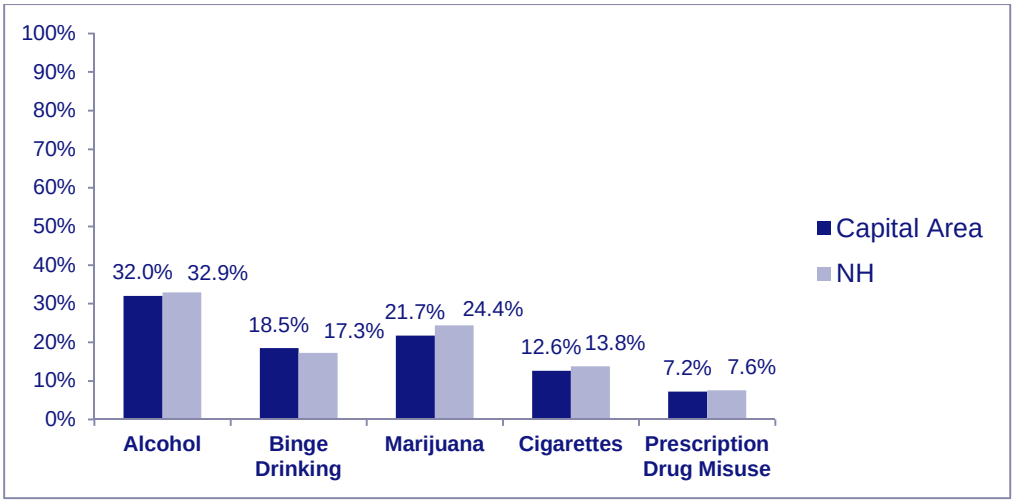
Focus Area 1: Misuse of Alcohol and Drugs *

BACKGROUND

The misuse of alcohol and drugs is one of the most devastating public health issues faced by New Hampshire (NH) communities today. In fact, according to data from the National Survey on Drug Use and Health (NSDUH), NH has some of the highest nationwide rates of alcohol use, marijuana use, and prescription drug misuse, particularly among youth and young adults. Capital Area rates of substance use are typically similar or slightly lower than NH state averages. *Figure 1* below illustrates past 30-day use of key substances of concern among high school aged youth in the Capital Area and in NH.

Figure 1. Past 30-Day Use by Substance among High School Aged Youth *(YRBS, 2013)*.



By all accounts, the misuse of alcohol and drugs is a key concern of NH residents, including those in the Capital Area. According to a recent poll conducted in October 2015 by the University of NH Survey Center, 25% of NH adults now identify "drug abuse" as the most pressing issue facing the state, followed by jobs and the economy (21%), which has held the top position for the past eight years. In October of 2014, only 3% of NH adults identified "drug abuse" as the most important issue. In the Capital Area, according to the 2015 Capital Region Community Health Needs Assessment, "Drug and Substance Use" was rated as one of the top five priority health needs. Nearly all stakeholders interviewed and more than half of the 12 focus groups conducted as part of the assessment identified the need to address substance misuse in the region. This topic was also rated as a high priority by telephone respondents, with 39% of those surveyed identifying drug use as an *extremely* or *very serious* problem and 30% identifying alcohol use as an *extremely* or *very serious* problem. [1]

* Also see Appendix A for the 2016-2019 Capital Area Substance Misuse Prevention Strategic Plan, which provides additional data, as well as background information on prevention efforts taking place in the region.

[1] Concord Hospital. 2015. Capital Region Community Health Needs Assessment.

This significant increase in community concern is likely connected to the growing number of overdose deaths attributed to the use of opioids, including heroin and fentanyl. Overdose deaths have surpassed traffic-related deaths in NH every year since 2008.[2] According to the NH Medical Examiner's office, there were 326 drug-related overdose deaths in the state in 2014. In the Capital Area, there were 29 overdose deaths in the same year. The average age of those who died by an overdose in the Capital Area was 40 years old *(see Figures 2a and 2b)*. Opioids/opiates were present in 93% of overdose deaths and 41% of the deaths occurred in Concord. Eighty-six percent (86%) of these deaths were ruled accidental deaths, 10% were suicide deaths, and 4% were undetermined.

Figures 2a and 2b. Drug-related overdose deaths in Capital Area *(NH Medical Examiner's Office, 2014)*.

Figure 2a.

