



Community Health Needs Assessment

May 2012

Presented by



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Executive Summary

Background

The Affordable Care Act of 2010 requires not-for-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. In addition, the State of New Hampshire requires one to be done every five years. New London Hospital (NLH) worked with Crescendo Consulting Group, LLC, (CCG) to bring together key healthcare and public service stakeholders, collect quantitative and qualitative data, and reach out to the community in order to elicit feedback directly from them and their service providers. The quantitative and qualitative findings included in this report are based on the most currently available data from the community resources, the State of New Hampshire, and other regional sources.

This document serves to fulfill the federal and state requirements and to also serve as a guidepost for community outreach efforts and as a benchmark with which to compare future progress.

The purpose of the research design was to do the following:

- Clearly define the community served by NLH
- Define a data-based and qualitative methodology to identify needs in the community
- Develop a prioritized list of community resources
- Develop a list of healthcare resources in the service area

In order to generate the information, CCG and NLH incorporated input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. This group included community opinion leaders (a diverse set of service providers) and healthcare consumers. In addition, statistical data was integrated with other community data to provide a detailed profile of needs and resources. The six stages of research included the following:

Convening a Leadership Group comprised of community leaders. Members were selected based upon their perceived community health vision, knowledge, and power to impact the well-being of the community.

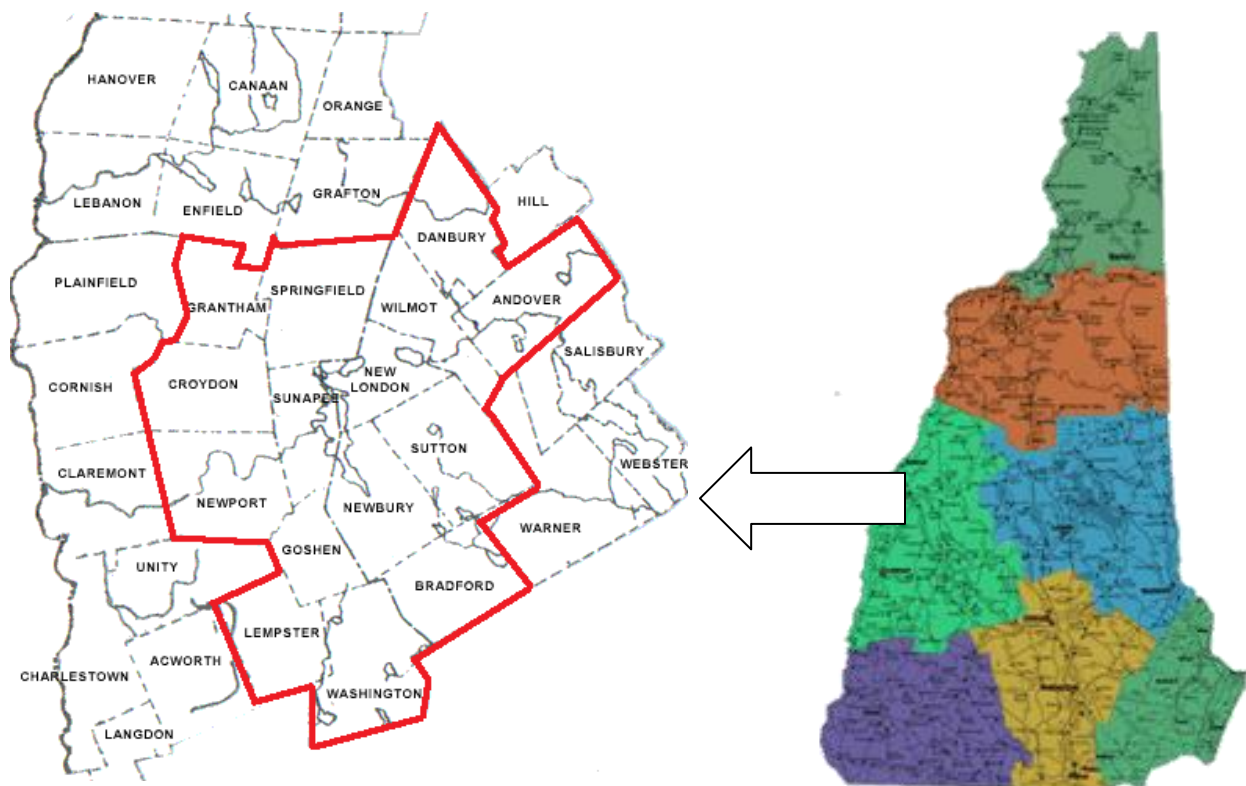
- The Leadership Group included the following members:
 - Camp Coniston, John Tilley, Executive Director
 - Colby Sawyer College, Tom Galligan, President
 - Community Dental Care of Claremont, Sue Schroeter, Managing Director
 - Lake Sunapee Region Visiting Nurse Association, Scott Fabry, RN, President
 - Life Long Care, Sean Lyon, APRN

- Newport/Middle High School, Kassie Heeley, School Nurse
 - New London Town Recreation Department, Chad Denning, Director of Youth Programs
 - Turning Points Network, Deborah Mozden, Executive Director
 - New London Hospital, Susan Bryant, Senior Director, Marketing & Community Relations
 - West Central Behavioral Health, Sueellen Griffin, Executive Director
- The Leadership Group helped to build and refine the list of community needs, available resources, and service gaps; and, helped build consensus around the prioritized list of community needs identified in this report.

Description of the Community Served

The goal of this phase was to define the community in NLH's primary service area (PSA). NLH's PSA includes the town of Andover, Bradford, Croydon, Danbury, Goshen, Grantham, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Washington, and Wilmot.

The PSA includes towns in Sullivan and Merrimack counties. The map below shows New London Hospital service area towns outlined in red. Health and lifestyle characteristics of these areas are described in detail in the appendices.



Assessment Methodology

Qualitative and Quantitative Methods

The NLH CHNA methodology includes qualitative and quantitative components. The major sections of the methodology include the following:

Strategic secondary research

Data tables used in the analyses are included in the appendix of this report. Key sources include, but are not limited to, the following:

- Demographic Data.
 - U.S. Census
 - State of New Hampshire, Employment Security
 - State of New Hampshire, Office of Energy and Planning
- Health Risk Behavior Data from the U.S. Centers for Disease Control and Prevention
 - Behavioral Risk Factor Surveillance System Survey (BRFSS)
 - Youth Risk Behavior Survey (YRBS)
 - State of New Hampshire, Department of Education
- Existing materials from other organizations

Quantitative analysis of existing survey data

In order to gain a better understanding of the morbidity and mortality data pertaining to the NLH PSA, the CHNA includes an extensive review of quantitative metrics as presented by sources including the following:

- State of New Hampshire, Department of Health and Human Services, Division of Public Health Services
- Hospital Discharge Data
- Birth and Death Statistics
- Cancer Registry

Additional quantitative analysis was conducted during the “needs prioritization” phase described later in this assessment.

Focus group discussions

In order to gain the perspective of a diverse set of community stakeholders, the New London Hospital conducted four focus group discussions with the following community segments:

- **Leadership Group Members.** This group included executives from service area organizations that have direct contact with healthcare consumers and/or provide affiliated services. The Leadership Group heard presentations regarding community health data and the results of the community focus group. The Group used the information to verify community needs previously identified, add to the list where possible, further populate the list of resources, and incorporate public opinion regarding service gaps.
- **Healthcare Consumers.** An especially important part of the research was to conduct extensive discussions with consumers in the New London service area. Consumers included the homeless, people from diverse age groups and economic strata, individuals with varying degrees of chronic illnesses, and others. Healthcare consumers provided insights regarding community health needs and reflected on the results of the secondary data research (conducted prior to the focus group).
- **Community Opinion Leaders.** The Opinion Leader Group was comprised of healthcare consumers who live in the NLH PSA and also provide healthcare support services such as in-school nursing, public safety, behavioral health counseling, senior housing, and others. Members of this group also contributed their thoughts regarding community needs and insight about ways that disparate community organizations may be able to work together with NLH to address needs.

