

Community Health Needs Assessment

2026



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

New London Hospital

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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 contacting:

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New London Hospital

2026 Community Health Needs Assessment

Executive Summary

In September 2026, New London Hospital completed a Community Health Needs Assessment (CHNA) with technical support from Population Health Strategies (PHS). This abbreviated assessment was conducted to satisfy federal and state community benefits requirements for the 2026 fiscal year and to provide an updated understanding of health and health-related needs across the New London Hospital service area. In 2027, New London Hospital will participate in a more comprehensive, system-wide assessment with other Dartmouth Health hospitals that will include additional community engagement activities.

The 2026 assessment was designed to better understand the health-related issues and concerns affecting area residents; inform community health improvement plans, partnerships, and initiatives; and guide the community benefit activities of New London Hospital and partner organizations. The assessment focused on the 15 municipalities that comprise New London Hospital's primary service area, which together have a population of 33,716 residents.

The assessment drew on multiple sources of quantitative and qualitative information, including a community resident survey distributed online through community partners and in paper form at New London Hospital and Newport Health Center; four key informant interviews with six participants representing community health, home health and hospice, public health, business, and community outreach perspectives; open-ended survey comments; and available demographic and health-status indicators. Community engagement and information-gathering activities sought to capture the experiences of populations that may face greater barriers to health-related services and resources due to factors such as income, age, disability, and social or physical isolation. Findings across these sources were synthesized to identify common themes, areas of concern, community strengths, and opportunities for improvement.

Across the assessment, residents and community partners consistently identified challenges obtaining timely primary, specialty, mental health, dental, and in-home services. Long wait times, limited provider capacity, insurance and cost barriers, transportation challenges, and the need to travel outside the service area often overlap, creating multiple barriers to accessing care. Regional health indicators reinforce several of these concerns, including elevated emergency department use for non-traumatic dental conditions, a significantly higher opioid overdose mortality rate, and higher premature mortality in Sullivan County compared with New Hampshire overall.

Community health is also shaped by the economic and social conditions in which residents live. Survey and interview findings highlighted housing affordability, food costs, transportation, and the challenges associated with aging in place. The service area has a larger share of older adults than New Hampshire overall, increasing the importance of accessible transportation, caregiver support, home-based services, and opportunities for social connection. Interview participants also emphasized workforce shortages, fragmented information about available resources, and the value of trusted navigators who can help residents understand and access services.

At the same time, the assessment identified important community assets and signs of progress, including improved primary care access at Newport Health Center, open-access mental health options, mobile dental care, community health workers, home health and hospice services, food assistance programs, outreach efforts, and strong local partnerships. These existing strengths provide a foundation for collaborative action focused on local and flexible service delivery, centralized resource navigation, transportation, workforce development, and supports that help residents remain healthy and connected in their communities.

The following table summarizes the priority community health needs and issues identified through the 2026 assessment.

Summary of Community Health Needs and Issues by Information Source			
Priority Community Health Need	Community Survey	Community Health Status Indicators	Community Interviews and Open-Ended Survey Comments
Timely access to primary, specialty, and in-home care	Specialty medical care was among the most frequently reported access difficulties, cited by 22% of respondents. Primary care and in-home support services were each cited by 20%. Long waits were the leading barrier for specialty care (88%), primary care (77%), and in-home support services (68%).	Sullivan County has fewer providers relative to population than New Hampshire overall, including one primary care physician for every 1,630 residents, compared with 1,160 statewide. Sullivan County also had a somewhat higher rate of preventable hospital stays among Medicare enrollees than New Hampshire overall.	Health care access, provider availability, and wait times were the most common theme in responses to the open-ended survey question. Interview participants described long waits, difficulty finding providers accepting new patients or certain insurance plans, workforce shortages, and the need to travel outside the area. Participants also identified improved primary care access at Newport Health Center as a recent strength.
Availability and affordability of dental care	Dental care for adults was the most frequently reported health-service access difficulty, cited by 23% of respondents. Among respondents reporting difficulty obtaining adult dental care, 74% cited long waits and 48% cited having no insurance or insufficient insurance.	Only 65.6% of Greater Sullivan adults reported a dental visit within the previous year, compared with 72.2% statewide. Emergency department visit rates for non-traumatic dental conditions were significantly higher than the state rate in both Sullivan and Merrimack Counties.	Written comments called for more affordable dental care and shorter waits. Interview participants described the mobile dental program as an important community resource but identified gaps for young adults transitioning out of pediatric care and older adults who need dentures or restorative services.
Mental health and substance use services	Mental health care was the third most frequently reported health-service access difficulty, cited by 21% of respondents. Among those reporting difficulty, 78% cited long waits, 53% cited cost, and 49% cited inadequate insurance coverage. Mental health and substance use services were also a recurring open-ended theme (n=10).	Sullivan County has one mental health provider for every 440 residents, compared with one for every 240 residents statewide. The Greater Sullivan region also had significantly higher rates of self-harm-related emergency department visits and opioid overdose mortality than New Hampshire overall.	Interview participants described limited behavioral health capacity, changing referral criteria, and primary care teams continuing to support patients while they wait for specialty services. Walk-in and open-access mental health hours were identified as a positive recent development.

Health care affordability, insurance, and service navigation	More than two-thirds of respondents (68%) said the ability to afford health care services and insurance had worsened in recent years. Cost and insufficient insurance coverage were prominent barriers across multiple service types.	The overall uninsured rate in the service area was similar to the state rate, at 5.2% compared with 5.3%. However, 15.1% of Greater Sullivan adults reported being unable to see a doctor because of cost, compared with 11.4% statewide, based on the most recent regional estimate included in the report.	Participants described the combined burden of premiums, deductibles, medications, transportation, and time away from work. They also discussed changing insurance networks, complex forms and notices, health-literacy barriers, and fragmented information. Community health workers and other trusted navigators were identified as important resources.
Housing, food, childcare, and household economic security	Housing affordability showed the greatest perceived decline, with 81% of respondents saying it had worsened. About half said access to affordable childcare (51%) and healthy, affordable food (49%) had worsened. Only 22% agreed that housing was available in their community, and 23% agreed that healthy food was affordable.	Approximately 40.7% of service-area renters spend at least 30% of their income on housing. Food insecurity affects approximately 11% of Merrimack County residents and 12% of Sullivan County residents. Although service-area averages for income and poverty are similar to statewide figures, substantial differences exist among municipalities.	Housing, living costs, and economic pressure were the second most frequent open-ended theme, followed by healthy food and nutrition, and child and family supports. Interview participants described a shortage of housing affordable to working households, rising food costs, limited food-pantry hours, difficulty navigating SNAP, and challenges obtaining foods appropriate for chronic disease management.
Transportation and geographic access	Help with rides was the most frequently reported social-service access difficulty, cited by 20% of respondents. Public transportation was selected by 39% as a service respondents would use if it were more available. Transportation and community mobility were also a prominent open-ended theme (n=18).	An estimated 426 service-area households have no vehicle available. Only 0.1% of service-area workers use public transportation, reflecting the limited availability of transit and the area's reliance on private vehicles. Rural distances also contribute to longer travel times for some health services.	Participants described limited transit schedules, rural distances, fares, and accessibility challenges for people using wheelchairs or other mobility devices. Written comments also raised concerns about transportation to specialty care, ambulance response and destination arrangements, and the need for safer sidewalks and bicycle routes.

Supports for older adults, caregivers, and aging in place	In-home support services were cited by 20% of respondents reporting health-service access difficulties, while 19% reported difficulty obtaining help caring for an aging family member. Respondents also expressed interest in fall-prevention programs (31%), caregiver respite (23%), and adult day care (20%).	Adults age 65 and older account for 26.4% of the service-area population, compared with 20.1% statewide. Approximately 23.3% of service-area residents age 65 and older report at least one disability.	Interviews emphasized the need for in-home assistance, caregiver respite, long-term care planning, accessible transportation, and a larger home-care workforce. Participants also described social isolation among older adults who live alone or no longer drive. Written comments identified aging-in-place supports and information, outreach, and social connection as recurring themes.
Health promotion and prevention opportunities	Recreation and fitness programs generated the greatest interest among respondents who selected at least one service (47%). Other frequently selected resources included bike and walking paths (40%), nutrition and cooking programs (33%), and balance and fall-prevention programs (31%).	Approximately 74% of Greater Sullivan adults were classified as overweight or having obesity, compared with 68% statewide. Obesity among Greater Sullivan high school students was also higher than the statewide percentage.	Written comments called for walking and bicycle paths, recreation programs, nutrition support, vaccination access, and additional health education. Interview participants also emphasized affordable healthy food and year-round opportunities for activity and social connection.

A. Community Overview with Selected Service Area Characteristics

The total population of the New London Hospital primary service area was 33,716, according to the United States Census Bureau’s 2020-2024 American Community Survey 5-year estimates, equivalent to about 2.4% of the total population of New Hampshire.

Table 1 displays the service area population distribution by municipality, as well as the median age, the proportion of residents who are under 18 years of age and the proportion who are 65 and older.

Compared with New Hampshire overall, the service area has an older population. Approximately 26% of service area residents are age 65 or older, compared with 20% statewide, and the service area’s median age is eight years higher than the state median. Age distributions vary considerably across the region. The proportion of residents age 65 or older ranges from 17% in Grantham to 38% in New London, while the proportion under age 18 ranges from 10% in Sunapee to 27% in Goshen.

Table 1: Service Area Population by Municipality

Municipality (in alphabetical order)	Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Andover	2,135	6%	46	13%	28%
Bradford	1,565	5%	50	21%	26%
Croydon	798	2%	43	19%	27%
Danbury	1,451	4%	47	17%	24%
Goshen	1,042	3%	54	27%	28%
Grantham	3,465	10%	50	19%	17%
Lempster	953	3%	51	13%	25%
New London	4,433	13%	53	12%	38%
Newbury	2,027	6%	53	17%	24%
Newport	6,375	19%	47	13%	24%
Springfield	1,122	3%	51	15%	20%
Sunapee	3,416	10%	57	10%	33%
Sutton	2,239	7%	48	21%	22%
Washington	1,208	4%	55	14%	29%
Wilmot	1,487	4%	53	17%	24%
Total NLH Service Area	33,716	--	51	15%	26%
New Hampshire	1,394,868	---	43	18%	20%

Source: US Census Bureau American Community Survey 5-Year Estimates (2020-2024)

Table 2 presents additional demographic and economic indicators for the towns in the primary service area. Overall, the region is similar to New Hampshire across these measures. The average

municipal household income is \$98,291, compared with \$99,031 statewide. Approximately 6.6% of service-area residents live below the federal poverty level, compared with 7.2% statewide. The service area also closely mirrors the state in the percentage of families with children headed by a single parent (18.5% versus 19.5%) and the percentage of residents living with a disability (12.8% versus 13.3%). However, these indicators vary considerably across municipalities. Median household income ranges from \$70,417 in Goshen to \$130,313 in Sutton. Estimated poverty rates range from 0% in Grantham to 12.4% in both Danbury and Sunapee, followed closely by Newport at 11.8%. The percentage of families with children headed by a single-parent ranges from 0% in Newbury and Springfield to 35.3% in Newport, while the percentage of residents living with a disability range from 5.1% in Grantham to 21.6% in Goshen.

Table 2: Selected Demographic and Economic Indicators

Municipality (highest to lowest median household income)	Median Household Income	% with income below the federal poverty level	% of family households with children headed by a single parent	% of population with a disability
Andover	\$88,514	10.5%	25.3%	11.1%
Bradford	\$108,015	9.6%	11.9%	11.4%
Croydon	\$98,333	6.4%	32.6%	9.3%
Danbury	\$71,685	12.4%	23.6%	16.9%
Goshen	\$70,417	5.5%	9.2%	21.6%
Grantham	\$106,403	0.0%	28.1%	5.1%
Lempster	\$86,607	7.2%	11.1%	14.0%
New London	\$107,773	0.9%	1.9%	14.6%
Newbury	\$116,477	3.4%	0.0%	10.5%
Newport	\$80,341	11.8%	35.3%	15.6%
Springfield	\$100,893	3.4%	0.0%	6.9%
Sunapee	\$101,393	12.4%	32.8%	14.8%
Sutton	\$130,313	4.8%	12.5%	11.8%
Washington	\$89,453	8.7%	8.9%	18.5%
Wilmot	\$117,759	2.3%	8.1%	7.3%
Total NLH Service Area	\$98,291 (avg)	6.6% (avg)	18.5%	12.8%
New Hampshire	\$99,031	7.2%	19.5%	13.3%

Source: US Census Bureau American Community Survey 5-Year Estimates (2020-2024)

As displayed in Table 3, approximately 94% of the population of the New London Hospital service area identifies as white, and about 2% identify as Hispanic ethnicity. In general, the service area is less diverse regarding race and ethnicity compared to New Hampshire overall.

Table 3: Race and Ethnicity Characteristics

Area	Race							Ethnicity
	White	Black / African American	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Other Race	2 or more races	Hispanic or Latino (of any race)
NLH Service Area	94%	0.6%	<1%	1%	<1%	<1%	4%	2%
New Hampshire	88%	2%	<1%	3%	<1%	1%	6%	5%

Source: US Census Bureau American Community Survey 5-Year Estimates (2020-2024)

Social Drivers of Health. Household income, wealth, and poverty are among the many factors that shape health and well-being. These factors are commonly referred to as Social Drivers of Health (SDOH), or Social Determinants of Health. SDOH are the conditions in the environments where people are born, live, learn, work, play, and age that influence health, quality of life, and health outcomes. They include access to quality health care and affordable, nutritious food; educational opportunities and attainment; transportation; safe and stable housing; employment and economic opportunities; public infrastructure; and other social, economic, and environmental conditions.

The World Health Organization (WHO) recognizes addressing SDOH as an important strategy for improving health and reducing inequities.¹ Research suggests that social determinants may account for 30–55% of health outcomes. Unlike many individual-level health risks, SDOH are shaped by broader social and economic conditions and can be influenced through public policy, community investment, cross-sector partnerships, and community health improvement efforts. As shown in Table 4, SDOH are commonly organized into five broad domains.

Given the significant role these conditions can play in shaping health and opportunities for good health, the 2026 Community Health Needs Assessment incorporated SDOH throughout the assessment process, including in the community survey and discussions with community leaders.

¹ World Health Organization. *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Table 4: Social Drivers of Health

Economic Stability	Physical Location and Environment	Development and Education	Community, Safety and Social Context	Food	Health Care System
• Employment • Income and Wealth • Expenses and Debt • Health insurance • Financial safety net	• Housing affordability, quality • Transportation • Walkability • Safety of built environment • Parks, green space • Recreation, leisure opportunities • Clean air and water	• Literacy • Language • Early childhood development • Strong families • Vocational training • Higher education	• Community engagement • Community support systems, social capital • Stress • Exposure to violence, trauma • Community safety, crime, justice • Discrimination, stigma	• Food security • Access to affordable, healthy food options	• Health professional and Pharmacy availability • Access to culturally appropriate and respectful care • Quality of care

Adapted from the Kaiser Family Foundation²

B. Community Input on Health Issues and Priorities

In September 2026, New London Hospital fielded a Community Health Needs Assessment Survey. The survey was distributed via unique email link to community members and individuals in leadership positions within agencies, municipalities, businesses, and civic and volunteer organizations serving the New London Hospital service area. Distribution prioritized representation across a diverse range of sectors and areas of interest, including aging services, business, community mental health, disability services, education, family supports, financial stability, housing, mental health, dental health, general health, spiritual health, substance misuse, and municipal services. A total of 295 community members completed the Community Resident Survey. Table 4 displays the number of responses received from residents in each service area municipality, and Table 5 presents selected characteristics of survey respondents.

² Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity, Kaiser Family Foundation Issue Brief, 2018.

Table 5: Respondents by Geography

Town	# of respondents	% of total*
New London	138	47%
Sutton	24	8%
Newbury	23	8%
Sunapee	22	8%
Newport	21	7%
Andover	18	6%
Wilmot	12	4%
Grantham	10	3%
Bradford	9	3%
Springfield	9	3%
Danbury	6	2%
Goshen	5	2%
Croydon	3	1%
Lempster	2	1%
Washington	0	0%
Other response	4	1%

*Percent of respondents who provided information on the location of their residence. Percentages add up to more than 100% given that some respondents named more than one community.

Table 6: Characteristics of Community Survey Respondents

Age < 45 years	Age > 65 years	Woman	Identified in a non-white racial or ethnic group
19%	47%	75%	4%
Household Income < \$50K	Household Income > \$100K	Currently Uninsured	Currently has Medicaid coverage
14%	45%	3%	3%

1. Progress on Community Health Priorities and Concerns

Assessments of community health needs are conducted every three years by New London Hospital and partner organizations. Over the course of these assessment cycles, a relatively consistent pattern has been observed regarding the priority issues and concerns identified for health improvement by the community. Among these priorities have been:

- Cost of health care services including health insurance and prescription drugs;
- Access to behavioral health services including mental health care and substance use treatment;
- Availability of health care services including primary care and medical sub-specialties;
- Senior services and concerns of aging;
- Availability and affordability of dental services; and
- Affordability and availability of basic needs including housing, healthy food and childcare.

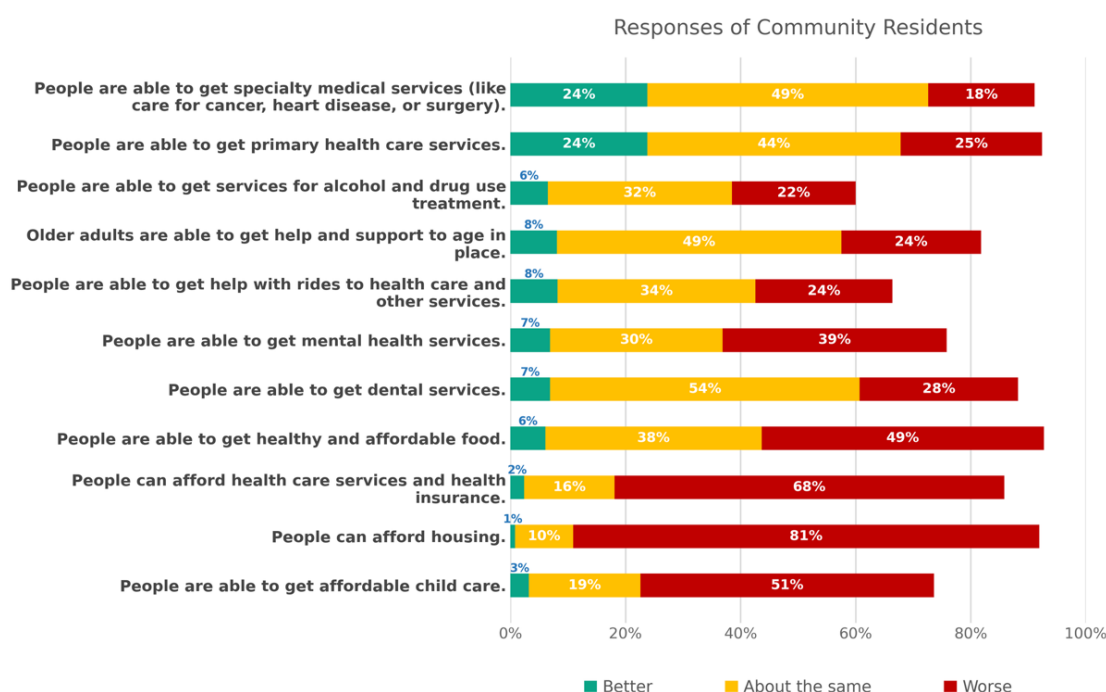
In consideration of this observed consistency over time, the 2026 Community Health Needs Assessment asked respondents to the Community Resident survey to reflect on a set of statements describing the main priorities and themes identified in the recent past by indicating if there has been improvement or not in those areas. Specifically, the survey included the following statement and question:

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

Figure 1 displays the results for this question set for respondents to the community resident survey. In general, more community residents reported needs getting worse compared to those reporting needs getting better in each of the topic areas over the last few years.

More than half of survey respondents indicated that the ability to afford housing (81%), health care services and health insurance (68%), and childcare (51%) has worsened in recent years. Primary health care and specialty medical services were the only areas in which more than 10% of respondents reported improvement, with approximately 24% indicating that access to each type of care has gotten better.

Figure 1: Do you think these needs have gotten worse, are about the same, or have gotten better in the last few years?



Note: Percentages are based on all respondents who answered each item. "Don't know or not sure" responses are not displayed; therefore, percentages may not total 100%.

The survey also included an open-ended question following the list of priority areas: *"Are there other health needs that you think are important for your community to address now?"* Seventy-eight respondents answered this question. After excluding six responses indicating that there were no additional needs, 72 comments identified one or more community health concerns. Thematic analysis identified the following topics:

- 1. Health care access, provider availability, and service quality (n=33):** Respondents described shortages of primary and specialty care providers, long appointment wait times, difficulty obtaining timely care, pharmacy access challenges, and concerns about communication and service delivery.
- 2. Affordability and the rising cost of living (n=23):** Comments addressed the cost of health care, insurance, medications, dental care, and other necessities. Several respondents noted that households may struggle financially even when their incomes exceed eligibility limits for assistance.

3. **Transportation and emergency medical services (n=16):** Respondents identified a need for transportation to medical appointments and essential services. Comments also raised concerns about ambulance availability, response times, and transport destinations.
4. **Housing availability and affordability (n=12):** Respondents described limited housing options, high rents and home prices, and a need for affordable housing for families and older adults.
5. **Food security and nutrition (n=12):** Comments addressed the affordability of healthy food, food insecurity, nutrition guidance, and grocery or prepared-meal delivery for older adults.
6. **Services for older adults and caregivers (n=10):** Respondents identified needs related to aging in place, dependable home-based care, caregiver assistance, technology support, assisted living, nursing care, and rehabilitation services.
7. **Mental health and substance use services (n=8):** Comments emphasized the availability of psychiatric care, counseling, crisis services, substance use treatment, and peer-support opportunities.
8. **Children, youth, and families (n=6):** Respondents identified needs related to affordable childcare, after-school programming, health insurance for children, physical activity, and youth safety and well-being.
9. **Social connection, inclusion, and accessible services (n=5):** Comments called for community spaces, support groups, bilingual services, LGBTQ+ supports, personal-safety education, and greater respect and inclusion within the community.

2. Characteristics of a Healthy Community

The Community Resident Survey included fourteen statements describing characteristics of a healthy and resilient community. The statements addressed the availability and affordability of basic needs, access to health services, opportunities for social participation, community connection, and perceptions of the community as a good place to live. Respondents were asked to think about the area they consider their community and indicate whether they agreed, disagreed, or were unsure about each statement.

Figure 2 displays the results for this set of questions. Community residents were most likely to agree that, in their community:

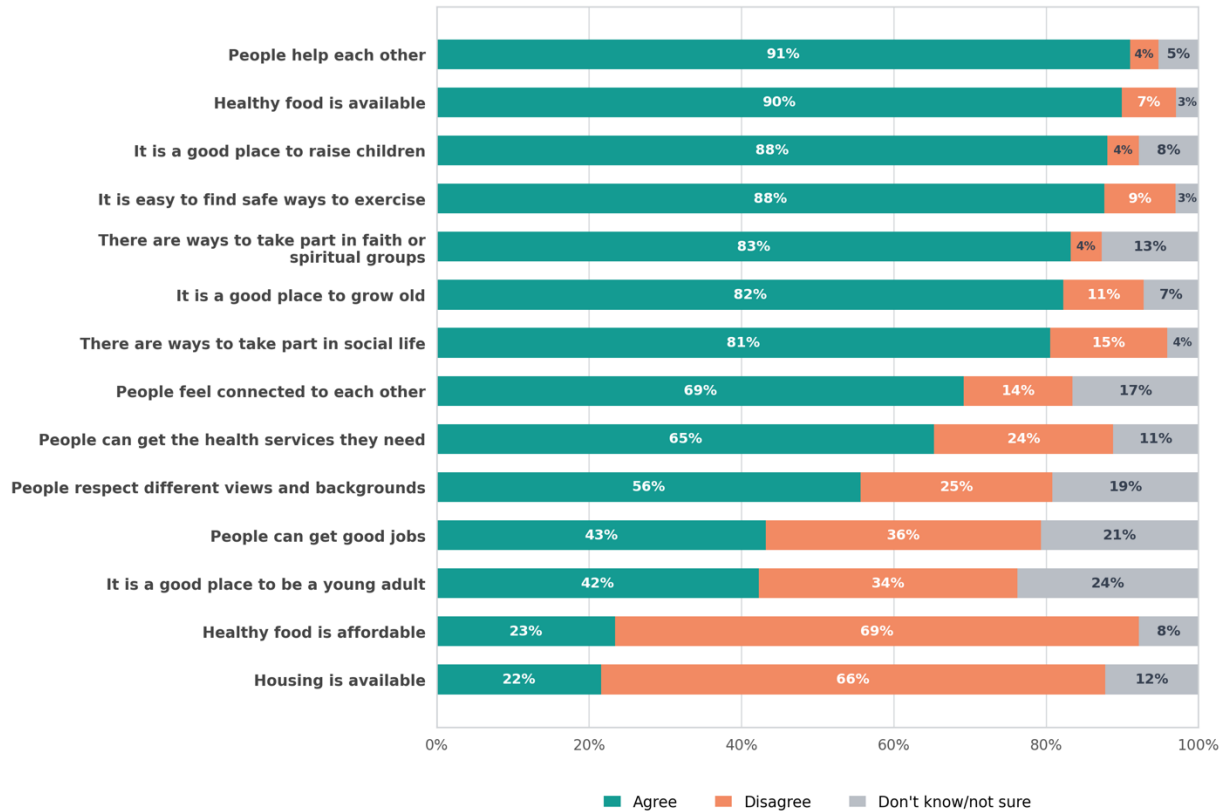
- People help each other (91%).
- Healthy food is available (90%).
- It is a good place to raise children (88%).
- It is easy to find safe ways to exercise (88%).

Community residents were least likely to agree that, in their community:

- Housing is available (22%).
- Healthy food is affordable (23%).
- It is a good place to be a young adult (42%).

Regarding access to health services, nearly two-thirds of respondents (65%) agreed with the statement, “People can get the health services they need.” About one-quarter (24%) disagreed, while 11% responded “Don’t know or not sure.”

Figure 2: Do you agree or disagree with these statements about your community?

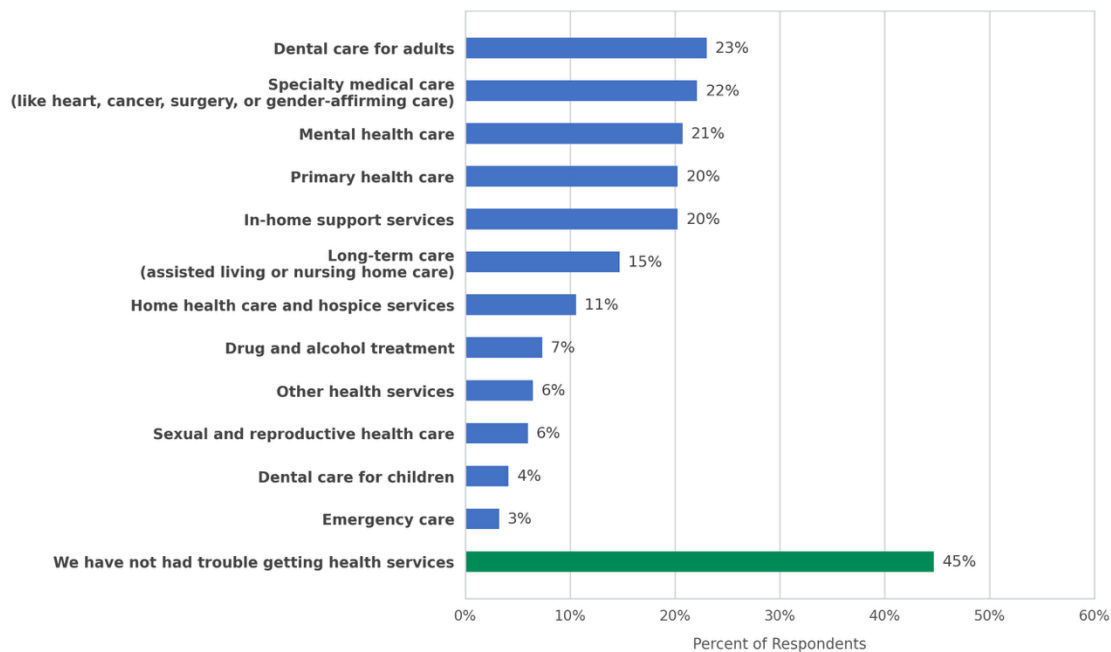


Note: Percentages are based on respondents who answered each statement (n=265-269). Totals may differ slightly from 100% due to rounding.

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 close to you had trouble getting any of the following types of **health services** that you needed?” As displayed in Figure 3 below, dental care for adults was the most frequently reported access difficulty, cited by 23% of respondents. Other commonly reported difficulties included specialty medical care (22%), mental health care (21%), primary health care (20%), and in-home support services (20%). Overall, 45% of respondents indicated that they had not had trouble getting needed health services during the past year.

