP	With Children Under 18 (% of all households receiving SNAP)	With one or more people in the household 60 years and over (% of all households receiving SNAP)
Capital & Lakes Region	**7%**	**43%**	**47%**
New Hampshire	6%	44%	40%

Data Source: Data Source: U.S. Census Bureau, 2020-2024 American Community Survey 5-Year Estimates

Physical Activity (Adults)

This indicator shows 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 the region self-report a lack of physical activity in the 'past month'.

| TABLE 30 |

Area	Percent of Adults Participating in Physical Activity Outside of Work, past month
Capital Area Public Health Region	82%
Winnipesaukee Public Health Region	81%
New Hampshire	81%

Data Source: NH Behavioral Risk Factor Survey via NH Data Portal, 2024

Pneumonia and Influenza Vaccinations (Adults)

The table below displays the percentage of adults who self-report they received an influenza vaccine (either shot or spray) in the past year (at the time of the survey) or, for ages 65 and older, 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 or opportunities for health education including addressing concerns for vaccine safety and efficacy.

| TABLE 30 |

Area	Had a seasonal flu vaccine in past 12 months, all adults	Ever Had a Pneumococcal Vaccination, ages 65+
Capital Area Public Health Region	49%	75%
Winnipesaukee Public Health Region	45%	79%
New Hampshire	48%	76%

Data Source: NH Behavioral Risk Factor Survey via NH Data Portal, 2024

Substance Misuse

Substance misuse, involving alcohol, illicit drugs and misuse of prescription drugs, or 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.

Excessive alcohol use: 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 (5 or more drinks within 2-3 hours for men or 4 or more drinks within 2-3 hours for women), can lead to increased risk of health problems such as liver disease or unintentional injuries.

Table 31 shows the percentage of adults who reported binge and heavy alcohol use. Regional estimates are somewhat lower, although not statistically different than statewide percentages for excessive drinking among adult residents.

| TABLE 31 |

Area	Binge Alcohol Use			Heavy Alcohol Use, All Adults
	All Adults	Adult females	Adult males	
Capital Area Public Health Region	15%	7%	22%	6%
Winnipesaukee Public Health Region	15%	6%	23%	9%
New Hampshire	16%	11%	20%	8%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2024 (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.

| TABLE 32 |

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
Capital Area Public Health Region	23%	10%	29%
Winnipesaukee Public Health Region	22%	10%	30%
New Hampshire	23%	12%	29%

Data Source: NH Youth Behavior Risk Survey (YRBS), 2023.

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 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 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 33 on the next page shows an estimate for the percent of NH adults who have taken prescription pain relievers in the past year and the percent who also reported having used a prescription pain medication in the past year not prescribed specifically for them by a health care provider.

| TABLE 33 |

Area	Used a prescription pain medication prescribed for you; all adults, past year	Used a prescription pain medication not specifically prescribed for you; all adults, past year
Capital Area Public Health Region	22%	Data suppressed, insufficient sample size
Winnipesaukee Public Health Region	20%	Data suppressed, insufficient sample size
New Hampshire	22%	1.4%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2020, 2021

According to results from the 2023 Youth Risk Behavior Survey, about 9% of high school students in the Capital Area and Lakes Region reported having ever taken a prescription drug without a doctor's prescription and about 5% had done so at least once in the 30 days prior to the survey administration.

| TABLE 34 |

Area	High School Students	
	Ever took prescription drugs without a doctor's prescription	Took a prescription drug without a doctor's prescription, in past 30 days
Capital Area Public Health Region	8%	5%
Winnipesaukee Public Health Region	10%	4%
New Hampshire	9%	5%

Data Source: NH Youth Behavior Risk Survey (YRBS), 2023.