In sum, the focus groups attained direct insight from a breadth of consumers and community groups regarding their perceptions of healthcare service gaps and helped to triangulate information gleaned through review of the quantitative data. Specific community groups include, but are not limited to, the following:

- C-5 District—EMS, Pam Drewniak, Coordinator
- Camp Coniston, John Tilley, Executive Director
- Colby Sawyer College, Tom Galligan, President
- Communities United Regional Network, Liz Henning, Service Coordinator
- Community Dental Care of Claremont, Sue Schroeter, Managing Director
- Consumers of Healthcare Services (including the disabled and economically disadvantaged)
- Lake Sunapee Region Visiting Nurse Association, Scott Fabry, RN, President
- Life Long Care, Sean Lyon, APRN
- New London Hospital, Susan Bryant, Senior Director, Marketing & Community Relations
- New London Town Recreation Department, Chad Denning, Director of Youth Programs
- Newport Chamber of Commerce, Ella Casey
- Newport/Middle High School, Kassie Heeley, School Nurse
- Sturm Ruger, Gary Gray, Company Nurse
- Turning Points Network, Deborah Mozden, Executive Director
- West Central Behavioral Health, Sueellen Griffin, Executive Director

Needs Prioritization

Subsequently, as noted above, information gathered during the quantitative and qualitative phases of the research was used to establish an extensive list of community health needs. In order to prioritize the list, NLH and CCG used a modified Delphi technique. The technique used qualitative and quantitative method to rank order the list of 30 community health needs that was generated in prior research phases. The comprehensive list of 30 needs is contained in the appendix of this report.

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

- Leadership Group members were asked to complete a survey in which they were to quantitatively and qualitatively evaluate each of the 30 community needs identified in earlier research and to submit their responses to CCG. They were also asked to provide feedback regarding the rationale for their rating.
- CCG rank-ordered the needs based on the average score and aggregated the qualitative comments. The results were sent to Leadership Group members in the form of a second survey. The second survey included the same list of 30 needs, as well as the ranking from the previous survey and a list of qualitative comments. Leadership Group members re-rated the 30 needs based on their own opinions and the insights of others as expressed in the list of aggregated comments. Group members submitted their responses to CCG.
- The results of the second survey were rank-ordered based on the average scores and submitted to New London Hospital.

List of Prioritized Needs

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

Prioritized Community Needs		
Rank	Health Need	Code Number **
1	Availability of affordable healthcare, prescriptions, and related services	101
2	Communication between healthcare providers and other community service providers regarding the breadth of services available (i.e., so that providers can effectively refer clients/patients to other services in the community)	999
3	Primary care physician availability	120
4	Drug and alcohol abuse early detection and treatment	407
5	Insurance coverage rates	100, 101
6 tie	Chronic disease screenings - hypertension, cancer, heart disease	350
6 tie	Coordination of care among provider organizations	999
6 tie	Dementia spectrum issues / Elder care services	501, 372
6 tie	Obesity / Nutrition / Exercise education and services	420, 421, 422

** NOTE: Code numbers shown are used by the State of New Hampshire for the Community Benefits Plan to categorize needs and develop clearer, more uniform understanding of initiatives. See Appendix I

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

- Availability of affordable healthcare, prescriptions, and related services. Community members and others involved in the CHNA project often mentioned the socio-economic issues that face the service area, and that healthcare and pharmacy costs impact when and where patients receive services. High costs were identified as a reason for delayed healthcare treatment – often leading to an Emergency Department visit to treat an avoidable condition.
- Communication between healthcare providers and other community service providers regarding the breadth of services available. Leadership Group members and community leaders said that inefficient coordination and incomplete awareness of services marginalizes the effectiveness of community health resources. One said, “From being part of this discussion, [community opinion leader focus group], I’ve learned a lot about what other services are available in Sullivan County. That makes me better able to refer my clients, when needed.”

- Primary care physician availability. Leadership Group members and healthcare consumers perceived a lack of access to PCPs. For example, one consumer commented, “There is a primary care [practice] right down the road from me, but there is a long wait or they aren’t even taking new patients. I don’t think New London Hospital attracts many [primary care] doctors.”
- Drug and alcohol abuse early detection and treatment. Given the direct and secondary impact of these behaviors, community and Leadership Group members identified this as an ongoing community need. According to 2009 BRFSS and YRBSS data, two of five New Hampshire high school students (39%) had at least one drink of alcohol on at least one day (during the 30 days before the survey); approximately 23% had had five or more drinks of alcohol in a row within a couple of hours on at least one day (during the 30 days before the survey). Approximately 25% had used marijuana one or more times during the same time period.
- Insurance coverage rates. Similar to the affordable healthcare point above, insurance rates were identified as major financial burden to the service area residents. Being uninsured also reduces access to care and increases the propensity that patients would go directly to the Emergency Department when sick.
- Chronic Disease Screenings – Hypertension, Cancer, and Heart Disease. Heart disease and cancer are the leading causes of death in NLH’s service area. Specifically, death rates for these diseases – and most other leading causes of death – are higher in the NLH PSA than for the overall State of New Hampshire.

**Leading Causes of Death in New London Service Area,
(Per 100,000 Population, Weighted Between Sullivan and
Merrimack Counties Based on New London Hospital’s Service
Area), 2003-2007**

Cause of Death	New London Service Area	New Hampshire
Heart Disease ***	226.3	179.4
Cancer	215.6	183.7
Chronic Lower Respiratory Diseases	50.5	46.2
Stroke ***	46.6	35.5
Accidents ***	43.9	35.2
Dementia ***	31.8	26.1
Diabetes ***	27.8	22.5
Influenza and Pneumonia	21.3	19.4
Kidney Disease	12.4	12.4
Suicide	13.3	11.2

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012); National Vital Statistics Report, Vol. 56, No. 10, "Deaths: Final Data for 2005"

*** More than 20% above state rates

- Coordination of care among provider organizations. A recent national needs assessment by Crescendo for the American Society of Radiation Therapy (ASTRO) indicated that coordination of care and communication among members of a patient’s healthcare team is one of the greatest opportunities to improve the effectiveness and efficiency of the healthcare system. Similarly, consumers and opinion leaders in the NLH PSA indicated the same sentiment.
- Elder Care Services and Dementia Spectrum Issues. Community leaders and Leadership Group members agree that with the median age of some communities approaching 50 years, there will be increasing needs for the elderly. Demographic data shows that the median age in the service area is 45.3 years – higher than the New Hampshire state figure and far above the U.S. median. Nearly one in five (18.4%) of service area residents are 65 or more years of age. In New London, over 30% of residents are 65 or older.

Age Group Profile		
Town	Median Age	65 years and over
Andover	41.4	13.7%
Bradford	46.3	13.2%
Croydon	48.0	15.8%
Danbury	44.0	13.4%
Goshen	47.0	17.5%
Grantham	47.3	20.9%
Lempster	46.1	12.6%
New London	48.7	30.7%
Newbury	47.6	17.2%
Newport	41.7	16.0%
Springfield	42.3	14.4%
Sunapee	46.2	19.1%
Sutton	45.8	16.2%
Washington	46.5	20.4%
Wilmot	46.6	16.5%
Total Area	45.3	18.4%
NH	41.1	13.5%
U.S.	37.2	13.1%

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

- Obesity / Nutrition / Exercise. For 2009, BRFSS data shows that NLH PSA residents' obesity rates are on par with New Hampshire state averages. However, this indicates that over one-third of the population is considered to be overweight. Leadership Group members indicated that this appears to be a broad-based community need – not particularly correlated to income status or other demographic strata.