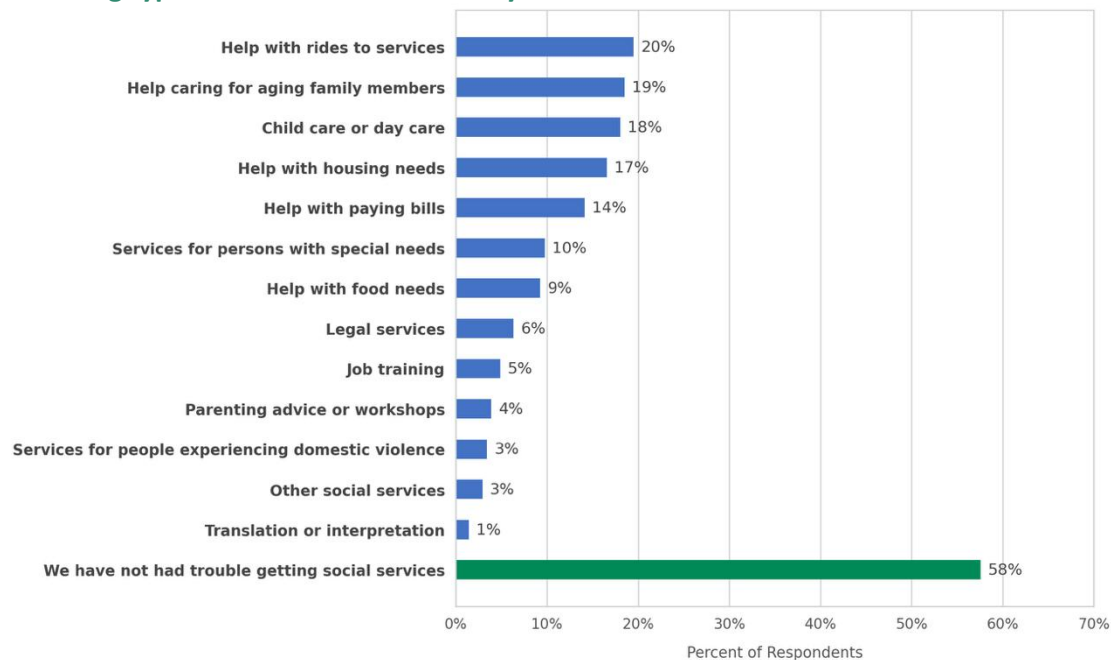
Figure 3: In the past year, have you or someone close to you had trouble getting any of the following types of HEALTH services that you needed?



Note: Multiple responses were permitted. Percentages are based on respondents who answered the question (n=217).

In a similar question, the Community Resident Survey asked, “*In the past year, have you or someone close to you had trouble getting any of the following types of **social** services that you needed?*” As displayed in Figure 4, help with rides to services was the most frequently reported access difficulty, cited by 20% of respondents. Other commonly reported difficulties included help caring for aging family members (19%), childcare or day care (18%), help with housing needs (17%), and help with paying bills (14%). Overall, 58% of respondents indicated that they had not had trouble getting needed social services during the past year.

Figure 4: In the past year, have you or someone close to you had trouble getting any of the following types of SOCIAL services that you needed?

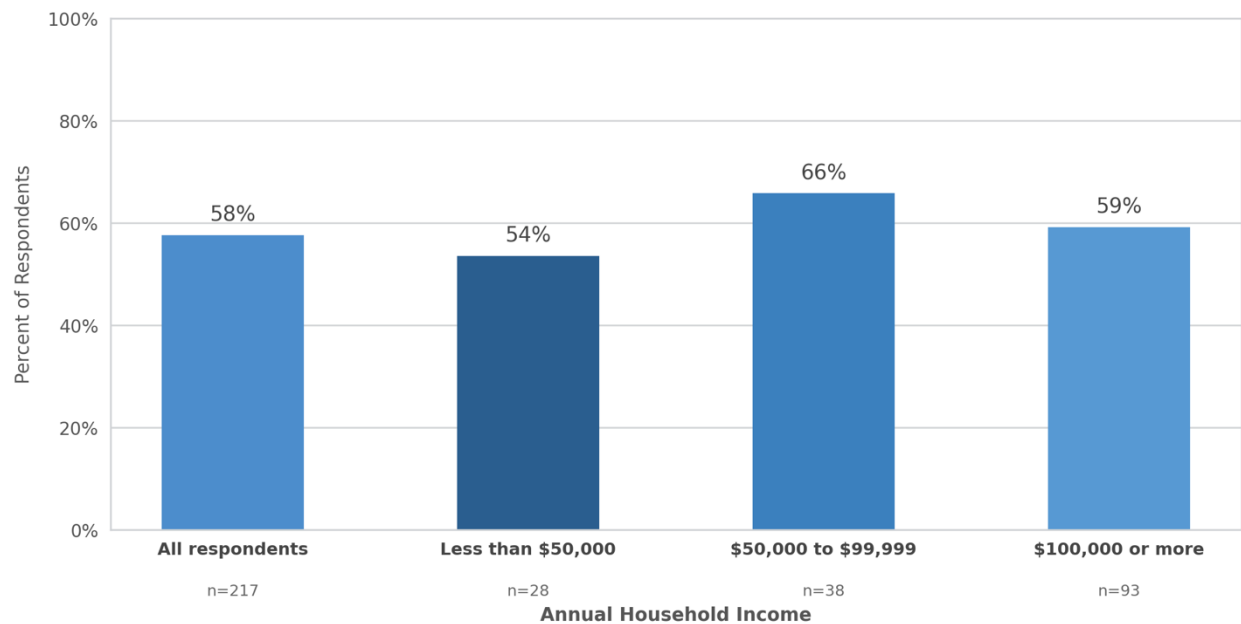


Note: Multiple responses were permitted. Percentages are based on respondents who answered the question (n=205).

Overall, respondents were more likely to report difficulty accessing health services than social services. Among respondents who answered each question, 58% reported difficulty accessing at least one type of health service, compared with 43% who reported difficulty accessing at least one type of social service. This difference may partly reflect variation in the proportion of respondents who needed or attempted to access each type of service during the past year.

Figure 5 displays the percentage of respondents who reported difficulty accessing at least one type of health service by household income. Respondents with annual household incomes of \$50,000 to \$99,999 were most likely to report an access difficulty (66%), followed by those with incomes of \$100,000 or more (59%) and those with incomes below \$50,000 (54%).

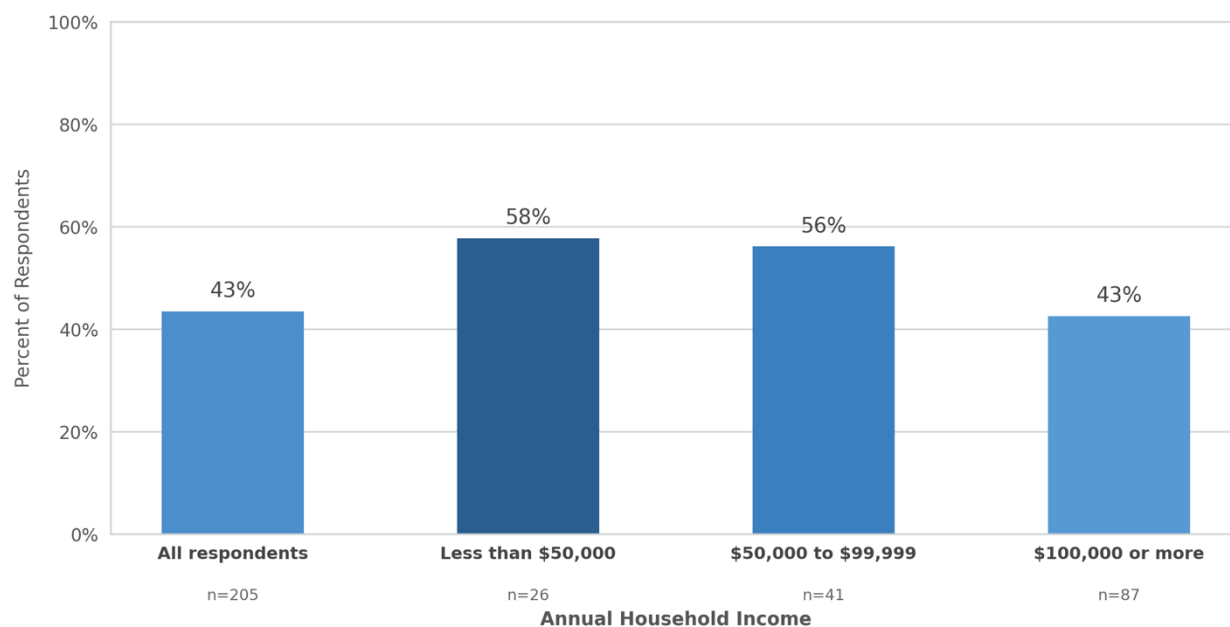
Figure 5: Respondents reporting difficulty accessing at least one type of HEALTH service, by household income



Note: Income-category percentages exclude respondents who did not report household income or selected "prefer not to say."

As displayed in Figure 6, 43% of respondents reported difficulty accessing at least one type of social service during the past year. Respondents with annual household incomes below \$50,000 were most likely to report an access difficulty (58%), followed closely by those with incomes of \$50,000 to \$99,999 (56%). Among respondents with household incomes of \$100,000 or more, 43% reported difficulty accessing at least one type of social service.

Figure 6: Respondents reporting difficulty accessing at least one type of SOCIAL service, by household income



Note: Income-category percentages exclude respondents who did not report household income or selected “prefer not to say.”

Survey respondents who reported difficulty accessing one or more health services during the past year were asked what prevented them from getting the services they needed. Figure 7 focuses on the five most frequently reported health-service access difficulties: dental care for adults, specialty medical care, mental health care, primary health care, and in-home support services.

“Wait time too long” was the most frequently reported barrier across all five service types. It was cited by 88% of respondents who reported difficulty accessing specialty medical care, 78% of those reporting difficulty accessing mental health care, 77% of those reporting difficulty accessing primary health care, 74% of those reporting difficulty accessing adult dental care, and 68% of those reporting difficulty accessing in-home support services.

“Not accepting new patients” was also consistently reported, cited by 58% to 69% of respondents across the five service types. Cost was particularly prominent among respondents reporting difficulty accessing in-home support services (61%) and mental health care (53%). Nearly half of respondents reporting difficulty accessing mental health care (49%) or adult dental care (48%) also cited having no insurance or insufficient insurance coverage.

Figure 7: Commonly reported barriers to accessing HEALTH services

	Dental care for adults (n=50; 23%)	Specialty medical care (n=48; 22%)	Mental health care (n=45; 21%)	Primary health care (n=44; 20%)	In-home support services (n=44; 20%)
Wait time too long	74%	88%	78%	77%	68%
Not accepting new patients	60%	58%	69%	64%	66%
Service not available	52%	27%	47%	36%	52%
Cost too much	46%	40%	53%	41%	61%
No insurance or not enough insurance	48%	38%	49%	39%	45%

Note: Respondents could select multiple services and multiple barriers. The follow-up question did not link each barrier to a specific service; values show cross-tabulated responses. Other options included scheduling, transportation, internet, language, discrimination, stigma, and write-in reasons.

Survey respondents who reported difficulty accessing one or more social services during the past year were asked what prevented them from getting the services they needed. Table 8 focuses on the four most frequently reported social-service access difficulties: help with rides to services, help caring for aging family members, childcare or day care, and help with housing needs.

Among respondents who reported difficulty getting rides to services, the most frequently reported barrier was that the service was unavailable (63%), followed by cost (53%) and having no way to get there (42%). Cost was the most common barrier among respondents reporting difficulty accessing childcare or day care (73%), help with housing needs (68%), and help caring for aging family members (58%). Service availability was also a consistent concern across these three service types, cited by 51% to 53% of respondents. Long wait times were reported by half of respondents who had difficulty getting help with housing needs, 46% of those reporting difficulty accessing childcare, and 37% of those reporting difficulty getting help caring for aging family members.

Figure 8: Commonly reported barriers to accessing SOCIAL services

	Help with rides to services (n=40; 20%)	Help caring for aging family members (n=38; 19%)	Child care or day care (n=37; 18%)	Help with housing needs (n=34; 17%)
Cost too much	52%	58%	73%	68%
Service not available	62%	53%	51%	53%
Wait time too long	35%	37%	46%	50%
Not accepting new clients	30%	37%	43%	32%
Had no way to get there	42%	32%	24%	41%

Note: Respondents could select multiple services and multiple barriers. The follow-up question did not link each barrier to a specific service; values show cross-tabulated responses. Other options included scheduling, information, internet, language, discrimination, and write-in reasons.

In a separate question, Community Resident Survey respondents were asked, “In the past year, how often have you or someone close to you missed getting health care or social services because of unfair treatment?” Unfair treatment was defined as discrimination or stigma based on race, religion, ethnicity, gender, sexual orientation, age, disability, language, or education. Among the 221 respondents who answered this question, 1.4% indicated that they or someone close to them had “Often” missed getting health care or social services because of unfair treatment, 6.3% responded “Sometimes,” and 92.3% responded “Never.”

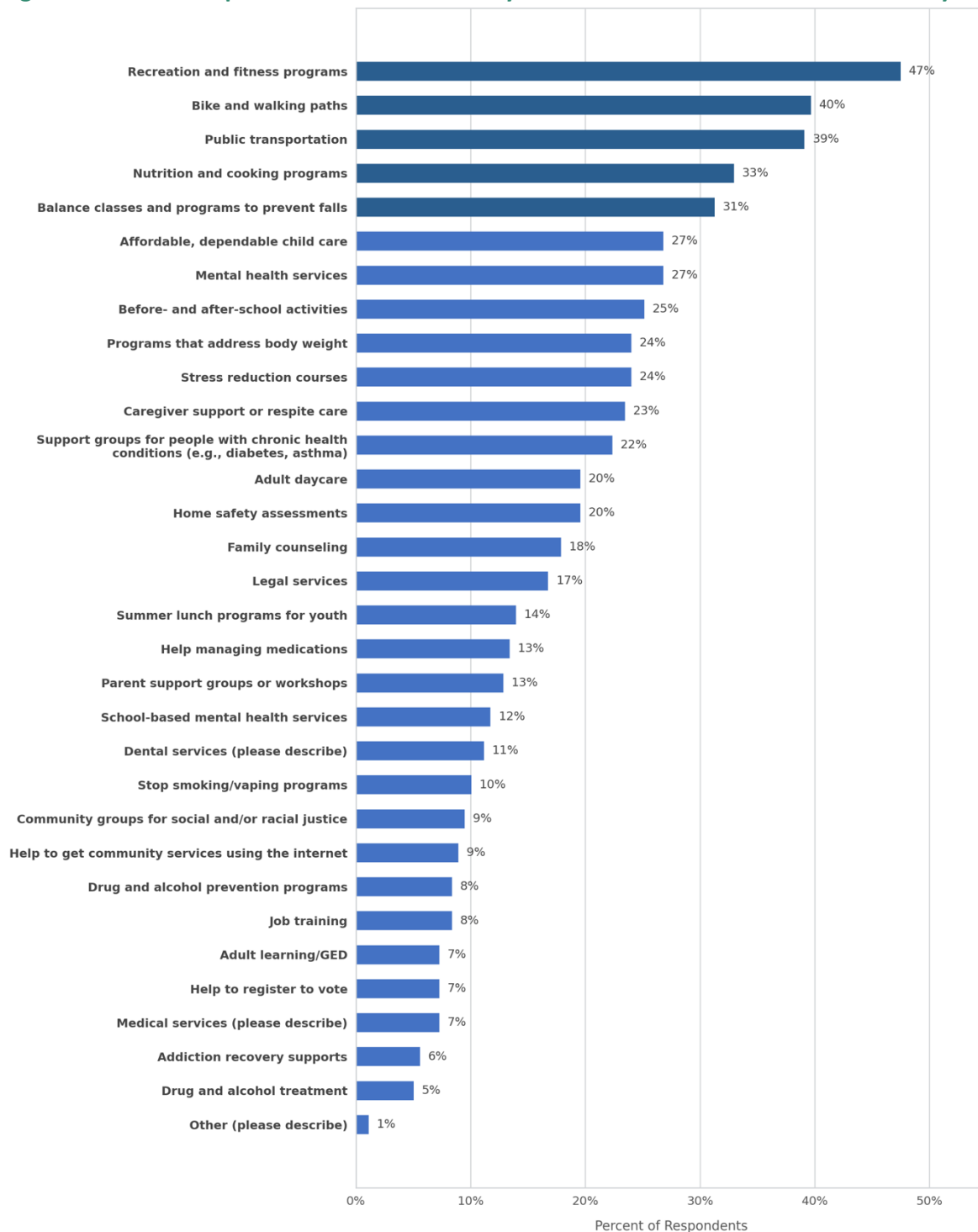
4. Interest in Specific Community Health Programs or Services

Community residents were also asked about services and resources that could support health and well-being: “Would you or your family use any of these services if they were more available in your community?” The survey presented 31 service options, as well as an “Other” option, organized into six conceptual groups: Services for Children and Parents; Services for Older Adults; Healthy Living Programs; Counseling and Mental Health Services; Health Care Services; and Community Services and Supports. Respondents could select any number of services across the different groups.