Marijuana: Results from the 2023 YRBS indicate that about 1 in 5 students in the Winnipesaukee region self-report having used marijuana in the past 30 days prior to survey administration. The percentage in the Capital Area (about 15%) is significantly lower than the Winnipesaukee and overall state percentages. About 1 in 5 high school age also report having been offered, sold, or given an illegal drug on school property.

| TABLE 35 |

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*
Capital Area Public Health Region	15%*	4%	19%
Winnipesaukee Public Health Region	22%	6%	20%
New Hampshire	20%	5%	20%

Data Source: NH Youth Behavior Risk Survey (YRBS), 2023.
**Statistic is significantly different and lower than the state rate.*

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

The percent of adults in the Winnipesaukee region surveyed through the 2024 Behavioral Risk Factor Survey who currently smoked cigarettes – about 12% - was higher than the percent in the Capital Region - about 7% - although the difference is not statistically significant. The percentage of high school age youth in the Winnipesaukee region who currently smoke cigarettes is significantly lower than the overall state rate.

| TABLE 36 |

Area	Percent of High School Students Who Currently Smoke Cigarettes	Percent of Adult Population Who Currently Smokes Cigarettes
Capital Area Public Health Region	4%	7%
Winnipesaukee Public Health Region	2%*	12%
New Hampshire	4%	9%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2024; NH Youth Behavior Risk Survey (YRBS), 2023.
**Statistic is significantly different and lower than the state rate.*

As displayed by Table 37, use of an electronic vapor product among high school age students is substantially more common than cigarette use in New Hampshire.

| TABLE 37 |

Area	Percent of High School Students Who Currently Use an Electronic Vapor Product
Capital Area Public Health Region	14%
Winnipesaukee Public Health Region	20%
New Hampshire	17%

NH Youth Behavior Risk Survey (YRBS), 2023.

Smoking during pregnancy can have a significant impact on preterm birth and other birth outcomes. Between 2020 and 2024, about 5% of births in the region were to mothers who indicated smoking during pregnancy (479 out of 8,989 total births). The percentage of births to mothers who indicated smoking during pregnancy is significantly lower in the Capital Area, while significantly higher in the Winnipesaukee region compared to the state overall. About 14% of percent of births associated with smoking during pregnancy were preterm births.

| TABLE 38 |

Area	Percent of Mothers Who Reported Smoking During Pregnancy	Percent of births associated with smoking during pregnancy that were preterm
Capital Area Public Health Region	**4.2%***	14.1%
Winnipesaukee Public Health Region	**7.7%****	13.4%
New Hampshire	4.9%	13.9%

Data Sources: NH Vital Records Birth Certificate Data, 2020-2024

** Statistic is significantly different and lower than the state percent.*

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

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 39 shows the percentage of pregnant women who initiated prenatal medical care in the first trimester. In recent years, about 3% of pregnant women in New Hampshire receive late prenatal care, defined as third trimester entry in care, or no prenatal care at all.[6]

| TABLE 39 |

Area	Early Prenatal Care (first trimester entry, % of births)
Belknap County	83.4%
Merrimack County	86.0%
New Hampshire	85.0%

NHDHHS, Maternal Health Characteristics and Outcomes in New Hampshire – 2025 Data Brief (2024 data)

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.

The indicator shown on the next page 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 40 |

Area	Full term low birthweight among WIC enrolled pregnant women	Low and Very Low Birthweight among WIC enrolled pregnant women, all births
Belknap County	8.0%	9.8%
Merrimack County	8.2%	10.0%
New Hampshire	6.5%	8.9%

Data Sources: NH Pregnancy Nutrition Surveillance System (PNSS), 2024

[6] March of Dimes, NH State Summary 2025 accessed at https://www.marchofdimes.org/peristats/

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 Capital Area and Lakes Region is similar to the overall NH state rate.

| TABLE 41|

Area	Teen Birth Rate (per 1,000 female teens)		
	Total (ages 15-19)	Ages 15-17	Ages 18-19
Capital Area Public Health Region	4.6	1.7	9.3
Winnipesaukee Public Health Region	6.7	2.6	14.5
New Hampshire	5.2	1.8	9.8

Data Source: NH Vital Records Birth Certificate Data, 2020 – 2024

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 substantiated child maltreatment and foster care entry were higher in the region than across NH overall in 2020 (most recent statistics available at the sub-state level).

| TABLE 42 |

Area	Screened-in reports of child maltreatment, rate per 1,000 children under age 18	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Foster Care Entries, rate per 1,000 children
Belknap County	83.2	6.9	6.1
Merrimack County	73.1	5.9	3.5
New Hampshire	63.0	4.7	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. 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' – triggering a nurse case management and environmental investigation - is a blood lead level of 5 micrograms per deciliter (µg/dL) for a child 72 months and younger. In 2021, the Centers for Disease Control established a screening reference level for blood lead in young children at 3.5 µg/dL.