Greater Sullivan County* Public Health Region Profile		
Key Indicators at a Glance		
	Region	NH
<i>Health Behaviors</i>		
Obese, percent of adults (2008–2009)	26.0	25.8
Overweight, percent of adults (2008–2009)	34.3	37.2

* Greater Sullivan County Public Health Region: Acworth, Charlestown, Claremont, Croydon, Goshen, Langdon, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Unity, Wilmot

Source: New Hampshire Department of Health and Human Services, Division of Public Health Services, 2011 Snapshot of New Hampshire's Public Health Regions, Counties, and the Cities of Manchester and Nashua. 2011

Appendix A: Leadership Group Presentation Details

Two focus groups were held with the Leadership Group.

- During the first session, held at the outset of the project, Leadership Group members critiqued the project methodology and the strategic purpose of the community assessment, provided their insights regarding effective ways to gather pertinent information (quantitative and qualitative), and helped generate an initial list of community needs, available resources, and potential service gaps.
- The second meeting included a review of community health data and the findings of the community focus group. Based on these two major research components, the Leadership Group helped refine and append the initial list of needs, resources, and service gaps. The moderator's guide included in the meeting is attached in a separate appendix.

Throughout the project, information was exchanged regularly via e-mail or telephone conversations with Leadership Group members and others.

Appendix B: Health Issues Evaluated in the Modified Delphi Method

During Leadership Group discussions and community research, 30 community health needs were identified. Leadership Group members and community leaders were then asked to rate the needs on a 5-point scale in order to develop a ranked list. The results of the evaluation are contained in the table below.

Health Issue Evaluation Scores	
Community Need as Identified by the Leadership Group	Rank
Availability of affordable healthcare, prescriptions, and related services	1
Communication between healthcare providers and other community service providers regarding the breadth of services available (i.e., so that providers can effectively refer clients/patients to other services in the community)	2
Primary care physician availability	2
Drug and alcohol abuse early detection and treatment	4
Insurance coverage rates	4
Chronic disease screenings - hypertension, cancer, heart disease	6
Coordination of care among provider organizations	6
Dementia spectrum issues	6
Elder care services	6
Obesity / Nutrition / Exercise education and services	6
Behavioral health - early detection and intervention	11
Domestic violence and abuse prevention	11
End of life issues (including palliative care)	11
Pediatric health and development - identification / intervention	11
Dental health services	15
Diabetes awareness and management	15
Drug and alcohol abuse prevention	15
Mammography screening services	15
Transportation to/from healthcare service providers	15
Public information regarding available community health services - the need for a central repository and reference for local services (similar to a "211" system)	20
Access to care - primary care weekend services	21
Interagency awareness of services / communications	21
Parenting classes including "well baby", "healthy mom", and similar subjects	21
Smoking cessation education and training	24
Educational attainment	25
Stress management education	25
"Urgent care" services - more than the primary care physician can provide but not as extensive or expensive as the hospital; extended hours	25
Environmental issues - lead exposure / poisoning, waterborne arsenic	28
Holistic healthcare - integrating conventional and non-conventional care	28
Autism spectrum disorders and other learning disabilities - early detection and services	30

When generating the final list of nine prioritized community needs, the Leadership Group decided to combine some categories due to the high amount of overlap. Specifically, “Elder care services” and “Dementia spectrum issues” were consolidated.

Appendix C: BRFSS and YRBS Data

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

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

New Hampshire, High School Youth Risk Behavior Survey, 2009

Question	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Rarely or never wore a bicycle helmet (among students who had ridden a bicycle during the 12 months before the survey)	57.0 (50.1–63.8)	66.3 (60.6–71.6)		X	
Rarely or never wore a seat belt (when riding in a car driven by someone else)	11.4 (8.5–15.2)	14.0 (10.6–18.4)			X
Rode with a driver who had been drinking alcohol one or more times (in a car or other vehicle during the 30 days before the survey)	24.6 (20.2–29.6)	21.7 (18.8–24.9)			X
Drove when drinking alcohol one or more times (in a car or other vehicle during the 30 days before the survey)	7.8 (5.5–10.9)	9.0 (6.7–12.1)			X
Carried a weapon on school property on at least 1 day (for example, a gun, knife, or club during the 30 days before the survey)	3.4 (2.1–5.3)	13.7 (10.7–17.4)		X	

Question	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Did not go to school because they felt unsafe at school or on their way to or from school on at least 1 day (during the 30 days before the survey)	4.8 (2.8–8.2)	4.2 (2.8–6.4)			X
Threatened or injured with a weapon on school property one or more times (for example, a gun, knife, or club during the 12 months before the survey)	—	—			
In a physical fight on school property one or more times (during the 12 months before the survey)	6.8 (4.8–9.5)	11.2 (8.6–14.4)		X	
Bullied on school property (during the 12 months before the survey)	24.4 (20.5–28.8)	19.9 (16.0–24.4)			X
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	32.1 (28.3–36.2)	18.4 (15.4–21.9)	X		
Seriously considered attempting suicide (during the 12 months before the survey)	13.8 (10.7–17.7)	10.2 (7.8–13.3)			X
Made a plan about how they would attempt suicide (during the 12 months before the survey)	11.9 (8.8–15.9)	7.7 (5.8–10.2)	X		
Attempted suicide one or more times (during the 12 months before the survey)	5.1 (3.1–8.3)	4.2 (2.7–6.6)			X
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	1.6 (0.7–3.6)	1.6 (0.9–2.8)			X
Carried a weapon on at least 1 day (for example, a gun, knife, or club during the 30 days before the survey)	—	—			
Carried a gun on at least 1 day (during the 30 days before the survey)	—	—			
In a physical fight one or more times (during the 12 months before the survey)	20.3 (16.0–25.5)	31.1 (27.2–35.2)		X	

Question	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Injured in a physical fight one or more times (injuries had to be treated by a doctor or nurse, during the 12 months before the survey)	3.6 (2.3–5.6)	4.3 (3.0–6.2)			X
Hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend (during the 12 months before the survey)	8.0 (6.0–10.5)	11.1 (8.4–14.4)			X
Ever physically forced to have sexual intercourse (when they did not want to)	9.4 (7.1–12.3)	4.8 (3.4–6.7)	X		
Ever tried cigarette smoking (even one or two puffs)	—	—			
Smoked a whole cigarette for the first time before age 13 years	9.8 (7.5–12.7)	11.0 (8.9–13.6)			X
Smoked cigarettes on at least 1 day (during the 30 days before the survey)	20.0 (16.0–24.6)	21.6 (18.2–25.4)			X
Smoked cigarettes on 20 or more days (during the 30 days before the survey)	9.6 (6.9–13.3)	9.2 (6.9–12.2)			X
Smoked more than 10 cigarettes per day (among students who currently smoked cigarettes, on the days they smoked during the 30 days before the survey)	—	—			
Smoked cigarettes on school property on at least 1 day (during the 30 days before the survey)	—	—			
Ever smoked at least one cigarette every day for 30 days	—	—			
Did not try to quit smoking cigarettes (among students who currently smoked cigarettes, during the 12 months before the survey)	—	—			
Usually obtained their own cigarettes by buying them in a store or gas station (among the students who were aged <18 years and who currently smoked cigarettes, during the 30 days before the survey)	—	—			