Among the 179 respondents who selected at least one service, recreation and fitness programs generated the greatest interest, selected by 47% of respondents. Other frequently selected services included bike and walking paths (40%), public transportation (39%), nutrition and cooking programs (33%), and balance classes and programs to prevent falls (31%). Mental health services and

affordable, dependable childcare were each selected by 27% of respondents. These results indicate particularly strong interest in opportunities for physical activity, transportation options, healthy living programs, and services that support older adults and families.

Figure 9: Services respondents would use if they were more available in their community



Note: Multiple responses were permitted. Percentages are based on respondents who selected at least one service line (n=179).

Interest varied by respondent characteristics. Among respondents ages 18–44, affordable, dependable childcare (64%) and before- and after-school activities (57%) were the most frequently

selected services. Households with children also expressed substantial interest in recreation and fitness programs (55%), bike and walking paths (49%), before- and after-school activities (49%), and affordable childcare (45%). Among respondents ages 65 and older, recreation and fitness programs (42%), balance classes or programs to prevent falls (36%), and public transportation (33%) received the most interest. Respondents with household incomes below \$50,000 most frequently selected affordable childcare (48%), programs addressing body weight (44%), and fall-prevention programs (40%).

These subgroup results are descriptive. The groups overlap, and the relatively small number of respondents with household incomes below \$50,000 (n=25) warrants particular caution when interpreting differences.

Figure 10: Interest in selected services by respondent characteristics

	All respondents (n=179)	Age 18-44 (n=44)	Age 65+ (n=73)	Households with children (n=51)	Household income below \$50,000 (n=25)
Recreation and fitness programs	47%	52%	42%	55%	36%
Bike and walking paths	40%	52%	32%	49%	28%
Public transportation	39%	45%	33%	33%	36%
Nutrition and cooking programs	33%	32%	25%	37%	24%
Balance classes and programs to prevent falls	31%	16%	36%	22%	40%
Affordable, dependable child care	27%	64%	10%	45%	48%
Before- and after-school activities	25%	57%	8%	49%	36%
Mental health services	27%	43%	19%	33%	32%
Family counseling	18%	32%	7%	20%	24%
Programs that address body weight	24%	27%	16%	25%	44%
Summer lunch programs for youth	14%	27%	5%	20%	28%
Dental services	11%	20%	11%	16%	24%

Note: Multiple responses were permitted. Percentages are based on respondents who selected at least one service. Subgroups overlap: interpret smaller groups cautiously.

The 2026 Community Health Needs Assessment Survey asked respondents, “If you could change one thing that you think would improve health in your community, what would you change?” A total of 108 respondents, representing 37% of all survey respondents, provided a written response. The comments emphasized improving access to health care, addressing economic pressures that affect

health, and strengthening transportation and community-based supports. Below is a summary of the most frequently mentioned themes.

1. **Health care access, provider availability, and wait times** (n=44): Increasing the availability of primary care, specialty care, dental care, mental health care, and other services; recruiting and retaining providers; reducing appointment wait times; and improving service delivery.
2. **Affordable housing, cost of living, and other economic pressures** (n=21): Expanding affordable housing, reducing the burden of rising living costs, and providing greater support for households struggling to meet basic needs.
3. **Transportation and community mobility** (n=18): Expanding transportation to medical appointments, grocery stores, and other services; improving transportation for older adults; and developing safer sidewalks, bicycle paths, and walking routes.
4. **Mental health and substance use services** (n=10): Increasing access to affordable mental health counseling, crisis services, school-based mental health supports, and substance use services.
5. **Healthy food, nutrition, and healthy weight** (n=10): Improving the availability and affordability of healthy food, strengthening food assistance, offering nutrition and cooking programs, and addressing obesity and unhealthy eating.
6. **Recreation and opportunities for physical activity** (n=10): Developing safe walking and bicycle paths, offering exercise and recreation programs, and creating more opportunities for residents to be physically active.
7. **Information, outreach, social connection, and inclusion** (n=9): Improving communication about available resources, connecting residents with services, reducing social isolation, and fostering a more inclusive and connected community.
8. **Preventive health services and education** (n=9): Expanding vaccination opportunities, health education, wellness programs, and other services that help residents prevent or manage health concerns.
9. **Supports for older adults and aging in place** (n=8): Expanding transportation, social supports, fall-prevention programs, assisted living options, home-based services, and other resources that help older adults remain safely in the community.
10. **Childcare, youth, and family supports** (n=7): Increasing access to affordable childcare, before- and after-school activities, summer programs, school meals, and school-based mental health services.

C. Community Interview Findings

Four key informant interviews were conducted in September 2026 with six people representing community health, home health and hospice, public health, business, and community outreach perspectives. Interviews explored current health concerns, changes since the previous assessment, barriers to care and services, community strengths, and opportunities for improvement. Since the number of interviews was small, the findings provide context for the survey and secondary data rather than a representative account of all community experiences.

Across interviews, participants described residents' health needs as interconnected. Financial pressure, transportation limitations, workforce shortages, and difficulty navigating available resources often compound one another. These observations closely aligned with survey findings related to provider availability, housing, food affordability, transportation, and supports for older adults.

1. Interconnected Financial and Access Barriers

Interview participants described housing affordability as a central concern, particularly for working households whose incomes may be too high for subsidized housing but insufficient for market-rate options. Food costs and access were also recurring concerns. Participants noted that limited food-pantry hours, appointment requirements, and the complexity of navigating SNAP can make assistance difficult to obtain. They also emphasized the need for affordable foods that support the management of diabetes, hypertension, and other chronic conditions.

Health care expenses were described as part of a broader financial burden that can include insurance premiums and deductibles, prescription medications, transportation, and time away from work. Participants noted that these costs can delay care even when a service technically exists.

2. Access to Health and Support Services

Participants reported continued difficulty accessing primary care, specialty care, mental health care, and dental services. Common barriers included long waits, providers not accepting new patients, insurance limitations, changing referral criteria, and the need to travel outside Newport. Behavioral health capacity was a particular concern because primary care teams may continue supporting patients while they wait for specialty services.

Participants also identified areas of recent progress. Newport Health Center's ability to accept new patients was viewed as an improvement in primary care access, and walk-in or open-access mental health hours were described as a helpful development. The mobile dental program was considered an important resource, although gaps remain for some young adults transitioning from pediatric care and for older adults who need dentures or restorative services.

3. Aging, Transportation, and Social Connection

The region's older population creates growing demand for services that support aging in place. Interview participants emphasized the need for in-home assistance with daily tasks, caregiver respite, long-term care planning, and a larger workforce of nurses, home health aides, homemakers, and other support staff. Even when assistance is available, the number of service hours may not meet residents' needs.

Transportation was described as a barrier to medical appointments, food and other essential services, and social participation. Public transportation is limited in parts of the rural service area and may not consistently accommodate wheelchairs or other mobility needs. For older adults who live alone or no longer drive, transportation barriers can deepen social isolation, particularly in winter. Participants highlighted community meals, concerts, educational lunches, senior programs, and other year-round activities as important opportunities for connection.

4. Navigation, Communication, and Coordination

Participants said that useful services exist, but information about them is fragmented and can be difficult to keep current. Digital communication and social media do not reach everyone, while complex insurance notices, government forms, and after-visit summaries can be difficult to understand. Community health workers and other trusted staff were described as especially valuable in helping residents understand options, complete applications, and connect with care.

Participants recommended a central, regularly updated source of information about local services, along with stronger routine coordination among health care providers, municipal agencies, and community organizations. These approaches could reduce duplication, improve referrals, and make it easier for residents to move between services.

5. Community Strengths and Opportunities

Interview participants identified strong local partnerships, community health workers, home health and hospice services, food programs, mobile dental care, and outreach efforts as important community assets. Building on these strengths, they suggested more local and co-located services, mobile or flexible service delivery, accessible transportation, expanded supports for aging in place and caregivers, workforce development, and year-round opportunities for social connection.

D. Community Health Status Indicators

This section of the 2026 Community Health Needs Assessment report provides information on key data indicators and measures of community health status. Where possible, statistics are presented specific to the 15-town primary service area of New London Hospital. In some instances, data are only available at the county level or the Public Health Network (PHN) region level.

Ten of the 15 towns comprising the New London Hospital primary service area are part of the Greater Sullivan Public Health Region as defined by the NH Department of Health and Human Services, accounting for 50% of the population of that public health region. The remaining 5 towns distributed across 4 other public health regions. Consequently, this report references health statistics for the Greater Sullivan Public Health Region when those data are available.

In some cases, population health data are only available at the county level, particularly from national sources. Seven of New London Hospital service area towns are in Merrimack County, while eight service area towns are in Sullivan County. For statistics included in this report at the County level, the data should be considered in the context that a majority of the population contributing to the statistic are geographically outside the hospital's primary service area.

Service area breakdown by County and Regional Public Health Network		
County	Town/City	Regional Public Health Network
Merrimack County	Andover	Capital Area
	Bradford	
	Danbury	Winnepesaukee
	New London	Greater Sullivan
	Newbury	
	Sutton	
	Wilmot	
Sullivan County	Croydon	
	Goshen	
	Lempster	
	Newport	
	Springfield	
	Sunapee	
	Grantham	Upper Valley
	Washington	Capital Area

1. Demographics and Social Drivers of Health

Social drivers of health are the conditions in which people are born, grow, live, work, and age. As described earlier in this report, these drivers include nonmedical factors such as economic security, community infrastructure, education, transportation, and access to safe housing and nutritious food. Together, these conditions can directly or indirectly shape health, well-being, and quality of life. Individual and community characteristics, including age, disability, and language, can also influence residents' health needs and their ability to access the health and social services necessary to thrive.

General Population Characteristics. The prevalence of many health conditions varies by age, and different age groups often have distinct health-related needs and priorities. Understanding the age distribution of a population can help communities anticipate demand for health care and supportive services, allocate resources appropriately, and plan for future needs.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, the combined population of the 15 municipalities that comprise the New London Hospital service area is 33,716, representing 2.4% of New Hampshire’s population. The service area has a larger proportion of older adults than the state overall. Adults age 65 and older account for 26.4% of the service-area population, compared with 20.1% statewide. Residents age 85 and older represent 2.9% of the service-area population, compared with 2.0% across New Hampshire.

Conversely, children under age 18 account for 15.4% of the service area population, compared with 18.2% statewide. Adults ages 18–64 represent 58.1% of the service area population, compared with 61.6% statewide. The service area and New Hampshire have nearly identical distributions by sex, with females accounting for 50.1% of both populations.

Table 7: Age and Gender Identity

Indicators	New London Hospital Service Area	New Hampshire
Total Population	33,716	1,394,868
Under Age 18	15.4%	18.2%
Ages 18-64	58.1%	61.6%
Ages 65 and older	26.4%	20.1%
Ages 85 and older	2.9%	2.0%
Female	50.1%	50.1%
Male	49.9%	49.9%

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

Education. Educational attainment is an important social driver of health. Lower levels of educational attainment are associated with fewer employment opportunities, lower earnings, and poorer health outcomes. As displayed in Table 8, the percentage of New London Hospital service-area residents age 25 and older who have earned at least a high school diploma is nearly identical to the statewide percentage.

Table 8: Educational Attainment

Percent of Population Aged 25+	New London Hospital Service Area	New Hampshire
High School Diploma (or Equivalent) and Higher	94%	94%
Some College or Associate’s Degree	25%	27%
Bachelor’s Degree and Higher	42%	41%

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

The service area has a slightly lower percentage of adults with some college education or an associate degree than New Hampshire overall. Conversely, the percentage with a bachelor’s degree or higher is slightly higher in the service area. Educational attainment varies within the region, particularly at the bachelor’s degree level, which ranges from approximately 18% in Danbury to 66% in New London.

Higher educational attainment is historically associated with better health outcomes, in part because adults with more education often have greater access to employment opportunities, higher earnings, and comprehensive health-related benefits.

Employment. Stable employment can promote financial security by helping individuals and families afford food, housing, utilities, health care, and other necessities. Employment may also provide access to health insurance, paid leave, retirement programs, and wellness benefits. In addition to its financial benefits, steady employment can support mental health by providing social interaction, a sense of purpose, and connection to the community.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, the unemployment rate among residents in the New London Hospital service area civilian labor force was 2.4%, compared with 3.3% statewide. The service area also had lower labor force participation. Approximately 60.1% of service-area residents age 16 and older were in the labor force, compared with 66.3% across New Hampshire. This difference may partly reflect the service area’s larger proportion of residents age 65 and older.

Employment patterns vary across the service area. Municipal unemployment estimates range from 0.0% in Sunapee to 7.8% in Goshen.

Table 9: Employment

Percent of Population Aged 25+	New London Hospital Service Area	New Hampshire
Population age 16 and older	29,303	1,173,489
In the labor force	60.1%	66.3%
Employed	58.5%	63.9%
Not in the labor force	39.9%	33.7%
Unemployment rate	2.4%	3.3%

***Source:** U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates. Service-area percentages were calculated from combined counts for all 15 municipalities. The unemployment rate represents unemployed residents as a percentage of the civilian labor force; the other percentages use the population age 16 and older as the denominator.*

Income and Poverty. Economic well-being is closely connected to health. Household income affects the ability to obtain health care, nutritious food, safe and stable housing, transportation, and other resources that support health and quality of life.

Overall, the New London Hospital service area has income and poverty indicators that are similar to, or somewhat more favorable than, New Hampshire as a whole. Approximately 7.0% of service-area residents live below the poverty level, compared with 7.2% statewide. About 21.5% of service-area households have annual incomes below \$50,000, compared with 23.8% across New Hampshire. Just over half of service-area households have incomes of \$100,000 or more, similar to the statewide percentage.