In 2024, about three of every four children ages 1 or 2 years old in the Capital Area and Lakes Region had been tested for elevated BLL (Table 43). Of the children tested in the region, 165 children (5.7%) had elevated BLL of 3.5µg/dL or higher, a percentage higher than the overall statewide statistic of 4.3% testing positive for elevated blood lead levels.

| TABLE 43 |

Area	Percent Tested, Age 1 or 2 years (12-35 months old)	% EBLL 3.5µg/dL or higher
Capital Area Public Health Region	74%	5.4%
Winnipesaukee Public Health Region	76%	6.3%
New Hampshire	76%	4.3%

Source: NH DHHS, Division of Public Health Services, Healthy Homes & Lead Poisoning Prevention Program, 2024

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 disease and complications of childbirth as major contributors to 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, 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 two-thirds 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 44 |

Area	Percent of adults who are obese	Percent of adults who are overweight
Capital Area Public Health Region	30%	39%
Winnipesaukee Public Health Region	35%	31%
New Hampshire	31%	37%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2024

| TABLE 45 |

Area	High School Students Considered Obese	Female High School Students	Male High School Students
Capital Area Public Health Region	12%	9%	14%
Winnipesaukee Public Health Region	12%	10%	13%
New Hampshire	12%	10%	15%

Data Source: Youth Behavior Risk Survey (YRBS), 2023. Note:

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. A large majority of adults have been screened for blood cholesterol level within the past 5 years.

| TABLE 46 |

Area	Percent of adults told by a health professional they have high blood pressure	Percent of adults who had their blood cholesterol checked within the past 5 years
Capital Area Public Health Region	33%	89%
Winnipesaukee Public Health Region	34%	87%
New Hampshire	33%	90%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2023

Heart Disease Morbidity: Table 47 displays the rate of hospitalizations for acute myocardial infarction (commonly called a heart attack) and congestive heart failure (CHF). The rate of hospitalization for heart attack in the Winnipesaukee region was significantly higher than the overall state rate over the 5 year period from 2020 to 2024. The rate of hospital inpatient discharges for CHF, often a consequence and end stage of various heart diseases, was lower in the Capital Area and Lakes Region over the same time period, although not statistically different than the rest of New Hampshire.

| TABLE 47 |

Area	CHF hospitalizations (inpatient) age-adjusted rate per 100,000	Heart attack hospitalizations (inpatient) age-adjusted per 100,000
Capital Area Public Health Region	1.6	128.5
Winnipesaukee Public Health Region	1.3	159.6*
All Other New Hampshire	2.1	135.5

Data Source: NH Hospital Discharge Data Set for NH Residents, 2020 to 2024

**Rate is significantly different and higher than the rate for the rest of New Hampshire.*

Heart Disease and Stroke Mortality: Heart disease is the leading cause of mortality in New Hampshire and in the Winnipesaukee Public Health Region where the mortality rate for heart disease was significantly higher than the statewide rate over the period 2020 to 2024. In the Capital Area, heart disease is the second leading cause of mortality after cancer.

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, a group of conditions including stroke affecting the brain's blood vessels, is the fifth leading cause of death in New Hampshire. The mortality rate from cerebrovascular disease was significantly higher in the Capital Area compared to overall state rate from 2020 to 2024.

| TABLE 48 |

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)
Capital Area Public Health Region	144.7	80.1	**37.4***
Winnipesaukee Public Health Region	**168.5***	**98.3***	34.9
New Hampshire	147.6	83.8	30.6

Source: NH Vital Records Death Certificate Data, 2020 – 2024
**Rate is significantly different and higher than the NH statewide rate.*

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 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 with about 10% of adults reporting on the 2024 Behavioral Risk Factor Survey having been diagnosed with diabetes.

| TABLE 49 |

Area	Percent of Adults Diagnosed with Diabetes
Capital Area Public Health Region	10.4%
Winnipesaukee Public Health Region	10.0%
New Hampshire	10.1%

Data Sources: Behavioral Risk Factor Surveillance System, NH 2024

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 2020 and 2024 for diabetes-related conditions. The rate of diabetes-related hospitalizations in the Winnipesaukee region was higher than the overall rate across New Hampshire during that time frame.

| TABLE 50 |

Area	Diabetes-Related Hospital Discharges; age adjusted rate per 100,000
Capital Area Public Health Region	1,375
Winnipesaukee Public Health Region	**1,462***
New Hampshire	1,386