Question	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Used chewing tobacco, snuff, or dip on at least 1 day (during the 30 days before the survey)	2.6 (1.3–5.2)	13.8 (11.3–16.8)		X	
Used chewing tobacco, snuff, or dip on school property on at least 1 day (during the 30 days before the survey)	—	—			
Smoked cigars, cigarillos, or little cigars on at least 1 day (during the 30 days before the survey)	9.7 (6.8–13.6)	22.1 (18.9–25.7)		X	
Smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day (during the 30 days before the survey)	23.8 (19.4–28.8)	33.8 (29.3–38.5)		X	
Ever had at least one drink of alcohol on at least 1 day (during their life)	69.8 (64.1–74.9)	67.2 (62.4–71.6)			X
Drank alcohol for the first time before age 13 years (other than a few sips)	11.5 (9.1–14.4)	17.7 (14.9–20.9)		X	
Had at least one drink of alcohol on at least 1 day (during the 30 days before the survey)	39.4 (33.4–45.7)	39.2 (34.5–44.1)			X
Had five or more drinks of alcohol in a row within a couple of hours on at least 1 day (during the 30 days before the survey)	24.6 (20.4–29.3)	23.4 (19.4–27.9)			X
Usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol during the 30 days before the survey)	33.7 (27.9–40.1)	28.4 (22.6–35.2)			X
Had at least one drink of alcohol on school property on at least 1 day (during the 30 days before the survey)	3.9 (2.3–6.6)	4.6 (3.3–6.3)			X
Ever used marijuana one or more times (during their life)	37.7 (32.1–43.7)	43.1 (38.5–47.9)			X
Tried marijuana for the first time before age 13 years	7.3 (5.2–10.1)	9.4 (7.4–11.7)			X

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

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











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

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

Question	Percent by Gender (95% confidence interval)		Statistical Significance at 95% Confidence		
	Female	Male	Female More Likely Than Male	Male More Likely Than Female	No Difference
Watched television 3 or more hours per day (on an average school day)	18.6 (15.2–22.7)	27.1 (24.0–30.3)		X	
Used computers 3 or more hours per day (played video or computer games or used a computer for something that was not school work on an average school day)	16.6 (13.9–19.6)	30.9 (27.5–34.6)		X	
Physically active at least 60 minutes per day on less than 7 days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	85.1 (82.2–87.7)	68.6 (64.4–72.5)	X		
Did not participate in at least 60 minutes of physical activity on any day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	16.2 (12.3–21.0)	10.1 (7.8–13.0)	X		

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

Teen Birth Rates by County and Statewide, 2008

County	Births Per 1,000 Females (age 15-19)
New Hampshire	18.4
Belknap	22.9 
Carroll	18.7 
Cheshire	18.2 
Coos	31.6 
Grafton	15.4 
Hillsborough	20.5 
Merrimack	16.9 
Rockingham	11.5 
Strafford	19.5 
Sullivan	41.9 

Definitions: Resident births where mother is age 15 to 19 per 1,000 women age 15 to 19.

Source: New Hampshire Division of Vital Records Administration birth certificate data

Appendix D: Community Profile Data

The following data tables were used to develop the content of the presentation regarding the State of New Hampshire morbidity, mortality, risk assessment, and demographics that was shared with the CHNA Leadership Group.

Key Demographic and Economic Indicators				
Town	Median Age	Population	65 years and over	Median Household Income
Andover	41.4	2,371	13.7%	\$62,742
Bradford	46.3	1,650	13.2%	\$67,882
Croydon	48.0	764	15.8%	\$58,125
Danbury	44.0	1,164	13.4%	\$46,250
Goshen	47.0	810	17.5%	\$48,621
Grantham	47.3	2,985	20.9%	\$87,245
Lempster	46.1	1,154	12.6%	\$55,721
New London	48.7	4,397	30.7%	\$66,771
Newbury	47.6	2,072	17.2%	\$66,765
Newport	41.7	6,507	16.0%	\$45,593
Springfield	42.3	1,311	14.4%	\$74,808
Sunapee	46.2	3,365	19.1%	\$58,869
Sutton	45.8	1,837	16.2%	\$62,391
Washington	46.5	1,123	20.4%	\$47,604
Wilmot	46.6	1,358	16.5%	\$75,197
Total Area	45.3	32,868	18.4%	\$61,639
NH	41.1	1,316,470	13.5%	\$63,277
U.S.	37.2	305,745,538	13.1%	\$51,222

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

Population of New London Service Area by Town			
Total Population			
Town	2010 Population	2000 Population	Percent Change
Andover	2,371	2,109	12.4%
Bradford	1,650	1,454	13.5%
Croydon	764	661	15.6%
Danbury	1,164	1,071	8.7%
Goshen	810	741	9.3%
Grantham	2,985	2,167	37.7%
Lempster	1,154	971	18.8%
New London	4,397	4,116	6.8%
Newbury	2,072	1,702	21.7%
Newport	6,507	6,269	3.8%
Springfield	1,311	945	38.7%
Sunapee	3,365	3,055	10.1%
Sutton	1,837	1,544	19.0%
Washington	1,123	895	25.5%
Wilmot	1,358	1,144	18.7%
Total Area	32,868	28,844	14.0%

Source: U.S. Census Bureau, 2011

Percentage of Population by Municipality and Education		
Municipality	High school degree or higher	Bachelor's degree or higher
Andover	90.3%	34.2%
Bradford	94.6%	36.3%
Croydon	85.0%	21.4%
Danbury	87.2%	21.0%
Goshen	85.1%	20.1%
Grantham	96.9%	54.7%
Lempster	84.5%	20.8%
New London	96.8%	52.3%
Newbury	95.8%	37.0%
Newport	84.4%	17.1%
Springfield	95.2%	48.4%
Sunapee	94.3%	48.7%
Sutton	94.8%	40.5%
Washington	89.4%	31.9%
Wilmot	98.0%	46.7%
NH	91.5%	32.8%
U.S.	85.3%	28.0%

Source: U.S. Census Bureau, American FactFinder, 2011

Percent of Families Living Below the
Poverty Line by Municipality within
the New London Hospital Service
Area

Municipality	Percent of Families
Andover	4.2%
Bradford	2.8%
Croydon	12.5%
Danbury	21.1%
Goshen	7.6%
Grantham	8.5%
Lempster	14.0%
New London	14.6%
Newbury	12.6%
Newport	20.4%
Springfield	11.3%
Sunapee	14.9%
Sutton	4.0%
Washington	12.1%
Wilmot	16.7%
Service area Average	11.8%
NH	8.6%
U.S.	15.1%

Source: U.S. Census Bureau, American FactFinder, 2011

**New Hampshire and Counties, Age 5 - 17 in
Families in Poverty, 2003**

Place	Estimated Number	Percent
Belknap	1,001	10.9%
Carroll	929	14.3%
Cheshire	1,139	10.6%
Coos	842	19.2%
Grafton	1,333	11.8%
Hillsborough	6,340	9.3%
Merrimack	2,012	8.6%
Rockingham	3,168	6.3%
Strafford	1,984	11.1%
Sullivan	811	12.8%
NH	13,140	9.4%

Source: U.S. Bureau of the Census, SAIPE

Appendix E: Morbidity and Mortality Data

Major Causes For Inpatient Hospitalization, 2003-2007 (Weighted between Sullivan and Merrimack Counties based on NLH's Service Area)		
Major Condition	Crude Rate per 100,000 People	
	New London Service Area	State of New Hampshire
Diseases of the circulatory system (including heart disease)	1,566	1,517
Pregnancy, childbirth, the puerperium, and complications	1,129	1,142
Newborn	1,058	1,076
Diseases of the digestive system	897	833
Diseases of the respiratory system	856	887
Injury and poisoning	825	767
Mental disorders ***	646	495
Diseases of the musculoskeletal system and connective tissue ***	706	570
Neoplasms	519	508
Symptoms, signs, and ill-defined conditions	470	428
Diseases of the genitourinary system	489	408
Endocrine, nutritional and metabolic diseases, and immunity disorders	298	300
Supplementary classifications	199	211
Infectious and parasitic diseases	174	195
Diseases of the skin and subcutaneous tissue	164	147
Diseases of the nervous system and sense organs ***	207	163
Diseases of the blood and blood-forming organs	77	73
Congenital anomalies	49	49
Certain conditions originating in the perinatal period	48	51