These regional figures, however, mask substantial economic differences among the 15 municipalities. Median household income ranges from \$70,417 in Goshen and \$71,685 in Danbury to \$130,313 in Sutton. Overall poverty rates range from an estimated 0.0% in Grantham to 12.4% in both Danbury and Sunapee. Newport also has a comparatively high overall poverty rate of 11.8% and the highest estimated poverty rate among adults age 65 and older, at 17.8%. These differences indicate that some communities and population groups experience considerably greater economic hardship than service-area averages suggest.

Table 10: Income and Poverty

Indicator	New London Hospital Service Area	New Hampshire
Households with income below \$50,000	21.5%	23.8%
Households with income of \$100,000 or more	50.5%	49.5%
Households receiving SNAP benefits	4.3%	6.1%
Residents living below the federal poverty level	7.0%	7.2%
Children under 18 living below the poverty level	4.0%	7.9%
Adults over 65 living below the poverty level	7.2%	7.7%

Source: U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates. Service-area percentages were calculated from combined counts for all 15 municipalities.

Language. Language barriers can affect residents’ ability to locate and access services, communicate with health care and social service providers, navigate complex systems, and understand health information. Difficulty understanding instructions, medication dosages, treatment options, or follow-up recommendations can have direct implications for health and safety. Language barriers may also contribute to frustration, anxiety, and social isolation.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, 2.4% of New London Hospital service-area residents age 5 and older speak a language other than English at home, compared with 7.9% statewide. Other Indo-European languages are the most frequently reported language group in the service area, followed by Spanish and Asian and Pacific Islander languages.

An estimated 0.3% of service-area residents age 5 and older speak English less than “very well,” compared with 2.3% across New Hampshire. Although this represents a relatively small proportion of the service-area population, language access remains important because communication barriers can have substantial consequences when residents seek health care or other essential services. The percentage of residents who speak a language other than English at home is highest in New London, Wilmot, and Danbury, at approximately 4% to 5% in each community.

Table 11: Language Spoken at Home

Language characteristic, population age 5+	New London Hospital Service Area	New Hampshire
English only	97.6%	92.1%
Language other than English	2.4%	7.9%
Other Indo-European languages	1.2%	3.4%
Spanish	0.6%	2.6%
Asian and Pacific Islander languages	0.4%	1.4%
Other languages	0.2%	0.6%
Speak English less than “very well”	0.3%	2.3%

Source: U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates. Service-area percentages were calculated from combined counts for all 15 municipalities.

Housing. Housing affordability, stability, and physical condition can have significant effects on health. Households that spend a large share of their income on housing may have fewer resources available for food, health care, transportation, education, and other essential needs. High housing costs can also contribute to housing instability, overcrowding, deferred maintenance, and difficulty finding housing that meets a household’s needs. Physical housing conditions may also create health risks. Inadequate ventilation and moisture can contribute to mold and pest exposure, while older or poorly maintained housing may increase the risk of lead exposure or other environmental hazards. The absence of complete plumbing or kitchen facilities can create additional challenges related to sanitation, food safety, and access to nutritious meals.

The New London Hospital service area has a higher rate of homeownership than New Hampshire overall. Approximately 85.1% of occupied housing units in the service area are owner-occupied, compared with 72.8% statewide. The service area also has a substantially larger share of vacant housing units, at 31.7% compared with 14.3% statewide. The available data does not identify whether these units are vacant because they are seasonal or recreational properties, available for rent or sale, or vacant for another reason.

Housing cost burden remains a concern, particularly for renters. Approximately 40.7% of service-area renters spend 30% or more of their household income on rent and related housing costs. Although this is lower than the statewide rate of 48.2%, it represents about two of every five renter households. Among homeowners, 24.1% spend 30% or more of their income on housing costs, similar to the statewide rate of 24.8%. Housing cost burden varies across municipalities, although town-level renter estimates should be interpreted cautiously because some communities have relatively few renter households.

Table 12: Housing

Housing Characteristic	New London Hospital Service Area	New Hampshire
Occupied housing units	68.3%	85.7%
Vacant housing units	31.7%	14.3%
Owner-occupied units	85.1%	72.8%
Renter-occupied units	14.9%	27.2%
Owner households spending 30% or more of income on housing	24.1%	24.8%
Renter households spending 30% or more of income on housing	40.7%	48.2%
Occupied units lacking complete kitchen facilities	0.7%	0.7%

Source: U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates, DP04. Service-area percentages were calculated from combined counts for all 15 municipalities. Note: The U.S. Department of Housing and Urban Development generally considers a household cost-burdened when it spends 30% or more of its income on housing costs. Housing-cost calculations exclude units for which cost burden could not be computed.

The age of housing can have implications for health and safety because construction materials, building standards, ventilation systems, plumbing, energy efficiency, and accessibility features have changed over time. Older homes may be more likely to contain lead-based paint or require repairs and modifications, although the age of a structure alone does not indicate that it is unsafe or in poor condition.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, 53.2% of housing units in the New London Hospital service area were built in 1979 or earlier, compared with 51.5% statewide.³ Approximately one in five service-area housing units was built in 1939 or earlier.

The age of housing varies considerably across the service area. The percentage of housing units built in 1979 or earlier ranges from 30.7% in Grantham to 70.4% in Newport. Goshen, Sutton, and Bradford also have comparatively large proportions of older housing, with more than 60% of housing units in each community built in 1979 or earlier.

³ The use of lead paint and asbestos-containing materials, including pipe and block insulation, were banned in 1978.

Transportation. Reliable transportation supports access to employment, health care, food, education, social services, and community activities. Limited transportation options can make it more difficult for residents to meet essential needs, maintain independence, and participate in community life. Transportation barriers may be particularly significant in rural communities where services are geographically dispersed and alternatives to driving are limited.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, 3.2% of households in the New London Hospital service area have no vehicle available, compared with 4.6% statewide. This represents an estimated 426 service-area households. The percentage is highest in Danbury at 7.6%, followed by Newport at 6.4% and Washington at 5.8%.

Workers in the service area rely heavily on private vehicles. Approximately 75.0% drive alone to work and another 7.7% carpool. Only 0.1% use public transportation to commute, compared with 0.5% statewide. The combination of high reliance on private vehicles and very limited use of public transportation underscores the importance of alternative transportation options for residents who do not drive or have access to a vehicle.

Table 13: Transportation

Transportation Characteristic	New London Hospital Service Area	New Hampshire
Households with no vehicle available	3.2%	4.6%
Workers who drive alone	75.0%	72.0%
Workers who carpool	7.7%	7.0%
Workers who use public transportation	0.1%	0.5%
Workers who walk to work	2.7%	2.3%
Workers who work from home	12.9%	16.8%

Source: U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates. Service-area percentages were calculated from combined counts for all 15 municipalities. Note: Vehicle availability is reported for occupied households. Commuting measures are reported for workers age 16 and older and do not capture transportation used by residents who are not employed or commuting to work.

Disability Status. The U.S. Census Bureau identifies disability based on six types of functional difficulty: hearing, vision, cognitive, ambulatory, self-care, and independent living. These include deafness or serious difficulty hearing; blindness or serious difficulty seeing; difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition; serious difficulty walking or climbing stairs; difficulty dressing or bathing; and difficulty completing errands alone because of a physical, mental, or emotional condition. A person reporting one or more of these difficulties is classified as having a disability.

According to the U.S. Census Bureau’s 2020–2024 American Community Survey 5-year estimates, 12.8% of the New London Hospital service area’s civilian noninstitutionalized population has at least one disability, compared with 13.3% statewide. Disability prevalence increases with age in both the service area and New Hampshire. Approximately 23.3% of service-area residents age 65 and older have a disability, compared with 28.5% of older adults statewide.

Disability prevalence varies considerably across the service area. Overall estimates range from 5.1% in Grantham to 21.6% in Goshen. Washington, Danbury, and Newport also have disability rates above the service-area average. These differences may affect the types and levels of accessible health care, transportation, housing, and community-based supports needed within individual municipalities.

Table 14: Population with a Disability

Age Group	New London Hospital Service Area	New Hampshire
Total civilian non-institutionalized population with a disability	12.8%	13.3%
Under age 18 with a disability	5.4%	5.1%
Ages 18-64 with a disability	10.0%	10.9%
Age 65 and older with a disability	23.3%	28.5%

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

2. Access to Care

Access to care refers to an individual’s ability to obtain appropriate health services when they are needed. Access is shaped by multiple factors, including insurance coverage and affordability, provider availability and capacity, appointment wait times, transportation and geographic proximity, and the extent to which services are accessible, culturally responsive, and appropriate for the population’s needs. Barriers in any of these areas can delay needed care, reduce the use of preventive services, and contribute to poorer health outcomes.

Insurance Coverage. Health insurance coverage can affect whether individuals obtain preventive services, seek care when health concerns arise, and receive ongoing treatment for chronic conditions. People without insurance may delay or forgo needed care because of cost, which can contribute to poorer health outcomes and greater reliance on emergency services. However, insurance coverage alone does not always ensure consistent access to care, as changes in health plans, provider networks, and covered services can create additional barriers for insured residents. This is particularly relevant for older adults in New Hampshire, where the Medicare Advantage market is undergoing significant changes in 2026. According to the New Hampshire Insurance Department, major carriers are withdrawing from the market or reducing their plan offerings and service areas, affecting approximately 77,000 Medicare beneficiaries statewide. These changes may require affected residents to select new coverage and confirm that their existing providers and prescription medications remain covered, creating the potential for disruptions in continuity of care.

According to the U.S. Census Bureau's 2020–2024 American Community Survey 5-year estimates, 94.8% of the New London Hospital service-area population has health insurance. The service-area uninsured rate is 5.2%, nearly identical to the statewide rate of 5.3%. Among residents under age 19, the uninsured rate is 1.8%, compared with 3.4% statewide.

The service area has a higher percentage of residents with public health insurance coverage than New Hampshire overall, at 38.6% compared with 32.8%. Its larger proportion of older adults may contribute to this difference. Conversely, 72.8% of service-area residents have private insurance, compared with 76.3% statewide.

Insurance coverage varies substantially across the service area. Springfield and Danbury have the highest estimated uninsured rates, at 16.8% and 16.2%, respectively. Goshen, Newport, and Washington also have uninsured rates above the service-area and statewide averages. Since some municipalities have small populations, town-level estimates should be interpreted cautiously.

Table 15: Health Insurance Coverage

Area	No health insurance	Private coverage	Public coverage
Andover	1.8%	76.8%	39.2%
Bradford	3.3%	75.5%	38.8%
Croydon	6.5%	65.4%	40.5%
Danbury	16.2%	62.3%	42.8%
Goshen	9.1%	53.1%	53.2%
Grantham	2.6%	85.3%	25.6%
Lempster	3.4%	68.0%	43.9%
New London	1.4%	83.4%	38.0%
Newbury	3.9%	82.2%	28.4%
Newport	8.0%	63.0%	43.5%
Springfield	16.8%	56.9%	37.6%
Sunapee	1.5%	64.8%	49.8%
Sutton	5.7%	79.0%	31.1%
Washington	7.1%	75.3%	40.0%
Wilmot	3.3%	82.6%	29.7%
NLH Hospital Service Area	5.2%	72.8%	38.6%
New Hampshire	5.3%	76.3%	32.8%

Source: U.S. Census Bureau, 2020–2024 American Community Survey 5-Year Estimates. Service-area percentages were calculated from combined counts for all 15 municipalities. Note: Private and public insurance categories are not mutually exclusive because a person may have more than one type of coverage.

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. In the Greater Sullivan region, about 15% of respondents to the NH Behavioral Risk Factor Survey reported being unable to see a doctor because of cost.

Table 16: Could Not See a Doctor Due to Cost

Area	Percent of Population Who Could Not See a Doctor because of Cost
Greater Sullivan Public Health Region	15.1%
New Hampshire	14%

Source: NHDHHS, Behavioral Risk Factor Surveillance System 2024

Provider Capacity. Access to health care depends in part on whether a community has enough providers to meet the population’s needs. Population-to-provider ratios offer one measure of provider availability. Higher ratios indicate that each provider potentially serves more residents and may reflect more limited capacity, although these measures do not account for differences in provider workloads, acceptance of new patients, insurance participation, or residents seeking care outside their county.

Provider capacity differs substantially between the two counties that contain New London Hospital service-area municipalities. Merrimack County compares favorably with New Hampshire overall. The county has fewer residents per primary care physician and mental health provider than the state and the same population-to-dentist ratio.

Sullivan County has more limited provider capacity across all three categories. The county has one primary care physician for every 1,630 residents, compared with one for every 1,160 residents statewide. The difference is especially pronounced for dental care, with one dentist for every 2,590 Sullivan County residents, more than twice the statewide ratio of 1,260 residents per dentist. Sullivan County also has one mental health provider for every 440 residents, compared with one for every 240 residents statewide.

These findings suggest that provider availability may present a greater access challenge for service-area residents in Sullivan County, particularly for dental and mental health services. Since the data are reported at the county level, they may not fully reflect provider availability within individual municipalities or the extent to which residents obtain care across county boundaries.

Table 17: Provider to Population Ratios

Area	Ratio of Population to Primary Care Physicians	Ratio of Population to Dentists	Ratio of Population to Mental Health Providers*
Merrimack County	980:1	1,260:1	170:1
Sullivan County	1,630:1	2,590:1	440:1
New Hampshire	1,160:1	1,260:1	240:1

*Source: Found through County Health Rankings; Area Health Resource File/American Medical Association, 2023-2024, US Department of Health and Human Services; *Source: CMS, National Provider Identifier Downloadable File, 2024*

Table 18 displays the percentage of NH adults who self-reported not having a primary care provider (PCP). About 1 in 6 residents (16%) of the Greater Sullivan region responded on the NH Behavioral Risk Factor survey that they do not have a ‘personal doctor or health care provider’.

Table 18: No Primary Care Provider

Area	Percent of Population (18+) Without a PCP
Greater Sullivan Public Health Region	15.8%
New Hampshire	11.5%

Data Source: NHDHHS, Behavioral Risk Factor Surveillance System 2019

Travel Time. The NH State Office of Rural Health (SORH) classifies Public Health Network regions throughout the state as rural or non-rural including the Greater Sullivan PHN, which is classified as rural. The SORH has also reported that health disparities exist between rural and non-rural populations as measured by select primary care-associated health indicators including primary care access.⁴ One measure of access to primary care is travel time to health care visits. As displayed by the table below, about twice as many primary care visits for rural populations – including for residents of the Greater Sullivan region - require one-way travel time of 30 minutes or more compared to non-rural populations. Among the 13 PHN regions across the state, the Greater Sullivan region had the third highest percentage on this measure after the Winnepesaukee and Carroll County regions.

⁴ Annual Report on the Health Status of Rural Residents and Health Workforce Data Collection, NH State of Rural Health and Primary Care, December 2022.