Data Sources: NH Uniform Healthcare Facility Discharge Dataset, 2020-2024
**Rate is significantly different and higher than the NH statewide rate.*

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

| TABLE 51 |

Area	Deaths due to Diabetes Mellitus (per 100,000 people, age adjusted)
Capital Area Public Health Region	23.0
Winnipesaukee Public Health Region	24.0
New Hampshire	19.6

Source: NH Vital Records Death Certificate Data, 2020 – 2024

Cancer

Cancer is the leading cause of death in the Capital Area 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 40% of cancer cases and 44% of cancer deaths in the U.S. are linked to modifiable risk factors.[7] 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.

Cancer Screening: Table 52 displays screening rates for several of the most common forms of cancer including colorectal cancer, breast cancer, cervical cancer and prostate cancer.

| TABLE 52 |

Cancer Screening Type		Capital Area Public Health Region	Winnipesaukee Public Health Region	New Hampshire
Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2024)		**87%***	78%	80%
Females age 50-74 who had a Mammogram in the past 2 years (2022)		83%	79%	81%
Females age 18+ who had an HPV test at most recent cervical cancer screening (2024)^		46%	48%	43%
	Females age 25-34			66%
	Females age 35-44			68%
	Females age 45-54			43%
	Females age 55-64			31%
Males age 40+ who ever had a PSA test (2020)		46%	38%	43%

Data Sources: NH Behavioral Risk Factor Surveillance System via NHDHHS data portal.
^The question was: "At your most recent cervical cancer screening, did you have an H.P.V. test?"
Note: HPV screening percentages by age group are not available at the regional level

[7] Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States, 2019; Farhad Islami et al. CA Cancer J Clin DOI, Volume74, Issue 5, September/October 2024, Pages 405-432.

Cancer Incidence: The table below shows cancer incidence rates for the cancer types that account for a majority of new cancer cases (incidence). The overall rate of cancer incidence in the Capital Area was higher than the NH statewide rate over the period 2020 to 2024.

| TABLE 53 |

	Cancer Incidence by Type per 100,000 people, age adjusted rate		
Cancer Type	**Capital Area Public Health Region**	**Winnipesaukee Public Health Region**	**New Hampshire**
Overall cancer incidence (All Invasive Cancers)	**492***	482	471
Cancer Incidence by Type			
Breast (Female)	145	142	141
Prostate (male)	130	113	120
Lung and Bronchus	58	64	58
Colorectal	35	36	34
Uterus (female)	34	34	30
Melanoma of Skin	28	34	28
Bladder	27	24	26
Non-Hodgkin Lymphoma	21	19	20
Kidney and Renal Pelvis	19	20	17

Data Source: NH State Cancer Registry, 2018-2022

**Rate is significantly different and higher than the rate for the rest of New Hampshire.*

Cancer Mortality: The table below shows the overall cancer mortality rate and the cancer mortality rate for types that cause a 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 137 per 100,000 in 2024.

The overall rate of cancer incidence in the Winnipesaukee region was higher than the NH statewide rate over the period 2020 to 2024.

| TABLE 54 |

	Cancer Mortality per 100,000 people, age adjusted		
Cancer Type	**Capital Area Public Health Region**	**Winnipesaukee Public Health Region**	**New Hampshire**
Overall cancer mortality (All Invasive Cancers)	147	**157***	141
Cancer Mortality by Type			
Lung and bronchus	28	35	31
Prostate (male)	23	19	18
Breast (female)	18	19	18
Pancreas	12	13	11
Colorectal	11	12	11
Liver and Intrahepatic Bile Duct	5	**8***	6
Ovary	5	7	6
Brain and other CNS	6	6	5
Leukemia	6	6	5
Uterus	6	4	5

Data Source: NH State Cancer Registry, 2020 – 2024

**Rate is significantly different and higher than the rate for the rest of New Hampshire.*

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 2024, about 14% of adults responding to the Behavioral Risk Factor Survey from the overall Capital Area and Lakes Region reported they currently have asthma.

| TABLE 55 |

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Capital Area Public Health Region	NA	15%
Winnipesaukee Public Health Region	NA	13%
New Hampshire	8%	13%

Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2024

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 higher in the Winnipesaukee Public Health Region compared to NH overall, while the rate of inpatient hospitalizations for asthma as the primary diagnosis is significantly lower in the region.