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012)

*** NLH service area more than 20% above state rate

**Leading Causes of Death in New England by State,
Rates per 100,000 people**

Disease / Condition	Conn.	Maine	Mass.	<u>New Hampshire</u>	Rhode Island	Vermont
Heart Disease	172.9	182.7	172.7	179.4	213.8	173.6
Cancer	175.7	201.9	185.2	183.7	184.1	172.9
Stroke	34.7	42.8	38.1	35.5	37.4	36.5
Chronic Lower Respiratory Diseases	35.3	52.3	35.8	46.2	39.0	55.6
Accidents	29.8	41.1	27.7	35.2	26.7	41.2
Diabetes	19.7	24.2	17.4	22.5	21.6	25.1
Dementia	16.1	29.1	19.8	26.1	18.8	25.7
Influenza / Pneumonia	20.5	21.8	24.2	19.4	17.2	13.7
Kidney Disease	13.1	15.5	18.4	12.4	11.2	7.4
Septicemia	14.5	8.6	13.2	6.7	8.6	4.0

Source: National Vital Statistics Report, Vol. 56, No. 10, "Deaths: Final Data for 2005"

**Leading Causes of Death in New London Hospital Service Area,
(Weighted between Sullivan and Merrimack Counties Based on New
London Hospital's Service Area), 2003-2007,
Rates per 100,000 people**

Cause of Death	New London Service Area	New Hampshire
Heart Disease	226.3	179.4
Cancer	215.6	183.7
Chronic Lower Respiratory Diseases	50.5	46.2
Stroke	46.6	35.5
Accidents	43.9	35.2
Dementia	31.8	26.1
Diabetes	27.8	22.5
Influenza and Pneumonia	21.3	19.4
Kidney Disease	12.4	12.4
Suicide	13.3	11.2

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012); National Vital Statistics Report, Vol. 56, No. 10, "Deaths: Final Data for 2005"

Greater Sullivan County Health Region* Deaths by Heart Disease by Age Group

Age Group	Incidence Per 100,000 People	95% Confidence Interval	State Incidence
0 - 4	—	—	—
5 - 14	—	—	—
15 - 24	—	—	1.6
25 - 34	—	—	4.5
35 - 44	—	—	17.3
45 - 54	73.0	47.2 - 107.8	56.0
55 - 64	206.5	156.0 - 268.2	152.9
65 - 74	407.2	322.9 - 506.8	415.3
75 - 84	1,270.4	1,081.1 - 1,459.7	1346.1
85 - +	4,496.9	3,928.0 - 5,065.8	4841.1

* Greater Sullivan County Public Health Region: Acworth, Charlestown, Claremont, Croydon, Goshen, Langdon, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Unity, Wilmot

Note that the Greater Sullivan County Health Region (above) includes a slightly different list of towns than the New London Hospital Service Area on the previous page

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012)

Cancer Incidence Rates for New Hampshire by County, 2004-2008

County	Incidence Rate and 95% Confidence Interval †
New Hampshire ⁶	449.3 (442.5, 456.2)
U.S. (SEER+NPCR) ¹	410.4 (409.9, 410.8)
Strafford County ⁶	475.8 (452.0, 500.6)
Rockingham County ⁶	467.0 (452.1, 482.2)
Merrimack County ⁶	463.9 (443.5, 485.0)
Cheshire County ⁶	452.2 (425.1, 480.6)
Grafton County ⁶	446.7 (420.9, 473.8)
Belknap County ⁶	444.0 (414.7, 475.0)
Hillsborough County ⁶	439.1 (426.6, 452.0)
Sullivan County ⁶	433.5 (399.2, 470.2)
Coos County ⁶	431.0 (392.1, 473.1)
Carroll County ⁶	408.7 (378.1, 441.4)

Notes:

Created by statecancerprofiles.cancer.gov on 04/04/2012 2:33 pm.

[State Cancer Registries](#) may provide more current or more local data.

† Incidence rates (cases per 100,000 population per year) are age-adjusted to the [2000 U.S. standard population](#) (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only (except for bladder cancer which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The U.S. populations included with the data release have been adjusted for the [population shifts due to hurricanes Katrina and Rita](#) for 62 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. The 1969-2008 U.S. Population Data File is used for SEER and NPCR incidence rates.

§ Because of the impact on Louisiana's population for the July - December 2005 time period due to Hurricanes Katrina/Rita, [SEER excluded Louisiana cases](#) diagnosed for that six month time period. The count has been suppressed due to data consistency issues.

¹ Source: CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) November 2010 data submission and [SEER November 2010 submission](#).

⁶ Source: State Cancer Registry and the CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS) November 2010 data submission. State rates include rates from metropolitan areas funded by [SEER](#).

[Interpret Rankings](#) provides insight into interpreting cancer incidence statistics. When the population size for a denominator is small, the rates may be unstable. A rate is unstable when a small change in the numerator (e.g., only one or two additional cases) has a dramatic effect on the calculated rate.

Source: National Cancer Institute, State Cancer Profiles, 2010

**Cancer Rates for Sullivan and Merrimack Counties
(with State Comparisons), 2009**

County	Age Range	Rate Per 100,000 People	95% Confidence Interval	State Rate	95% Significance (Higher than the state average)
Sullivan	0 - 4	*	*	3.5	
Sullivan	5 - 14	71.6	43.1 - 111.8	67	
Sullivan	15 - 24	983.8	864.2 - 1103.4	456.1	***
Sullivan	25 - 34	1492.0	1335.5 - 1648.5	665.6	***
Sullivan	35 - 44	1369.5	1239.9 - 1499.1	727.2	***
Sullivan	45 - 54	1054.0	945 - 1163	638.4	***
Sullivan	55 - 64	558.8	468.5 - 649.1	424.2	***
Sullivan	65 - 74	567.7	457.5 - 677.9	418.5	***
Sullivan	75 - 84	655.3	518 - 817.8	785.4	
Sullivan	85 +	748.6	515.3 - 1051.3	1,098.30	
Merrimack	0 - 4	*	*	3.5	
Merrimack	5 - 14	56.6	42.5 - 73.9	67	
Merrimack	15 - 24	513.6	470.3 - 556.9	456.1	
Merrimack	25 - 34	833.3	771.1 - 895.5	665.6	***
Merrimack	35 - 44	799.8	748.7 - 850.9	727.2	***
Merrimack	45 - 54	744.1	695.7 - 792.5	638.4	***
Merrimack	55 - 64	521.5	471.6 - 571.4	424.2	***
Merrimack	65 - 74	464.5	402.1 - 526.9	418.5	
Merrimack	75 - 84	682.9	591.6 - 774.2	785.4	***
Merrimack	85 +	806.3	659.6 - 953	1,098.30	***
Sullivan	Overall	881.0	801.4 - 881.0	484.6	***
Merrimack	Overall	558.9	525.3 - 558.9	484.6	***

Source: Cancer Report Card – April 2009 NH Department of Health and Human Services, Division of Public Health Services, Office of Health Statistics and Data Management

Cancer Related Risk Factor Compliance Rates, New Hampshire (with U.S. Comparisons), 2008