Table 19: Travel Time to Primary Care

Area	Percentage of primary medical care visits with travel times greater than 30 minutes, one way
Greater Sullivan Public Health Region	30.8%
All Rural New Hampshire	27.5%
All Non-Rural New Hampshire	15.3%

Source: NHDHHS, Office of Rural Health and Primary Care, 2019 data

Preventable Hospital Stays. Preventable hospital stays are hospitalizations for conditions that can often be managed effectively in outpatient settings, such as diabetes, hypertension, asthma, and chronic obstructive pulmonary disease. Higher rates of hospitalization for these ambulatory care-sensitive conditions may indicate challenges related to access, availability, continuity, or quality of primary and outpatient specialty care. This measure is reported for Medicare enrollees.

Sullivan County had 2,686 preventable hospital stays per 100,000 Medicare enrollees, approximately 6% higher than the New Hampshire rate of 2,528. Merrimack County had a lower rate of 2,258 preventable hospital stays per 100,000 Medicare enrollees, approximately 11% below the statewide rate. These results suggest that preventable hospitalization rates vary across the New London Hospital service region, with Sullivan County experiencing a somewhat higher rate than Merrimack County and New Hampshire overall.

Table 20: Preventable Hospital Stays

Area	Number of hospital stays for ambulatory care sensitive conditions per 100,000 Medicare enrollees
Merrimack County	2,258
Sullivan County	2,686
New Hampshire	2,528

Source: Centers for Medicare & Medicaid Services; accessed through County Health Rankings, 2023 data

Prevention quality indicators (PQIs) are a similar measure of acute (e.g., bacterial pneumonia, urinary tract infection) and chronic (e.g., diabetes, COPD or asthma) inpatient admissions that could 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. Interestingly, the rates of PQIs are statistically higher in non-rural NH compared to rural regions of NH. In other words, non-rural residents are more likely to be admitted to the hospital for preventable medical complications than their rural counterparts. As displayed by the table below, PQI rates for the Greater Sullivan region are generally higher than rates observed in all of rural NH, while the chronic

composite and overall PQI composite measures are lower (better) than observed for non-rural regions of the state.

Table 21: Prevention Quality Indicators

Preventive Quality Indicators: Inpatient Admissions (age-adjusted per 100,000, NH adults 18+)			
Area	Overall Composite	Acute Composite	Chronic Composite
Greater Sullivan Public Health Region	779.3	219.8	559.5
All Rural New Hampshire	646.9	165.7	481.2
All Non-Rural New Hampshire	837.7	208.4	629.3

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

Dental Care Utilization. Routine dental care supports oral health and can help prevent or identify conditions such as tooth decay, gum disease, and oral cancer. In 2024, 65.6% of adults in the Greater Sullivan Public Health Region reported visiting a dentist, dental hygienist, or dental clinic within the past year, compared with 72.2% of adults across New Hampshire. Greater Sullivan adults were also somewhat more likely to report that their last dental visit occurred two to five years ago, at 10.7% compared with 9.1% statewide.

Table 22: Dental Visits

Area	Percent of adults who visited a dentist or dental clinic in the past year	Percent of adults whose last visit to a dentist or dental clinic was between 2-5 years ago
Greater Sullivan Public Health Region	65.6%	10.7%
New Hampshire	72.2%	9.1%

Source: NHDHHS, Behavioral Risk Factor Surveillance System 2024

Hospital data provide further evidence of potential unmet dental care needs in the region. In 2024, the age-adjusted rate of emergency department visits for non-traumatic dental conditions was 942.2 per 100,000 residents in Sullivan County and 801.1 per 100,000 in Merrimack County. Both rates were significantly higher than the statewide rate of 574.8 per 100,000. The Sullivan County rate was approximately 64% higher than the state rate, while the Merrimack County rate was approximately 39% higher. Together, the lower prevalence of recent dental visits and elevated use

of emergency departments for dental conditions point to potential barriers to obtaining timely preventive and routine dental care.

Table 23: ED Dental Visits

Area	Emergency Department visits for non-traumatic dental condition; Age-adjusted rate per 100,000
Merrimack County	801.1**
Sullivan County	942.2**
New Hampshire	574.8

Source: NH Hospital Discharge Data, 2024

**Regional rates are significantly different and higher than the state rate

3. Health Promotion and Disease Prevention

Health promotion and disease prevention include the behaviors, community conditions, and preventive services that help people maintain health, reduce the risk of disease and injury, and manage existing health conditions. Regular physical activity, nutritious food, avoiding tobacco, and limiting alcohol use can reduce the risk of chronic diseases such as heart disease, cancer, and diabetes. However, people’s ability to adopt and sustain healthy behaviors is also shaped by factors such as access to affordable food, safe places for physical activity, health information, supportive programs, and preventive healthcare services.

This section examines both individual behaviors and the environmental conditions that support health and well-being. It also presents indicators related to clinical prevention, including recommended screenings that can identify disease or risk factors at earlier, more treatable stages. Cancer and cardiovascular screening measures introduced in this section are discussed further in later sections addressing related population health outcomes.

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 1 in 10 people in NH and in the service area experienced food insecurity in the past year, defined as the percentage of households unable to provide adequate food for one or more household members due to lack of resources.

Table 24: Food Insecurity

Area	Number of residents experiencing food insecurity	Percent of residents experiencing food insecurity
Merrimack County	17,180	11.0%
Sullivan County	5,380	12.3%
New Hampshire	158,000	11.2%

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

The Supplemental Nutrition Assistance Program (SNAP) helps eligible households purchase food and can reduce barriers to maintaining a nutritious diet. According to the 2020–2024 American Community Survey, 4.3% of households in the New London Hospital service area received SNAP benefits during the previous 12 months, compared with 6.1% of households statewide.

The characteristics of households receiving SNAP also differ between the service area and New Hampshire overall. Approximately 31% of service-area SNAP households included children under age 18, compared with 44% statewide. In contrast, more than half of service-area SNAP households included at least one person age 60 or older, compared with about 41% across New Hampshire. These findings highlight the importance of ensuring that nutrition assistance and food-access initiatives address the needs of older residents, who represent a substantial proportion of households receiving SNAP in the service area.

Table 25: Households Receiving SNAP Benefits

Area	Percent of All Households Receiving SNAP	With Children Under 18 (% of total households receiving SNAP)	With one or more people in the household 60 years and over (% of total households receiving SNAP)
NLH Service Area	4.3%	30.9%	51.9%
New Hampshire	6.1%	43.6%	40.5%

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

Physical Inactivity. Regular physical activity supports cardiovascular health, mobility, mental well-being, and the prevention and management of chronic disease. Opportunities to be physically active are influenced by individual circumstances as well as access to safe, convenient, and affordable places for recreation and exercise.

Approximately 24% of adults in Sullivan County reported no leisure-time physical activity during the past month, compared with 20% in Merrimack County and 19% across New Hampshire. Sullivan County’s rate was five percentage points higher than the statewide rate, while Merrimack County was similar to the state overall.

Table 26: Physical Activity

Area	Percent of adults reporting no leisure-time physical activity (age-adjusted)
Merrimack County	20%
Sullivan County	24%
New Hampshire	19%

Source: BRFSS via County Health Rankings, 2023

Influenza and Pneumonia Vaccination. Vaccination is an important preventive health measure that can reduce the risk of serious illness, complications, hospitalization, and death from influenza and pneumococcal disease. These self-reported measures also provide insight into the reach of preventive healthcare and opportunities for continued education and outreach.

In 2024, 52.7% of adults in the Greater Sullivan Public Health Region reported receiving an influenza vaccine during the previous 12 months, compared with 40.4% of adults statewide. Regional influenza vaccination coverage was therefore approximately 12 percentage points higher than the New Hampshire rate. Among adults age 65 and older, 71.7% in Greater Sullivan reported ever receiving a pneumococcal vaccination, compared with 76.4% statewide. While influenza vaccination was more common in the region than across the state, pneumococcal vaccination among older adults was approximately five percentage points lower.

Table 27: Vaccinations

Area	Had Flu Vaccine in Past 12 Months (all adults)	Ever Had a Pneumococcal Vaccination, ages 65+
Greater Sullivan Public Health Region	52.7%	71.7%
New Hampshire	40.4%	76.4%

Source: NHDHHS, Behavioral Risk Factor Surveillance System, 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 – not just for individuals, but for families and communities. Detrimental effects range from physical health issues, both acute and chronic; mental health disorders such as depression, anxiety, and psychosis; addiction and dependence; destructive social conditions such as family dysfunction, lower prosperity, domestic violence, social isolation, and more; impaired cognitive functioning including memory, attention, and decision-making deficits; financial strain; and much more.

Alcohol. Excessive alcohol use includes both binge drinking and heavy drinking and can increase the risk of liver disease, certain cancers, cardiovascular disease, mental health conditions, and unintentional injuries. Binge drinking is generally defined as consuming five or more drinks on one occasion for men or four or more for women. Heavy drinking is defined as consuming 15 or more drinks per week for men or eight or more for women.

In 2024, 14.3% of adults in the Greater Sullivan Public Health Region reported binge drinking, slightly below the New Hampshire rate of 15.6%. Regional estimates by sex were suppressed because of small sample sizes. Statewide, binge drinking was more commonly reported by men than women, at 20.2% and 11.0%, respectively. The most recent regional estimate for heavy drinking, from 2022, was 9.3% in Greater Sullivan, compared with 7.8% statewide. These findings show a mixed pattern, with somewhat lower reported binge drinking but somewhat higher reported heavy drinking in the region.

Table 28: Alcohol Misuse

Area	Binge Alcohol Use			Heavy Alcohol Use, All Adults*
	All Adults	Adult females	Adult males	
Greater Sullivan Public Health Region	14.3%	**	**	9.3%
New Hampshire	15.6%	11.0%	20.2%	7.8%

Source: NH DHHS Behavioral Risk Factor Surveillance System, 2024, *2022 **Data suppressed due to small numbers

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.

In the Greater Sullivan Public Health Region, the percentage of high school aged youth who self-report recent binge drinking is 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 29: Youth Alcohol Use

Area	High School Students		
	Currently Drink Alcohol (in past 30 days)	Reported Binge Drinking (in past 30 days)	Think it would be very easy to get alcohol
Greater Sullivan Public Health Region	21.7%	11.2%	26.8%
New Hampshire	23.1%	11.6%	28.5%

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

Table 30: Youth Perceptions on Acceptance of Alcohol Use

Area	High School Students: Approve/Strongly Approve of someone their age having one or two drinks of alcohol nearly every day		
	Total	Female	Male
Greater Sullivan Public Health Region	6.7%	4.8%	8.4%
New Hampshire	6.1%	4.5%	7.6%

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

Prescription Drugs & Opioids. New Hampshire has been significantly affected by the prescription drug and opioid crisis, much like many other states in the United States, experiencing a surge in opioid-related addiction and overdose deaths. This crisis involves the misuse, addiction, and overdose of prescription opioids, as well as illicit opioids like heroin and fentanyl. Several factors have contributed to the crisis, including:

- **Over-prescription of Opioids:** The misuse of prescription drugs, particularly prescription pain relievers, poses 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 opioids like heroin. Moreover, the rise of synthetic opioids like fentanyl, which is much more potent than other opioids, has contributed to a spike in overdose deaths.
- **Lack of Treatment and Support:** 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. This has made it difficult for individuals struggling with opioid addiction to receive the help they need.

- **Stigma and Misunderstanding:** Opioid addiction is often accompanied by stigma and misconceptions, deterring individuals from seeking help and contributing to an environment where people with addiction issues are not receiving the support they require.

Prescription pain medications can play an important role in managing acute or chronic pain when used as directed. However, taking medication prescribed to someone else can increase the risk of adverse reactions, dependence, and overdose.

In 2019, 23.6% of adults in the Greater Sullivan Public Health Region reported taking prescription pain medication that had been prescribed specifically to them during the previous 12 months, compared with 22.2% of adults statewide. In 2021, 1.4% of New Hampshire adults reported taking prescription pain medication that had not been prescribed specifically to them. The corresponding Greater Sullivan estimate was suppressed because of the small number of responses, so a reliable regional comparison is not available.

Table 31: Prescription Use

Area	In the past 12 months, have taken prescription pain medication prescribed specifically for them	In past 12 months, has taken prescription pain medication that was NOT prescribed specifically for them (2021)
Greater Sullivan Public Health Region	23.6%	**
New Hampshire	22.2%	1.4%

Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2021 **Data suppressed due to small numbers

The NH Youth Risk Behavior Survey monitors a variety of health and wellness indicators including drug use, behaviors, and perceptions among NH high school students. Below are selected results from the 2023 YRBS regarding prescription drugs and other opioids.

About 8% of high school students in the Greater Sullivan Public Health Region reported having ever taken a prescription drug without a doctor's prescription and about 6% reported having done so at least once in the 30 days prior to the survey administration. About 3% of high school students reported having used cocaine in the past 30 days.

Table 32: Youth Prescription Drug Use

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
Greater Sullivan Public Health Region	7.9%	5.8%
New Hampshire	8.9%	5.2%

Source: NH Youth Risk Behavior Survey, 2023

Table 33: Other Youth Substance Use

Area	High School Students		
	Used Cocaine, in past 30 days	Every Used Heroin	Ever Used Inhalants
Greater Sullivan Public Health Region	3.4%	2.7%	8.4%
New Hampshire	3.0%	2.2%	7.1%

Source: NH Youth Risk Behavior Survey, 2023

Marijuana. The tables below explore data from the 2023 Youth Risk Behavior Survey. About 1 in 5 students self report having used marijuana in the past 30 days prior to survey administration. A similar proportion of high school age youth report having been offered, sold, or given an illegal drug on school property.

Table 34: Youth Marijuana Use

Area	High School Students	
	Currently use marijuana	Ever used synthetic marijuana
Greater Sullivan Public Health Region	19.5%	9.3%
New Hampshire	19.8%	9.6%

Source: NH Youth Risk Behavior Survey, 2023

Table 35: Youth Marijuana Use and Solicitation

Area	High School Students	
	Tried marijuana for the first time before age 13 years	Were offered, sold, or given an illegal drug on school property
Greater Sullivan Public Health Region	6.5%	19.4%
New Hampshire	4.6%	19.9%

Source: NH Youth Risk Behavior Survey, 2023

Cigarette Smoking / Tobacco Use. Tobacco use is a leading preventable cause of illness and death and contributes to lung cancer, respiratory disease, cardiovascular disease, and other chronic health conditions. Smoking during pregnancy can also create serious short- and long-term risks for both the pregnant person and developing child.

In 2024, 18.3% of adults in the Greater Sullivan Public Health Region reported currently smoking cigarettes, compared with 9.1% of adults across New Hampshire. The regional rate was approximately twice the statewide rate, identifying cigarette smoking as a notable health concern in Greater Sullivan. By comparison, the percentage of adults who had ever used an e-cigarette or other electronic vaping device was nearly identical in the region and statewide, at 25.5% and 25.2%, respectively, based on the most recent available data from 2020. This measure reflects lifetime use and does not indicate how many adults currently vape.