| TABLE 56 |

Area	Asthma Emergency Department Visits, age adjusted rate per 100,000	Asthma Inpatient Hospitalizations age adjusted rate per 100,000
Capital Area Public Health Region	272	26
Winnipesaukee Public Health Region	**317****	**14***
New Hampshire	256	22

NH Uniform Healthcare Facility Discharge Dataset, 2020 - 2024
**Rate is significantly different and lower than the state rate.*
***Rate is significantly different and higher 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. The mortality rate from unintentional injury is significantly higher in the Winnipesaukee region in comparison to the Capital Area and the rest of the state.

| TABLE 57 |

Area	Unintentional (accidental) Injury Mortality, all causes Age adjusted rate per 100,000
Capital Area Public Health Region	55.3
Winnipesaukee Public Health Region	**77.1***
New Hampshire	59.3

Source: NH Vital Records Death Certificate Data, 2020 – 2024

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

Older Adult Falls: About one in four 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 exercise, vision correction and appropriate medication management. As displayed by the next table, the percent of residents aged 65 years and older who self-report having experienced a fall in the past 12 months is similar to overall state rate. However, the rate of fall-related ED visits is significantly higher in the region compared to NH overall.

| TABLE 58 |

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
Capital Area Public Health Region	25%	**8,358***
Winnipesaukee Public Health Region	27%	**9,008***
New Hampshire	27%	7,649

Data Sources: NH BRFSS, 2023. NH Hospital Discharge Data Set for NH Residents, 2020-2024

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 Capital Area Public Health Region experienced a significantly lower rate of emergency department visits and inpatient hospitalizations due to accidental opioid overdose compared to the rest of New Hampshire during the 5 year period from 2020 to 2024. In the Winnipesaukee Public Health Region the rate of ED visits for opioid overdose was significantly higher than the state rate over that same time frame.

| TABLE 59 |

Area	Opioid Overdose ED visits; Age-adjusted rate per 100,000 population	Opioid Overdose Hospitalizations (inpatient); age-adjusted per 100,000 population
Capital Area Public Health Region	**77.8***	**12.6***
Winnipesaukee Public Health Region	**115.3****	22.8
New Hampshire	89.8	19.8

Data Source: NH Hospital Discharge Data Set for NH Residents, 2020-2024

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

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

Drug Overdose Mortality: Over 90% of all accidental drug overdose deaths involve opioids. Table 60 displays the rate of opioid overdose mortality in recent years. Over the years from 2020 to 2024, the rate of opioid overdose deaths in the Winnipesaukee region was significantly higher than in the rest of New Hampshire.

The table also displays the rate of alcohol-related overdose deaths over the same time frame (cause of death defined as alcohol poisoning, suicide by exposure to alcohol, or excessive blood level of alcohol) as the underlying cause. The rate of alcohol-related overdose deaths in the region was similar to the rest of New Hampshire.

| TABLE 60 |

Area	Opioid Overdose Deaths, age-adjusted per 100,000	Alcohol-related overdose deaths, age-adjusted per 100,000
Capital Area Public Health Region	22.3	4.4
Winnipesaukee Public Health Region	**33.8****	3.6
New Hampshire	26.2	4.2

Data Source: NH Division of Vital Records Death Certificate Data, 2020 to 2024

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

Self Harm-related Emergency Department Visits and Hospitalizations: Table 61 (continued on the next page) 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 2020 and 2024. The rate of ED visits involving self-inflicted harm in the region was significantly higher than the state rate over this period of time. Rates of ED visits related to self-harm are also significantly higher among females than males in the region and across the state.

| TABLE 61 |

Sex	Area	Suicide or self harm-related hospital ED visits, age-adjusted rate per 100,000 people	Suicide or self harm-related hospitalizations (inpatient), age-adjusted rate per 100,000 people
Male	Capital Area PHR	**193 ****	38
	Winnipesaukee PHR	**160 ****	30
	New Hampshire	109	38
Female	Capital Area PHR	**311 ****+**	53
	Winnipesaukee PHR	**304 ****+**	42
	New Hampshire	218 +	59 +

Sex	Area	Suicide or self harm-related hospital ED visits, age-adjusted rate per 100,000 people	Suicide or self harm-related hospitalizations (inpatient), age-adjusted rate per 100,000 people
All Sexes	Capital Area PHR	**249 ** **	45
	Winnipesaukee PHR	**231 ** **	**36 * **
	New Hampshire	163	48