Cancer Type	Behavior	New Hampshire Rank	Percent of Target Population in Compliance	95% Confidence Interval	U.S. Percent of Target Pop.
Breast Cancer	Women aged 40+ who had a clinical breast exam in past 2 years	5	85.6		n/a
Breast Cancer	Women aged 40+ who have had a mammogram within the past two years	14	79	(77.2, 80.7)	76.5
Cervical Cancer	Women aged 18+ who had a pap smear in past 3 years	4	88	(86.1, 89.7)	84
Colorectal Cancer	People aged 50 + who have used home blood stool test in past 2 years	5	30.5	(28.7, 32.4)	24.1
Colorectal Cancer	People aged 50+ who had a home blood stool test in past year or a sigmoidoscopy or colonoscopy in past 5 years	9	62.3	(60.3, 64.3)	n/a
Colorectal Cancer	People aged 50 + who ever had a sigmoidoscopy or colonoscopy	15	63.6	(61.6, 65.5)	57.1
Prostate Cancer	Men aged 40+ who have had a PSA test within the past two years	n/a	50.2	(47.4, 53.0)	53.8

Source: Cancer Report Card – April 2009 NH Department of Health and Human Services, Division of Public Health Services, Office of Health Statistics and Data Management

New Cancer Cases per 100,000 Population, (with U.S. Comparisons), 2008

Cases Per 100,000 People and 95% Confidence Interval			
	NH Rank Among U.S. States (1 = Best)	New Hampshire	U.S.
All cancers	47	498.0 (486.1, 510.1)	458.2 (457.4, 459.0)
Bladder	47	27.4 (24.7, 30.4)	21.3 (21.1, 21.5)
Breast (Female)	44	127.9 (119.8, 136.4)	117.7 (117.2, 118.2)
Colorectal	27	50.1 (46.3, 54.1)	49.5 (49.3, 49.8)
Lung-bronchus	31	70.9 (66.4, 75.6)	67.4 (67.1, 67.7)
Melanoma of skin	49	28.0 (25.2, 31.0)	17.1 (17.0, 17.3)
Prostate	36	158.0 (148.1, 168.4)	145.3 (144.6, 145.9)

Source: Cancer Report Card – April 2009 NH Department of Health and Human Services, Division of Public Health Services, Office of Health Statistics and Data Management

Cancer Death Ranking and Rates by Type, 2008

Cancer Deaths Per 100,000 People, 2008			
Cases Per 100,000 People and 95% Confidence Interval			
	NH Rank Among U.S. States (1 = Best)	New Hampshire	U.S.
All cancers	29	186.9 (179.7, 194.4)	184.0 (183.5, 184.5)
Bladder	38	4.9 (3.8, 6.3)	4.3 (4.3, 4.4)
Breast (Female)	22	23.4 (20.1, 27.1)	24.0 (23.8, 24.2)
Colorectal	27	18.0 (15.8, 20.4)	17.4 (17.2, 17.5)
Lung-bronchus	27	53.8 (50.0, 57.9)	52.8 (52.5, 53.0)
Melanoma of Skin	19	2.8 (2.0, 3.9)	2.7 (2.7, 2.8)
Prostate	17	23.8 (19.6, 28.4)	24.6 (24.4, 24.9)

Source: Cancer Report Card – April 2009 NH Department of Health and Human Services, Division of Public Health Services, Office of Health Statistics and Data Management

Diabetes-related Hospitalizations
by NH County and by Age Group, 2003-2007

County	Age Range	Rate per 100,000 People	95% Confidence Interval	NH State Average	Significance at 95% Confidence
Belknap	0 - 4	*	*	25.1	
Belknap	5 - 14	56.4	34.9 - 86.2	54.9	
Belknap	15 - 24	59.9	38.4 - 89.1	127.9	***
Belknap	25 - 34	226.2	179.1 - 281.9	288.7	
Belknap	35 - 44	731.8	653.6 - 810	535.5	***
Belknap	45 - 54	1,052.00	962.4 - 1141.6	1,118.00	
Belknap	55 - 64	3,043.50	2869.3 - 3217.7	2,830.30	***
Belknap	65 - 74	4,984.50	4704.7 - 5264.3	5,695.20	***
Belknap	75 - 84	7,928.10	7506 - 8350.2	8,687.10	***
Belknap	85 +	7,967.70	7265.1 - 8670.3	7,967.70	
Carroll	0 - 4	*	*	25.1	
Carroll	5 - 14	78.5	48.6 - 120	54.9	
Carroll	15 - 24	174.9	129.8 - 230.6	127.9	
Carroll	25 - 34	395.7	318.2 - 486.4	288.7	***
Carroll	35 - 44	823.7	726 - 921.4	535.5	***
Carroll	45 - 54	1,176.10	1068.7 - 1283.5	1,118.00	
Carroll	55 - 64	2,314.50	2148.5 - 2480.5	2,830.30	***
Carroll	65 - 74	4,595.30	4320.7 - 4869.9	5,695.20	***
Carroll	75 - 84	7,123.10	6703.3 - 7542.9	8,687.10	***
Carroll	85 +	7,705.00	6967.2 - 8442.8	7,967.70	
Cheshire	0 - 4	*	*	25.1	
Cheshire	5 - 14	54.5	35.3 - 80.5	54.9	
Cheshire	15 - 24	70.2	51.4 - 93.6	127.9	***
Cheshire	25 - 34	228.3	185.3 - 278.2	288.7	
Cheshire	35 - 44	637.5	570.1 - 704.9	535.5	***
Cheshire	45 - 54	1,118.40	1033.8 - 1203	1,118.00	
Cheshire	55 - 64	2,518.40	2371.2 - 2665.6	2,830.30	***
Cheshire	65 - 74	5,131.10	4864.5 - 5397.7	5,695.20	***
Cheshire	75 - 84	8,803.20	8377.3 - 9229.1	8,687.10	
Cheshire	85 +	9,268.90	8580.3 - 9957.5	7,967.70	***
Coos	0 - 4	*	*	25.1	
Coos	5 - 14	73.8	40.3 - 123.8	54.9	

Diabetes-related Hospitalizations
by NH County and by Age Group, 2003-2007

County	Age Range	Rate per 100,000 People	95% Confidence Interval	NH State Average	Significance at 95% Confidence
Coos	15 - 24	87.6	51.9 - 138.4	127.9	
Coos	25 - 34	729.9	600.4 - 859.4	288.7	***
Coos	35 - 44	958.7	832.6 - 1084.8	535.5	***
Coos	45 - 54	1,737.30	1579.1 - 1895.5	1,118.00	***
Coos	55 - 64	4,540.40	4249.2 - 4831.6	2,830.30	***
Coos	65 - 74	8,720.90	8253.1 - 9188.7	5,695.20	***
Coos	75 - 84	11,373.30	10750.7 - 11995.9	8,687.10	***
Coos	85 +	11,280.10	10288.4 - 12271.8	7,967.70	***
Grafton	0 - 4	*	*	25.1	
Grafton	5 - 14	55	35.9 - 80.6	54.9	
Grafton	15 - 24	73.2	55.3 - 95.1	127.9	***
Grafton	25 - 34	182	146.2 - 224	288.7	***
Grafton	35 - 44	513.8	455.1 - 572.5	535.5	
Grafton	45 - 54	897.30	825 - 969.6	1,118.00	***
Grafton	55 - 64	2,183.30	2053.4 - 2313.2	2,830.30	***
Grafton	65 - 74	4,743.30	4498.9 - 4987.7	5,695.20	***
Grafton	75 - 84	6,248.50	5912.7 - 6584.3	8,687.10	***
Hillsborough	0 - 4	24.7	16.8 - 35.1	25.1	
Hillsborough	5 - 14	61.3	52.2 - 70.4	54.9	
Hillsborough	15 - 24	159.3	144.1 - 174.5	127.9	***
Hillsborough	25 - 34	289.2	267.8 - 310.6	288.7	
Hillsborough	35 - 44	555.1	530.1 - 580.1	535.5	
Hillsborough	45 - 54	1,162.90	1125.5 - 1200.3	1,118.00	***
Hillsborough	55 - 64	2,863.90	2791.8 - 2936	2,830.30	
Hillsborough	65 - 74	5,693.70	5556.7 - 5830.7	5,695.20	
Hillsborough	75 - 84	8,899.90	8687.2 - 9112.6	8,687.10	
Hillsborough	85 +	7,854.40	7540.9 - 8167.9	7,967.70	
Merrimack	0 - 4	*	*	25.1	
Merrimack	5 - 14	51.4	38 - 68	54.9	
Merrimack	15 - 24	99.9	80.8 - 119	127.9	***
Merrimack	25 - 34	396.1	353.2 - 439	288.7	***
Merrimack	35 - 44	525.8	484.3 - 567.3	535.5	