Table 36: Adult Cigarette and Vape Use

Area	Percent of Adult Population Who Currently Smokes Cigarettes	Percent of adult population who have ever used an e-cigarette or electronic vaping device*
Greater Sullivan PHR	18.3%	25.5%
New Hampshire	9.1%	25.2%

Source: NHDHHS, Behavioral Risk Factor Surveillance System, 2024; *2020

As displayed by the table below, about 16% of high school students report current use cigarettes or of an electronic vapor product in the past 30 days.

Table 37: Youth Cigarette and Vape Use

Area	Percent of High School Students Who Currently Smoke Cigarettes	Percent of High School Students Who Currently Use an Electronic Vapor Product
Greater Sullivan Public Health Region	4.8%	16.3%
New Hampshire	3.9%	16.7%

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

Smoking during pregnancy increases the risk of complications such as preterm birth, low birth weight, impaired fetal growth, and infant health problems. New Hampshire birth certificate data indicate that smoking during pregnancy remains a particular concern in the Greater Sullivan Public Health Region.

In 2024, smoking during pregnancy was reported for 11.2% of births in Greater Sullivan, compared with 2.9% statewide. The regional percentage was nearly four times the New Hampshire rate. Among births associated with smoking during pregnancy, 15.0% were preterm in Greater Sullivan, similar to the statewide percentage of 14.2%. These findings highlight the importance of accessible, nonjudgmental tobacco-cessation support before, during, and after pregnancy.

Table 38: Tobacco Use and Pregnancy

Area	Percent of Female Population that Reported Smoking During Pregnancy (all ages)	Percent of preterm births associated with smoking during pregnancy
Greater Sullivan Public Health Region	11.2%	15.0%
New Hampshire	2.9%	14.2%

Source: NH Vital Records Birth Certificate Data, 2024

Pregnancy

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutritious foods, nutrition education, breastfeeding support, and healthcare and social-service referrals to eligible pregnant and postpartum participants, infants, and children under age five. Monitoring birth outcomes among WIC participants can help identify opportunities to strengthen prenatal nutrition, healthcare access, and other supports that contribute to healthy pregnancies and infant development.

In 2024, 10.0% of full-term births among WIC participants in Merrimack County had low or very low birth weight, compared with 9.0% statewide and 6.4% in Sullivan County. Preterm births followed a

different pattern. Approximately 8.3% of births among WIC participants in Sullivan County occurred before 37 weeks, compared with 5.4% statewide and 5.0% in Merrimack County. These findings highlight different maternal and infant health concerns within the region, with full-term low birth weight more prevalent in Merrimack County and preterm birth more prevalent in Sullivan County.

Table 39: Birthweight and Preterm Births

Area	Full term low or very low birthweight among WIC enrolled pregnant women	Preterm birth (less than 37 weeks) among WIC enrolled pregnant women
Merrimack County	10.0%	5.0%
Sullivan County	6.4%	8.3%
New Hampshire	9.0%	5.4%

Source: NH Pregnancy Nutrition Surveillance System (PNSS), 2024

Prenatal Care. Prenatal care is the medical care and guidance provided to pregnant individuals before the birth of their baby. It plays a crucial role in ensuring the health and well-being of both the pregnant person and the baby. Prenatal care involves regular visits to healthcare professionals, such as obstetricians, midwives, and other medical experts, to monitor the progress of the pregnancy, address any potential complications, and provide essential guidance. 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.

The table below indicates the percentage of females who have given birth who received no or late prenatal care. Late prenatal care refers to the initiation of prenatal medical care after the first trimester. Over the time period 2017 to 2021, the Greater Sullivan Public Health Region had a lower (better) percentage of females who received no or late prenatal care of any region (2.0%) compared to the state overall (3.5%).

Table 40: Late or No Prenatal Care

Area	Percent of Female Population that Received No or Late Prenatal Care
Greater Sullivan Public Health Region	2.0%*
New Hampshire	3.5%

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

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

Teen Birth Rate. Teen birth rates are influenced by access to comprehensive health education, contraception, confidential reproductive healthcare, and broader social and economic conditions. Pregnant and parenting adolescents may also need additional support to continue their education and access healthcare, childcare, housing, and other essential resources.

From 2020 through 2024, the birth rate among females ages 15–19 in the Greater Sullivan Public Health Region was 11.1 births per 1,000, more than twice the New Hampshire rate of 4.6. Regional rates exceeded statewide rates for both age groups. Among females ages 15–17, the Greater Sullivan rate was 5.2 per 1,000, compared with 1.76 statewide. Among those ages 18–19, the regional rate was 26.2 per 1,000, compared with 9.8 statewide. Although birth rates were highest among older teens, the regional rate was elevated relative to New Hampshire across both age groups.

Table 41: Teen Births

Area	Teen Birth Rate (per 1,000 female teens)		
	Total (ages 15-19)	Ages 15-17	Ages 18-19
Greater Sullivan Public Health Region	11.1	5.2	26.2
New Hampshire	4.6	1.76	9.80

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 the NH Division of Children, Youth and Families (DCYF), as well as the rate of children in temporary, out of home placement. As displayed by the table below, the rates of child maltreatment, both screened-in and substantiated were higher in Sullivan County than in Merrimack County or across the NH overall.⁵

Table 42: Child Maltreatment

Area	Substantiated child maltreatment victims, rate per 1,000 children under age 18	Screened-in reports of child maltreatment, rate per 1,000 children under age 18
Merrimack County	5.9	73.1
Sullivan County	6.5	124.9
New Hampshire	4.7	63.0

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

⁵ 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.

Sullivan County also has a greater rate of children ages 0 to 17 who have entered foster care when compared to Merrimack County and the state.

Table 43: Foster Care Entry

Area	Foster Care Entries, rate per 1,000 children
Merrimack County	3.5
Sullivan County	5.7
New Hampshire	2.7

Source: U.S Department of Human Services, Children's Bureau, Adoption and Foster Care Analysis and Reporting System (AFCARS), 2023

Childhood Blood Lead Level Testing. Lead is a toxic metal that can have severe and long-lasting effects on children’s health and development. Ensuring children are tested for blood lead levels is crucial, especially given children, particularly infants and young children, are more vulnerable to the harmful effects of lead, as their bodies are still developing. Lead can interfere with the growth and development of certain organs, including the brain and nervous system. Lead exposure can also have significant negative effects on neurological and cognitive development. Even low levels of lead exposure have been associated with learning disabilities, lower IQ scores, attention deficits, and behavioral problems. Early detection and intervention are essential to minimize the potential for long-term cognitive and developmental impairments. Efforts to reduce lead exposure and prevent elevated blood lead levels include measures such as identifying and remediating lead hazards in the environment, promoting lead-safe practices, improving nutrition to mitigate lead's effects, and advocating for the removal of lead from consumer products and infrastructure.

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. New Hampshire's ‘action level’ under state statute a blood lead level of 5 micrograms per deciliter (µg/dL) for a child 72 months and younger. When a child has a blood lead level of 5µg/dL or higher, this triggers nurse case management and an environmental investigation. In 2021, the Centers for Disease Control established a screening reference level for blood lead in young children at 3.5 µg/dL.

In 2024, the NH Healthy Homes & Lead Poisoning Prevention Program reported that nearly 30% of all NH children aged 6 years and under - and 36% in the Greater Sullivan Public Health Region - had been tested for elevated BLL. Of the children tested in the Greater Sullivan region, 38 of the 399 children (11%) had BLL of 3.5µg/dL or higher and 41 children (12%) had EBLL of 5µg/dL or higher. These percentages were substantially higher than the state percentages of 5% and 6% respectively.

Table 44: Child Blood Lead Levels

Area	Percent Tested	% EBL 3.5µg/dL or higher	% EBL 5µg/dL or higher
Greater Sullivan Public Health Region	36%	11%	12%
New Hampshire	29%	5%	6%

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 child birth as major contributors to or causes of death and disease. Chronic diseases, such as heart disease, cancer, respiratory disease and diabetes, along with injury and violence, are now the primary burdens on the health and wellbeing of individuals, families and communities. In addition to considering the absolute 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. Body weight is shaped by a complex combination of factors, including access to nutritious food, opportunities for physical activity, income, stress, sleep, health conditions, medications, and genetics. Higher body mass index (BMI) is associated with increased risk for conditions such as cardiovascular disease, type 2 diabetes, joint problems, and some cancers. However, BMI is a population-level screening measure and does not provide a complete assessment of an individual's health.

Among adults, overweight is defined as a BMI from 25.0 to 29.9, while obesity is defined as a BMI of 30.0 or higher. In 2024, 30.0% of Greater Sullivan adults were classified as having obesity, similar to the New Hampshire rate of 31.1%. An additional 44.2% were classified as overweight, compared with 37.2% statewide. Combined, approximately 74% of Greater Sullivan adults were classified as overweight or having obesity, compared with 68% across New Hampshire. The regional difference was primarily attributable to the higher percentage of adults classified as overweight.

Among high school students, obesity is defined using age- and sex-specific BMI percentiles. In 2021, 18.3% of Greater Sullivan high school students were classified as having obesity, compared with 13.3% statewide. Regional percentages were higher for both female students, at 13.2% compared with 10.1% statewide, and male students, at 23.1% compared with 16.2%. Male students had higher percentages than female students in both the region and New Hampshire overall.

Table 45: Obese and Overweight

Area	Percent of adults who are obese	Percent of adults who are overweight
Greater Sullivan Public Health Region	30.0%	44.2%
New Hampshire	31.1%	37.2%

Source: NH DHHS Health Data Portal, BRFSS survey, 2024

Table 46: Obesity Among High School Students

Area	High School Students Considered Obese	Female High School Students	Male High School Students
Greater Sullivan Public Health Region	18.3%**	13.2%	23.1%**
New Hampshire	13.3%	10.1%	16.2%

Source: NH DHHS Health Data Portal, 2021 & NH Youth Behavior Risk Survey, 2021

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

Heart Disease. Heart disease is a major cause of illness and death and includes conditions such as coronary artery disease, heart attack, and heart failure. Risk is influenced by high blood pressure, high cholesterol, diabetes, tobacco use, physical inactivity, nutrition, family history, and other factors. Routine screening can identify high blood pressure and elevated cholesterol before they lead to more serious complications.

In 2023, 36.2% of adults in the Greater Sullivan Public Health Region reported that a health professional had told them they had high blood pressure, compared with 33.2% statewide. Most adults had received cholesterol screening within the previous five years, although the regional percentage was somewhat lower than the state rate, at 86.4% compared with 89.7%. These findings indicate a somewhat higher prevalence of diagnosed high blood pressure in the region alongside generally high, but slightly lower, cholesterol-screening coverage.

Table 47: Blood Pressure and Cholesterol

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
Greater Sullivan Public Health Region	36.2%	86.4%
New Hampshire	33.2%	89.7%

Source: NH DHHS Behavioral Risk Factor Surveillance System, 2023

Hospitalization data provide another measure of the burden of cardiovascular disease. Congestive heart failure occurs when the heart cannot pump blood effectively and often develops following other cardiovascular conditions, including long-term high blood pressure or coronary artery disease. In 2024, the Greater Sullivan rate of inpatient hospitalization for congestive heart failure was 3.0,

more than twice the New Hampshire rate of 1.3. The region also had a higher age-adjusted hospitalization rate for heart attack, at 136.1 per 100,000 residents compared with 121.9 statewide. Together, these findings suggest a greater burden of serious cardiovascular conditions requiring inpatient care in Greater Sullivan, particularly for congestive heart failure.

Table 48: Heart Disease

Area	CHF hospitalizations (inpatient) age-adjusted rate per 100,000	Heart attack hospitalizations (inpatient) age-adjusted per 100,000
Greater Sullivan Public Health Region	3.0	136.1
New Hampshire	1.3	121.9

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

Heart Disease and Stroke Mortality: 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 diseases, which happens when blood flow to a part of the brain stops, are the fifth leading cause of death in New Hampshire. The mortality rates for coronary heart disease and cerebrovascular disease in the region are higher in Greater Sullivan compared to the overall NH rates.

Table 49: Heart Disease Mortality

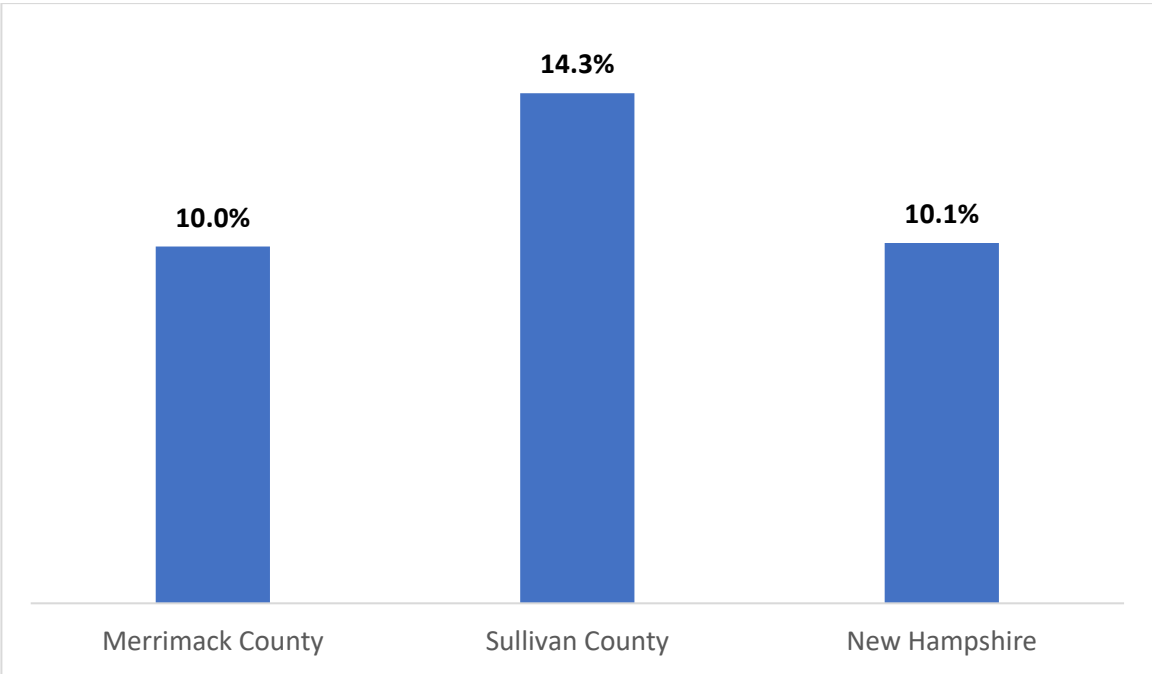
Area	Coronary Heart Disease Mortality (per 100,000 people, age-adjusted)	Cerebrovascular Disease Mortality (per 100,000 people, age-adjusted)
Greater Sullivan Public Health Region	81.8	33.5
New Hampshire	77.2	31.0

Source: NH Vital Records Death Certificate Data, 2024

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.

Prevalence. This indicator reports the percentage of adults who have ever been told by a doctor that they have diabetes. The percentage is higher in Sullivan County compared to both Merrimack County and the state of New Hampshire overall.