Data Source: NH Hospital Discharge Data Set for NH Residents, 2020 to 2024;
**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 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 females in the region and across New Hampshire, an inverse of the higher ED visit occurrence among females compared to males for intentional self-harm.

| TABLE 62 |

Area	Suicide Mortality, age-adjusted rate per 100,000		
	Total	Female	Male
Capital Area Public Health Region	18	5	25 +
Winnipesaukee Public Health Region	16	7	31 +
New Hampshire	16	7	25 +

Data Sources: NH Vital Records Death Certificate Data 2020 to 2024;
+Rate among males is significantly different and higher than among females.

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. Over the period 2020 to 2024, the Capital Area and Lakes Region had an infant mortality rate that was similar to the infant mortality rate in New Hampshire overall.

| TABLE 63 |

Area	Infant Mortality Rate per 1,000 Live Births
Capital Area Public Health Region	2.2
Winnipesaukee Public Health Region	4.3
New Hampshire	3.7

Data Source: NH Vital Records Birth Certificate Data, 2020-2024

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. 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 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 higher life expectancy than men. Life expectancy for residents of Belknap County was statistically lower than in New Hampshire overall during the years 2016 to 2020.

| TABLE 64. Life Expectancy at Birth (years) and by Sex |

Area	Life expectancy	Male	Female
Belknap County	**77.4 ***	**75.0 ***	**80.5 ***
Merrimack County	79.0	77.0	81.9
New Hampshire	78.9	77.0	82.1

Sources: State data, National Center for Health Statistics via County Health Rankings, 2020-2022
County data, NH Vital Records, death data, 2016 – 2020
**The statistic is significantly different and lower than the state statistic.*

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. Belknap County had a somewhat higher rate of premature mortality than in New Hampshire overall during the period 2020 to 2022, although the difference is not statistically significant.

| TABLE 65 |

Area	Years of Potential Life Lost before age 75, age-adjusted rate per 100,000
Belknap County	7,596
Merrimack County	6,692
New Hampshire	6,622

Data source: National Center for Health Statistics via County Health Rankings; 2020-2022

Leading Causes of Death

The top 2 leading causes of death - Diseases of the heart and Malignant neoplasms (cancer) - account for more deaths than the next 10 causes of death combined. In the Winnipesaukee region over the period 2020 to 2024, the rate of death was higher than the state rate for multiple causes including heart disease, cancer, accident, chronic lower respiratory disease and COVID-19. The rate of deaths attributed to Alzheimer's disease was lower in the region compared to the state over that period of time.

| TABLE 66 |

Cause of Death	Capital Area Public Health Region	Winnipesaukee Public Health Region	New Hampshire
Diseases of heart	145	**169****	148
Malignant neoplasms	147	**157****	141
Accidents (unintentional injuries)	50	**77****	59
Chronic lower respiratory diseases	34	**47****	35
Cerebrovascular diseases	33	35	32
COVID-19	25	**38****	30
Alzheimer's disease	22	**17***	25
Diabetes mellitus	20	24	20
Intentional self-harm (suicide)	15	16	15
Chronic liver disease and cirrhosis	12	17	13

Source: NH Vital Records Death Certificate Data, 2020 – 2024

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

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

Summary

The 2026 Community Health Needs Assessment provides a comprehensive overview of health needs and priorities in the Capital Region and Lakes Region of New Hampshire. With community input from multiple methods and channels, and analysis of demographic 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. Appendix 1 beginning on the next page is a table summarizing the key findings and priority community health issues identified through this assessment.

We extend our thanks and gratitude to all the people who contributed to this assessment through surveys and discussion groups. Hopefully, the assessment will 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 the Concord Hospital health system and partner organizations across the region.

What is being done well in the community to support good health and wellness?