Diabetes-related Hospitalizations
by NH County and by Age Group, 2003-2007

County	Age Range	Rate per 100,000 People	95% Confidence Interval	NH State Average	Significance at 95% Confidence
Merrimack	45 - 54	1,145.70	1085.6 - 1205.8	1,118.00	
Merrimack	55 - 64	3,112.80	2990.8 - 3234.8	2,830.30	***
Merrimack	65 - 74	6,105.70	5879.5 - 6331.9	5,695.20	***
Merrimack	75 - 84	8,467.80	8146.4 - 8789.2	8,687.10	
Rockingham	0 - 4	36.1	24.5 - 51.2	25.1	
Rockingham	5 - 14	47.1	38.2 - 57.5	54.9	
Rockingham	15 - 24	95.7	81.6 - 109.8	127.9	***
Rockingham	25 - 34	210.2	187.6 - 232.8	288.7	***
Rockingham	35 - 44	341.7	319.1 - 364.3	535.5	***
Rockingham	45 - 54	886.20	849.6 - 922.8	1,118.00	***
Rockingham	55 - 64	2,530.10	2454.4 - 2605.8	2,830.30	***
Rockingham	65 - 74	5,540.40	5386.9 - 5693.9	5,695.20	
Rockingham	75 - 84	9,356.90	9094.6 - 9619.2	8,687.10	***
Rockingham	85 +	8,686.90	8281.9 - 9091.9	7,967.70	***
Strafford	0 - 4	*	*	25.1	
Strafford	5 - 14	53.6	38.3 - 73	54.9	
Strafford	15 - 24	174.3	148.6 - 200	127.9	***
Strafford	25 - 34	308.2	269.9 - 346.5	288.7	
Strafford	35 - 44	633	581.8 - 684.2	535.5	***
Strafford	45 - 54	1,404.60	1326.1 - 1483.1	1,118.00	***
Strafford	55 - 64	3,524.60	3371.2 - 3678	2,830.30	***
Strafford	65 - 74	7,073.50	6795.7 - 7351.3	5,695.20	***
Strafford	75 - 84	9,710.30	9316.9 - 10103.7	8,687.10	***
Strafford	85 +	7,576.10	7017.6 - 8134.6	7,967.70	
Sullivan	0 - 4	*	*	25.1	
Sullivan	5 - 14	*	*	54.9	
Sullivan	15 - 24	355.7	287.4 - 435.3	127.9	***
Sullivan	25 - 34	371.9	297.9 - 458.7	288.7	
Sullivan	35 - 44	625.7	538.1 - 713.3	535.5	***
Sullivan	45 - 54	1,559.00	1426.4 - 1691.6	1,118.00	***
Sullivan	55 - 64	2,851.00	2647 - 3055	2,830.30	
Sullivan	65 - 74	5,042.60	4714.2 - 5371	5,695.20	***
Sullivan	75 - 84	7,670.30	7172.8 - 8167.8	8,687.10	***
Sullivan	85 +	7,350.30	6549.9 - 8150.7	7,967.70	

Diabetes-related Hospitalizations
by NH County and by Age Group, 2003-2007

County	Age Range	Rate per 100,000 People	95% Confidence Interval	NH State Average	Significance at 95% Confidence
NH	0 - 4	25.1	20.3 - 30.7	25.1	
NH	5 - 14	54.9	50 - 59.8	54.9	
NH	15 - 24	127.9	120.6 - 135.2	127.9	
NH	25 - 34	288.7	276.6 - 300.8	288.7	
NH	35 - 44	535.5	521.5 - 549.5	535.5	
NH	45 - 54	1,118.00	1097.9 - 1138.1	1,118.00	
NH	55 - 64	2,830.30	2791.7 - 2868.9	2,830.30	
NH	65 - 74	5,695.20	5623.7 - 5766.7	5,695.20	
NH	75 - 84	8,687.10	8577.8 - 8796.4	8,687.10	
NH	85 +	7,967.70	8133.6 - 8858	7,967.70	

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012)

Diabetes-Related Hospitalizations by NH County, 2003-2007

County	Age Range	Rate per 100,000 People	95% Confidence Interval	NH State Average	Significance at 95% Confidence
Belknap	Overall	1383.8	1346 - 1421.6	1,440.4	***
Carroll	Overall	1328.9	1287.9 - 1369.9	1,440.4	
Cheshire	Overall	1400.6	1365.1 - 1436.1	1,440.4	
Coos	Overall	2170.7	2108.5 - 2232.9	1,440.4	***
Grafton	Overall	1110.2	1080.2 - 1140.2	1,440.4	
Hillsborough	Overall	1,465.8	1448.7 - 1482.9	1,440.4	
Merrimack	Overall	1,490.5	1463.1 - 1517.9	1,440.4	***
Rockingham	Overall	1,367.2	1347.8 - 1386.6	1,440.4	
Strafford	Overall	1,695.0	1661.4 - 1728.6	1,440.4	***
Sullivan	Overall	1,458.0	1411.2 - 1504.8	1,440.4	
NH	Overall	1,440.4	1431.4 - 1449.4		

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012)

Appendix F: Lifestyle and Behavior Indicators

Greater Sullivan County* Public Health Region Profile Key Lifestyle and Behavior Indicators at a Glance		
<i>Health Behaviors</i>	Region	NH
Current smoking, percent of adults (2008–2009)	16.1	16.5
Fruits and vegetables five or more times per day, percent of adults	29.8	28.0
Obese, percent of adults (2008–2009)	26	25.8
Overweight, percent of adults (2008–2009)	34.3	37.2
Moderate or vigorous physical activity, percent of adults	53.4	53.5
Heavy drinking, percent of adults (2008–2009)	5.5	6.0
Binge drinking, percent of adults (2008–2009)	13.8	16.1
Teen birth rate per 1,000 females age 15–19 (2008)	358.5	18.4
Always use seatbelt, percent of adults (2006, 2008)	62.3	65.6
No health insurance, percent of adults (2008–2009)	16.2	10.8
Unable to see doctor when needed due to cost, percent of adults (2008–2009)	14.5	10.9
Have primary care provider, percent of adults (2008–2009)	85.6	88.9
Flu shot in past year, percent of adults age 65 and older (2008–2009)	80.5	74.9
Acute ambulatory care sensitive condition hospital discharges, age adjusted per 100,000 population (2003–2007)	657.5	697.3
Chronic ambulatory care sensitive condition hospital discharges, age adjusted per 100,000 population (2003–2007)	521.8	605.4
<i>Community and Environment</i>		
Children under 6 years of age with elevated blood lead level, percent among children tested (2009)	0.82	0.78
<i>Health Outcomes</i>		
Premature death, years of potential life lost before age 75 per 1,000 population (2003–2007)	69.8	56.7
Low birthweight per 1,000 births (2007)	6.0	6.2
Substance abuse-related emergency hospital discharges, age-adjusted per 10,000 population (2003–2007)	92.3	68.3
Activities limited due to health in at least 14 of previous 30 days, percent of adults (2008–2009)	7.5	5.4
New cancer diagnoses, age-adjusted per 100,000 population (2003–2007)	489.5	499.8
Cancer deaths, age-adjusted per 100,000 population (2003–2007)	190.3	185.0
Mammogram in past two years, percent of women age 40 and older (2006, 2008) ¹ 79.4 81.0	79.4	81.0
Colonoscopy or sigmoidoscopy in past five years, percent of adults age 50 and older (2006, 2008)	54.9	58.2