Figure 11: Percent of Adults Diagnosed with Diabetes (age-adjusted rates per 100,000)



Source: NH BRFSS, 2024

Diabetes-Related Hospitalization. As the number of those with diabetes has increased, diabetes related hospitalizations are increasing accordingly. Complications such as cardiovascular disease, kidney failure, amputations, and ketoacidosis frequently require hospitalization. The table below shows the age-adjusted rates of inpatient hospitalizations between 2020-2024 for diabetes-related discharges and diabetes mortality.

Table 50: Diabetes Hospitalizations and Mortality

Area	Diabetes-Related Hospital Discharges; age adjusted rate per 100,000	Diabetes mortality; age-adjusted rate per 100,000*
Greater Sullivan Public Health Region	1,405	No data
New Hampshire	1,361	19.6

Source: NH Uniform Healthcare Facility Discharge Dataset, 2020-2024 *NH Vital Records Death Certificate Data 2020-2024

Cancer. Cancer is the second leading cause of death in New Hampshire overall. Although not all cancers can be prevented, risk factors for some cancers can be reduced. It is estimated that about 42% of cancer cases and 45% of cancer deaths in the U.S. are linked to modifiable risk factors.⁶ These risk factors and health behaviors include tobacco use and secondhand smoke, body weight, alcohol consumption, a lack of physical activity, and poor nutrition. Cigarette smoking ranks as the highest risk factor, contributing to 19% of all cancer cases in the U.S. and nearly 29% of cancer deaths.

Cancer Screening. Cancer screening can identify some cancers at earlier stages, when treatment may be more effective, and certain screening tests can detect precancerous changes before cancer develops. Screening recommendations vary by cancer type, age, personal risk, and screening history.

Mammography was the strongest regional screening measure. In 2022, 92.3% of Greater Sullivan females ages 50–74 reported receiving a mammogram within the previous two years, significantly higher than the New Hampshire rate of 80.8%. The region had lower percentages for the other measures presented. In 2024, 74.0% of adults ages 50–75 were up to date with colorectal cancer screening, compared with 80.2% statewide. Approximately 79.1% of Greater Sullivan females ages 21–65 reported receiving a Pap test within the previous three years, compared with 84.1% across New Hampshire. Based on older data from 2018, 22.4% of Greater Sullivan males age 40 and older had received a PSA test within the previous two years, compared with 30.8% statewide. Because these measures use different populations, screening intervals, and reporting years, they should be interpreted separately.

Table 51: Cancer Screenings

Cancer Screening Type	Greater Sullivan PHR	New Hampshire
Colorectal cancer screening per USPSTF guidelines, age 50 to 75 (2024)	74.0%	80.2%
Females ages 50-74 who had a Mammogram in the past 2 years (2022)	92.3%*	80.8%
Females ages 21-65 who have had a pap test in the past 3 years	79.1%	84.1%
Males age 40+ who had a PSA test in the past 2 years+	22.4%	30.8%

*Data Sources: Behavioral Risk Factor Surveillance System (BRFSS) accessed via NH DHHS Wisdom, 2024
+accessed via NH WRQS, 2018*

**Rate is statistically different and higher than the overall NH rate*

⁶ Proportion and Number of Cancer Cases and Deaths Attributable to Potentially Modifiable Risk Factors in the United States; Farhad Islami et al. CA Can J Clin DOI, Jan;68(1):31-54.

Cancer Incidence. Cancer incidence measures the number of newly diagnosed cancer cases within a population. Age-adjusted rates allow comparisons between geographic areas with different age distributions, although incidence can also be influenced by screening practices and the detection of cancers at earlier stages.

From 2018 through 2022, the overall cancer incidence rate in the Greater Sullivan Public Health Region was 482.0 cases per 100,000 residents, compared with 447.7 statewide. Although the regional rate was higher, the difference was not statistically significant. Female breast cancer and prostate cancer had the highest incidence rates in the region, at 138.9 and 110.6 cases per 100,000, respectively.

Lung and bronchus cancer represented the most notable regional difference. The Greater Sullivan incidence rate was 67.7 cases per 100,000, significantly higher than the New Hampshire rate of 52.2. This regional rate was approximately 30% higher than the statewide rate. In contrast, the rate of female breast cancer diagnosed in situ was significantly lower in Greater Sullivan, at 16.8 per 100,000 compared with 32.1 statewide. Differences observed for the remaining cancer types were not statistically significant.

Table 52: Cancer Incidence, by Type

Cancer Incidence by Type per 100,000 people, age adjusted rate		
Cancer Type	Greater Sullivan PHR (2018-2022)	New Hampshire (2022)
Overall cancer incidence	482.0	447.7
Cancer Incidence by Type		
Breast (Female)	138.9	144.2
Breast (Female) In Situ	16.8*	32.1
Prostate (male)	110.6	119.4
Lung and Bronchus	67.7**	52.2
Colorectal	36.5	33.2
Melanoma of Skin	33.2	24.8
Uterus (female)	28.4	29.1
Bladder	28.2	22.4
Kidney and Renal Pelvis	15.7	15.1
Thyroid	15.6	13.5
Non-Hodgkin Lymphoma	16.7	18.1
Pancreas	12.6	13.3
Leukemia	12.8	13.9

Data Source: NH State Cancer Registry, 2018-2022

***Rate is statistically different and higher than the overall NH rate;*

**Rate is statistically different and lower than the overall NH rate; other rates not statistically different*

Cancer Mortality. Cancer mortality rates reflect several factors, including cancer incidence, stage at diagnosis, access to timely treatment, and treatment outcomes. From 2020 through 2024, the age-adjusted cancer mortality rate in the Greater Sullivan Public Health Region was 140.4 deaths per 100,000 people, compared with 136.5 per 100,000 statewide.

Among the cancer types shown, lung and bronchus cancer had the highest mortality rate in the region. Mortality rates for prostate and colorectal cancers were numerically higher in the Greater Sullivan region than statewide, while rates for female breast and pancreatic cancers were lower. However, neither the overall cancer mortality rate nor any of the site-specific rates differed significantly from the corresponding New Hampshire rates.

Table 53: Cancer Mortality, by Type

Cancer Mortality per 100,000 people, age adjusted		
Cancer Type	Greater Sullivan PHR (2020-2024)	New Hampshire (2024)
Overall cancer mortality (All Invasive Cancers)	140.4	136.5
Cancer Mortality by Type		
Lung and bronchus	31.2	29.4
Prostate (male)	20.9	15.8
Colorectal	12.3	11.2
Breast (female)	12.5	18.0
Pancreas	8.3	11.3
Esophagus	4.6	4.4
Ovary (female)	5.2	4.5

*Data Source: NH State Cancer Registry, 2020-2024
Regional rates are not significantly different than overall NH rates*

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 12% of adults responding to the Behavioral Risk Factor Survey from the Greater Sullivan Public Health Region reported they currently have asthma. This percentage is lower than the overall state estimate of 13%.

Table 54: Asthma Prevalence

Area	Percent of Children (ages 0 to 17) with Current Asthma	Percent of Adults (18+) with Current Asthma
Greater Sullivan Public Health Region	Not available	11.5%
New Hampshire	7.5%	12.8%

**Data Source: NH DHHS, Behavioral Risk Factor Surveillance System, 2024
Regional rate is not significantly different from the state rate.*

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 were significantly higher in the Greater Sullivan region than across the state overall during the 2020-2024 time frame.

Table 55: Asthma Hospitalizations

Area	Asthma Emergency Department Visits, age adjusted rate per 100,000	Asthma Inpatient Hospitalizations age adjusted rate per 100,000
Greater Sullivan Public Health Region	32.3**	2.6
New Hampshire	28.1	2.2

*NH Uniform Healthcare Facility Discharge Dataset, 2020-2024
**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.

Table 56 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 overdose. The rate of Unintentional Injury Mortality over the period 2020-2024 was higher in the region compared to the state overall.

Table 56: Unintentional Injuries

Area	Unintentional (accidental) Injury Mortality, all causes Age adjusted rate per 100,000
Greater Sullivan Public Health Region	75.0
New Hampshire	59.3

Source: NH Vital Records Death Certificate Data accessed through NH Health Wisdom 2020-2024

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

Older Adult Falls. Falls are a significant health concern for older adults and can lead to injury, loss of independence, and increased use of emergency and long-term care services. Many falls can be prevented by addressing home hazards, improving strength and balance, correcting vision problems, and reviewing medications that may increase fall risk.

In 2023, 29.3% of adults age 65 and older in the Greater Sullivan Public Health Region reported experiencing at least one fall during the previous 12 months, compared with 27.4% statewide. From 2020 through 2024, the region had 6,800.7 fall-related emergency department visits per 100,000 older adults. Although falls were common, the regional emergency department visit rate was significantly lower than the New Hampshire rate of 8,224.6 per 100,000.

Table 57: Older Adult Falls

Area	Percent of people age 65+ who report having experienced a fall in the past 12 months	Fall-related Emergency Dept. visits (per 100,000 people age 65 and older)
Greater Sullivan Public Health Region	29.3%	6,800.7*
New Hampshire	27.4%	8,224.6

Sources: NH Behavioral Risk Factor Surveillance System, 2023; NH Hospital Discharge Data Set for NH Residents, 2020-2024

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

Opioid Use-related Emergency Department Visits and Hospitalizations. The table below displays rates of hospitalization due to accidental overdose from opioid use. Opioid misuse includes prescription opioid pain relievers, heroin, and synthetic opioids such as fentanyl. The Greater Sullivan Public Health Region experienced a significantly higher rate of emergency department utilization due to opioid overdose compared to the state overall between 2020-2024.

Table 58: Opioid Hospitalizations

Area	Opioid Overdose Emergency Dept. visits; Age-adjusted rate per 100,000	Opioid Overdose Hospitalizations (inpatient) age-adjusted per 100,000
Greater Sullivan Public Health Region	71.7*	14.3
New Hampshire	66.4	16.7

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

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

Drug Overdose Mortality. Drug overdose deaths remain an important public health concern because they reflect the combined effects of substance use, access to treatment and recovery services, and the availability of effective harm-reduction resources.

From 2020 through 2024, the age-adjusted opioid overdose mortality rate in the Greater Sullivan Public Health Region was 36.8 deaths per 100,000 people, nearly twice the statewide rate of 18.5 per 100,000. This difference was statistically significant. The region's alcohol-related overdose mortality rate was 3.9 deaths per 100,000, similar to the New Hampshire rate of 3.5 per 100,000.

Table 59: Opioid and Alcohol Mortality

Area	Opioid Overdose Deaths, age-adjusted per 100,000	Alcohol-related overdose deaths, age-adjusted per 100,000
Greater Sullivan Public Health Region	36.8*	3.9
New Hampshire	18.5	3.5

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

*Rate is significantly different and higher than the state rate

Self Harm-related Emergency Department Visits and Hospitalization. Table 60 displays rates of emergency department (ED) visits and inpatient hospitalizations by sex for injury recorded as intentional, including self-intentional poisonings due to drugs, alcohol, or other toxic substances. Between 2020 and 2024, the rate of ED visits involving self-inflicted harm overall, and among males, was greater in the Greater Sullivan Public Health Region than the state overall.

Table 60: Suicide-related Hospitalizations and ED Discharges

Sex	Area	Suicide or self harm-related hospital visits (ED), age-adjusted rate per 100,000	Suicide or self harm-related hospitalizations (inpatient), age-adjusted rate per 100,000
Male	Greater Sullivan Public Health Region	138.2	42.8
	New Hampshire	109.9	38.5
Female	Greater Sullivan Public Health Region	296.7*	58.6
	New Hampshire	216.2	53.8
All Sexes	Greater Sullivan Public Health Region	214.7*	46.2
	New Hampshire	161.9	46.0

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

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

Suicide. 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. Between 2020-2024, the suicide mortality rate in the Greater Sullivan Public Health Region was not significantly different than in New Hampshire overall. However, the suicide mortality rate is significantly higher for males than females in the region and across the state.

Table 61: Suicide Mortality

Area	Suicide Mortality, age-adjusted rate per 100,000		
	Total	Female	Male
Greater Sullivan Public Health Region	16.4	7.6	25.7
New Hampshire	16.3	7.1	25.8

Source: NH Vital Records Death Certificate Data 2020-2024

Infant Mortality. Infant mortality rate is a significant public health indicator, measuring the number of deaths of infants under the age of one year per 1,000 live births. This rate can be used to measure the health and wellbeing of a population, along with the accessibility and quality of healthcare and social services. Infant mortality is an indicator of maternal health, community nutrition and wellness, health inequalities, and access to social support systems.

New Hampshire has historically had a low infant mortality rate relative to other states and the nation. The mortality rate for infants in the Greater Sullivan Public Health region was somewhat higher, but not different statistically than the overall state rate during the period 2020-2024.

Table 62: Infant Mortality

Area	Infant Mortality Rate per 1,000 Live Births
Greater Sullivan Public Health Region	4.32
New Hampshire	3.62

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

Leading Causes of Death. The leading cause of death in the Greater Sullivan Public Health Region was malignant neoplasms (cancer) accounting for 604 deaths over the five-year span of 2020 to 2024. Diseases of the heart (e.g., congestive heart failure, coronary heart disease, heart attack) was the second leading cause of death in the region and the leading cause of death across the state. Accidents were the third leading cause of death in the region and the state.

Compared to the state, the leading causes of death in the region are similar to the overall in rank order and rates.

Table 63: Leading Causes of Death; Age-adjusted Rates per 100,000

Cause of Death	Greater Sullivan PHR	New Hampshire
Malignant neoplasms	140.4	141.3
Heart diseases	138.0	147.6
Accidents (unintentional)	75.0	59.3
Chronic lower respiratory disease	37.7	35.1
Cerebrovascular diseases	33.5	30.6
COVID-19	26.0	29.8
Diabetes mellitus	21.5	19.6
Alzheimer's disease	21.0	25.3
Intentional self-harm (suicide)	16.7	15.4
Essential hypertension and hypertensive renal disease	10.7	6.7

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

*Regional rate is significantly different and lower than state rate.

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

Table 64: Life Expectancy at Birth (in Years); Age-adjusted Rates per 100,000

Geography	Life expectancy	Male	Female
Merrimack County	79.4	77.0	81.9
Sullivan County	79.4	76.8	81.9
New Hampshire	79.5	77.0	82.1

Source: NH Vital Records, death data, 2020-2024

Premature Mortality. Premature mortality refers to deaths occurring before age 75 and provides a broad measure of the impact of preventable disease, injury, and other factors that shorten life. Differences in premature mortality can reflect underlying patterns in chronic disease, behavioral health, substance use, injury, access to health care, and social and economic conditions.

From 2021-2023, the age-adjusted premature mortality rate was 370 deaths per 100,000 residents under age 75 in Sullivan County and 330 per 100,000 in Merrimack County. Both rates exceeded the New Hampshire rate of 320 per 100,000, with the greatest difference observed in Sullivan County.

Table 65: Premature Mortality

Area	Deaths among residents under 75 per 100,000 (age-adjusted)
Merrimack County	330
Sullivan County	370
New Hampshire	320

Source: National Center for Health Statistics via County Health Rankings; 2021-2023