"Our region has strong cross-sector collaboration and a growing commitment to whole-person wellness. There is meaningful coordination among healthcare providers, schools, community-based organizations, faith communities, and municipal leaders, particularly around behavioral health, early childhood supports, food access, and substance use prevention . . . . Continued investment in coordination and capacity-building will help build on these strengths." - Community Leader, Human Services

"I think that health care workers care about their patients, and that, generally, people care about each other." - Community Resident Survey Respondent

"Substance use disorder services have improved significantly in recent years, helping reduce stigma and expand access for those in need. Efforts to address food insecurity have also increased, with more nonprofits supporting vulnerable populations. - Community Leader, Information & Referral Services

"My community does a good job providing access to healthcare services, local wellness programs, and support for families. There are resources for mental health, food assistance, and activities for children and families that help people stay connected and supported. Community events, parks, walking areas, and local organizations also encourage healthier lifestyles and bring people together. - Community Resident Survey Respondent

"The individuals actually providing the care are amazing across the care continuum. - Community Leader, Long Term Care

Living in Concord we have access to many doctors, hospitals and community services. We have a system of well-maintained trails and access to grocery stores. Our city parks and pools encourage activities for all age ranges, and I regularly see neighbors walking for exercise and leisure. - Community Resident Survey Respondent

"The care and consideration of the needs of our growing community is truly phenomenal. Thank you doesn't seem to be enough for all the efforts your team continues to give, both genuinely and professionally. I am so grateful for your care." - Community Resident Survey Respondent

Appendix 1: 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 behavioral health services	Mental Health Care for Adults was the second most frequently mentioned health care service type people had difficulty accessing (23% of community resident survey respondents). Among people who had difficulty accessing mental health care, top reasons cited were 'Wait time too long (52%), and 'Cost too much' (43%). About 38% of community residents and 43% of community leader survey respondents think ability to get mental health services has gotten worse in the last few years. Among hospital staff, Mental Health Care for Adults and Mental Health Care for Children were the top 2 health services cited as being most difficult for patients to access.	The rate of Self Harm-related Emergency Department visits are significantly higher for residents of Capital Area Public Health Region (249 visits per 100,000 population) and the Winnipesaukee Public Health Region (231) compared to the state overall (163). Rates of ED visits related to self-harm are significantly higher among females than males in the region and across the state.	Mental health care and substance use treatment and recovers services were identified as a continuing and top priorities for community health improvement in community discussion groups. Discussion themes included concerns for insufficient local capacity and staff turnover, ongoing concerns of stigma, and escalating concerns for youth mental health and substance use associated with social media and perceptions of isolation.
Health care provider access and availability including primary care, urgent and emergency care	About 1 in 5 community resident survey respondents reported difficulty accessing Primary Health Care (22%) and medical sub-specialty care (20%). 'Wait time too long' was the top reason cited for difficulty accessing primary care (56%) and sub-specialties (63%). Among those with primary care access difficulty, 'Not accepting new patients' was the second most common reason (46%).	The Winnipesaukee Public Health Region has the second lowest ratio of primary care physicians (fewer providers per total population) among NH's 13 public health regions. The Winnipesaukee region has the highest percentage of primary medical care visits with one-way travel times greater than 30 minutes (39%) of any region in the state and the Capital Area has the second highest percentage on this measure (34% of primary care visits with one-way travel times greater than 30 minutes). In 2022, the Winnipesaukee Public Health Region had the highest percentage in NH of residents without a 'personal health care provider' (about 20% of adults).	More than 20% of nearly 1200 comments on a question about 'one thing you would change to improve health' described issues of access to medical care including provider turnover, appointment availability, difficulty navigating the health care system, emergency department overcrowding and long wait times due to limited primary care or urgent care access.

Appendix 1 (continued): Summary of Community Health Needs and Issues by Information Source			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Affordability of health care services and insurance	About 68% of community resident, 74% community leader, and 74% of hospital staff survey respondents indicated that the cost of health care and health insurance has 'gotten worse' over the last few years. Less than 4% of survey respondents thought this issue has 'gotten better'. 'Can't afford out of pocket expenses' was the most frequently identified barrier preventing people from accessing the health care services they need by community leaders (54%).	The estimated proportion of people with no health insurance (6%) is similar to the overall percentage in NH (5%). Within the region, there is a notable range of uninsurance by town from about 2% to 16%. About 14% of service area residents have Medicaid coverage. In 2024, about 9% of NH residents reported needing to see a doctor but could not afford it.	Cost of health care services including prescriptions, affordability of health insurance, low cost or subsidized services, health insurance costs, and health care payment reform was the second most frequently mentioned topic area in an open-ended question about 'one thing you would change to improve health'. Financial barriers and affordability of health care were also top themes across community discussion groups.
Non-medical drivers of health such as affordable housing, healthy food, and child care	Affordable, Safe Housing was by far the top issue selected by community leader respondents (78%) as a priority area for improvement to support a healthy community and 79% of community resident survey respondents said housing affordability has 'gotten worse' over the last few years. About two-thirds (67%) of community resident survey respondents disagreed with the statement, "In my community, healthy food is affordable." About 16% of community resident survey respondents reported difficulty accessing child care / day care with top reasons for access difficulty being "Cost too much" (77%) and "Service not available" (65%).	About 11% of area residents experienced food insecurity in the past year. About 1 in 4 owner-occupied housing units (25%) and nearly 1 in 2 renters (45%) in the service area have housing costs >30% of household income.	Socioeconomic issues and their effect on health and wellbeing were overarching themes in discussion groups and frequent topics of open ended survey comments. Issues included financial insecurity and cost of living outpacing income, affordability of housing and food, affordability and availability of childcare and transportation.