Greater Sullivan County* Public Health Region Profile Key Lifestyle and Behavior Indicators at a Glance

<i>Access to Care</i>		
Pap test in past three years, percent of women age 18 and older (2006, 2008)	88.5	87.1
Ever told had diabetes, percent of adults (2008–2009)	8.4	7.2
Ever told blood pressure was high, percent of adults (2007, 2009)	28.1	27.6
Cholesterol tested past five years, percent of adults (2007, 2009)	80.0	81.9
Current asthma, percent (2007, 2009)	8.9	10.2
Unintentional injury-related emergency hospital disc	129.6	110.2

* Greater Sullivan County Public Health Region: Acworth, Charlestown, Claremont, Croydon, Goshen, Langdon, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Unity, Wilmot

Source: New Hampshire Department of Health and Human Services, Division of Public Health Services, 2011 Snapshot of New Hampshire's Public Health Regions, Counties, and the Cities of Manchester and Nashua, 2011

Top Mental Health Hospitalizations by Age Group for Sullivan And Merrimack Counties (with NH State Comparison), 2003-2007

County	Age Range	Rate Per 100,000 People	95% Confidence Interval	State Rate	95% Significance
Sullivan	0 - 4	*	*	3.5	
Sullivan	5 - 14	71.6	43.1 - 111.8	67	
Sullivan	15 - 24	983.8	864.2 - 1103.4	456.1	***
Sullivan	25 - 34	1492.0	1335.5 - 1648.5	665.6	***
Sullivan	35 - 44	1369.5	1239.9 - 1499.1	727.2	***
Sullivan	45 - 54	1054.0	945 - 1163	638.4	***
Sullivan	55 - 64	558.8	468.5 - 649.1	424.2	***
Sullivan	65 - 74	567.7	457.5 - 677.9	418.5	***
Sullivan	75 - 84	655.3	518 - 817.8	785.4	
Sullivan	85 +	748.6	515.3 - 1051.3	1,098.30	
Merrimack	0 - 4	*	*	3.5	
Merrimack	5 - 14	56.6	42.5 - 73.9	67	
Merrimack	15 - 24	513.6	470.3 - 556.9	456.1	
Merrimack	25 - 34	833.3	771.1 - 895.5	665.6	***
Merrimack	35 - 44	799.8	748.7 - 850.9	727.2	***
Merrimack	45 - 54	744.1	695.7 - 792.5	638.4	***
Merrimack	55 - 64	521.5	471.6 - 571.4	424.2	***
Merrimack	65 - 74	464.5	402.1 - 526.9	418.5	
Merrimack	75 - 84	682.9	591.6 - 774.2	785.4	***
Merrimack	85 +	806.3	659.6 - 953	1,098.30	***
Sullivan	Overall	881.0	801.4 - 881	484.6	***
Merrimack	Overall	558.9	525.3 - 558.9	484.6	***

Source: State of New Hampshire, Health Web Reporting and Querying System (Health WRQS, 2012)

Appendix G: Existing Healthcare Resources and Facilities

<u>Organization List</u>	<u>Service Type</u>
Charlestown Senior Center 223 Old Springfield Road Charlestown, NH 03603 (603) 826-5987	Senior services
Cinnamon Street Childcare Center 3 Ice House Plaza Newport, NH 03773 (603) 863-4543	Early childhood education
Colby Sawyer College 541 Main Street New London, New Hampshire (603) 526-3000	Direct services and information to students
Community Alliance of Human Services 27 John Stark Highway Newport, NH 03773 (603) 863-7708	Broad based community services
Community Alliance of Human Services – Transportation (CATS) 27 John Stark Highway Newport, NH 03773 (603) 863-7708	Transportation
Community Dental Care 1 Tremont Street Claremont, NH 03743 (603) 287-1300	Dental services
Community Services Council of New Hampshire 79 Sheep Davis Road Pembroke, NH 03275 (603) 225-9694	Broad based community services
Family Planning & Prenatal 841 Central Street, # 102 Franklin, NH (603) 934-4905	Direct care services and information
Granite United Way – Merrimack County 46 South Main Street Concord, NH 03301-4855 (603) 224-2595	Broad based community services

<u>Organization List</u>	<u>Service Type</u>
Greater Sullivan County Public Health Network 5 Nursing Home Drive Unity, NH 03743 (603) 398-2222	Broad based community services
Habitat For Humanity New London, NH (603) 526-8464	Housing
Headrest 14 Church Street Lebanon, NH 03766 (603) 448-4400	Crisis intervention
Kearsarge Area Council on Aging 37 Pleasant Street New London, NH 03257 (603)526-6368	Broad based community services
Lake Sunapee VNA 107 Newport Road New London, NH 03257 (603) 526-4077	Direct care services
Meals On Wheels New London 37 Pleasant Street New London, NH (603) 526-6155	Nutritional health
New London – Town Hall 375 Main Street New London, NH 03257 (603) 526-4821	Broad based community services
New London Fire Department 237 Main Street New London (603) 526-6073	Public safety
New London Health Department 375 Main Street New London, NH 03257 (603) 526 4761	Public health
New London Hospital 273 County Road New London, NH (603) 526-5500	Direct care services
New London Police Department 25 Seamans Road New London (603) 526-2626	Public safety

<u>Organization List</u>	<u>Service Type</u>
NH West American Red Cross 83 Court Street Keene, NH 03431 (800) 464-6692	Broad based community services
Orion House 139 Elm Street Newport, NH (603) 863-4918	Behavioral Health
Servicelink: Sullivan County 1 Pleasant Street #105 Claremont, NH (603) 542-5177	Broad based community services
Southwestern Community Services; Head Start Center 360 Sunapee Street, Newport, NH 03773 (603) 863-3112	Broad based community services
Sullivan County Hospice (see Valley Regional Hospital)	Direct care services
Turning Points Network 20 Central Street Newport, NH (603) 863-4053	Behavioral Health
Twin Rivers Community Corporation 82 Elkins Street Franklin, NH 03235 (603) 934-8158	Housing
United Way of Sullivan County 23 Main Street Newport, NH 03773 (603) 543-0121	Broad based community services
University of New Hampshire, Cooperative Extension 24 Main Street Newport, NH 03773 (877) 398-4769	Nutrition education and other community classes
Valley Regional Hospital 243 Elm Street Claremont, NH 03743 (603) 542-7771	Direct care services
Warner Community Action Program 49 W Main Street Warner, NH 03278 (603) 456-2207	Broad based community services

<u>Organization List</u>	<u>Service Type</u>
Warner Community Action Program 49 West Main Street Warner, NH (603) 456-2207	Broad based community services
West Central Behavioral Health 167 Summer Street # 3 Newport, NH (603) 863-1951	Behavioral Health

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



New London Hospital Community Assessment

Focus Group Discussion Guide

Focus Group Discussion Guide

Introduction

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

CURRENT INVOLVEMENT AND EXPERIENCE IN THE COMMUNITY

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

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

CURRENT NEEDS

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

GAPS

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

ADDRESSING GAPS

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

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

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

Closing

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

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

Appendix I – State of New Hampshire Community Benefits Codes

(See following three pages)