Appendix 1 (continued): Summary of Community Health Needs and Issues by Information Source			
Community Health Issue	**Community Surveys**	**Community Health Status Indicators**	**Community Discussions and Open Comments**
Services for older adults including opportunities for social interaction and supports for aging in place	About 15% of community survey respondents indicated difficulty accessing 'in-home support services' and 13% had difficulty getting 'help caring for aging family members'. About 15% of respondents selected 'Caregiver support; respite care' as a service they would use if more available in the community. Among survey respondents ages 65+, about 1 in 4 (24%) selected 'Balance classes and programs to prevent falls' as program they would use. 'Services and resources for aging in a safe and supportive environment' was selected by nearly half (46%) of community leaders as a priority for focusing efforts to support a healthy community.	Similar to NH overall, the service area population is aging with about 21% of residents aged 65 years or older. In some service area towns more than 1 in 3 residents are aged 65 or older. About 29% of the 65+ population in Capital & Lakes region report having serious activity limitations resulting from one or more disability and1 in 4 area residents (26%) age 65+ report having experienced a fall in the past 12 months.	Senior services and ability to age in place were topics frequently raised in discussion groups and written comments with concerns expressed about costs and workforce availability to help with home maintenance chores and in-home personal care, lack of options for transportation to medical appointments and other activities, related concerns around social isolation, and the need for help to plan ahead for long-term caregiving needs.
Affordability and availability of dental care services	'Dental Care for Adults' was the most frequently selected service people had difficulty accessing (30% of community resident survey respondents). "Cost too much" was the top reason for difficulty accessing adult dental care (65%) followed by "No insurance or not enough insurance" (61%). After cost-related issues, the next most common reason for access difficulties "Not accepting new patients" (32%). A plurality of community residents (42%) perceive no change on this issue over the past several years while about 31% think ability to get dental services has gotten worse.	About 1 in 3 service area residents report not having visited a dentist or dental clinic in the past year. The Capital & Lakes Region experiences significantly more hospital emergency department dental visits for non-traumatic reasons (i.e., not resulting from an acute injury) compared to the rest of New Hampshire including the Winnipesaukee Public Health Region where the rate has been twice the rate for the rest of the state in recent years.	Affordability and availability of dental care was raised as an issue in open-ended survey comments and discussion groups, although not as frequently as issues related to behavioral health care, medical care, housing and other economic issues.

Appendix 1 (continued): **Summary of Community Health Needs and Issues by Information Source**			
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 (31%). Other top services or resources people would use more included 'Biking and walking paths' (27%), 'Arts, music and cultural events' (25%), and Nutrition and cooking programs (24%).	About 1 in 5 adults in the region can be considered physically inactive. One in every three adults (32%) in the region are considered obese and an additional 36% are considered overweight, percentages similar to adult population in NH overall. The heart disease mortality rate in the Winnipesaukee Public Health Region is significantly higher than the statewide rate and the mortality rate from cerebrovascular disease is significantly higher in the Capital Area than the state.	Common topics in survey comments included improved resources and programs for physical activity including safe biking and walking routes, affordable recreation and fitness, and more outlets for healthy food and nutrition. Resources and activities for supporting healthy youth and families including health education, wellness, and stress reduction were also common themes in discussion groups.

Appendix 2

2026 Capital Region & Lakes Region Community Health Needs Assessment Steering Committee

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