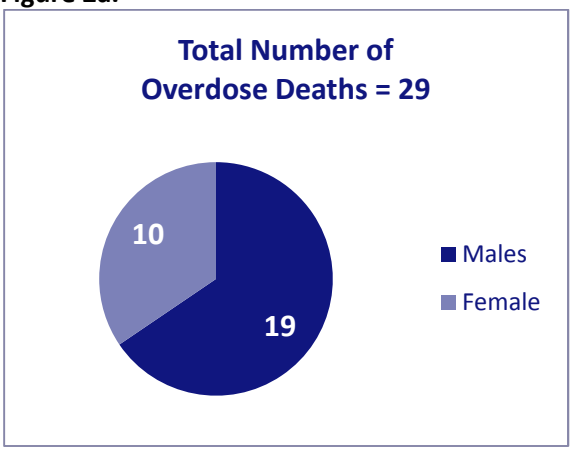


Figure 2b.

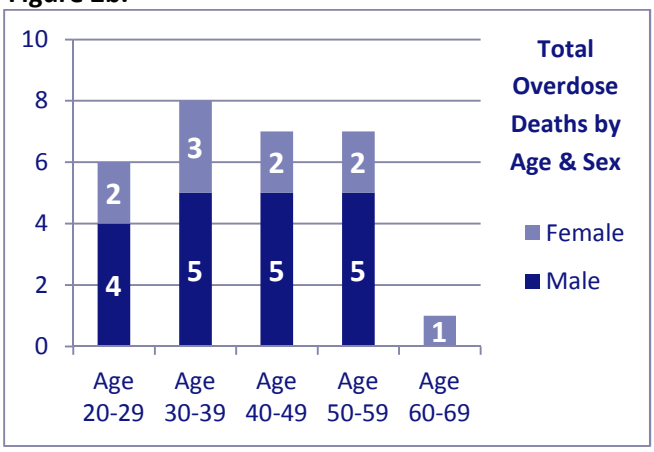
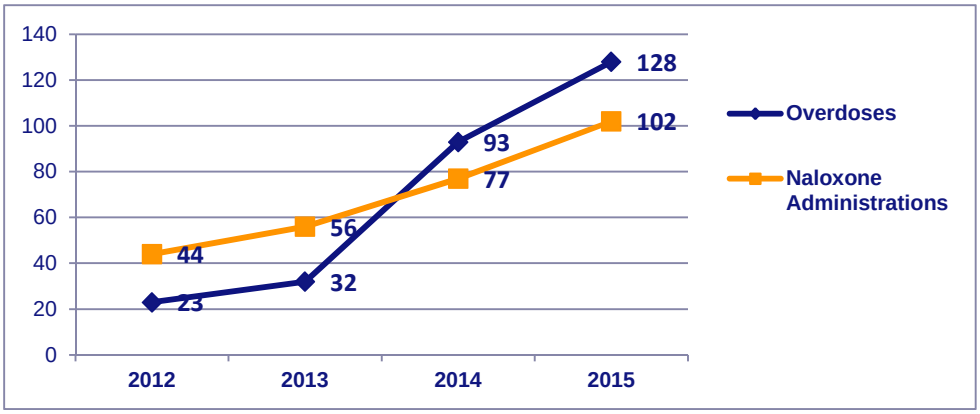


Figure 3 below shows the increasing number of overdoses (fatal and non-fatal) within the City of Concord since 2012, as well as the increasing rate of Naloxone administration by EMS personnel.

Figure 3. Overdoses (*non-fatal and fatal*) and Naloxone Administrations in Concord for 12 month periods ending July 31st of each year *(NH Trauma Emergency Medical Services Information System - TEMSIS, 2012-2015).*



[2] Office of the Chief Medical Examiner. New Hampshire Department of Justice. Concord, NH. Retrieved from http://doj.nh.gov/medical-examiner/documents/drug-deaths.pdf on 9/30/2015.

Substance misuse negatively impacts all sectors of society, from individuals and families to government and businesses. The effects of substance misuse are widespread, with negative implications for public health and wellbeing, including an alarming cadre of medical, social, safety, and economic costs. According to a recent analysis, substance misuse cost the NH economy over $1.84 billion dollars in 2012, an amount equal to about 2.8 percent of the state's gross state product or $1,393 dollars for every person in the state.[3] These costs include lost productivity and earnings, increased expenditures for healthcare, and public safety costs. In the same report, it is stated that only about six percent (6%) of individuals who misuse alcohol or drugs in NH currently receive treatment for their substance misuse. In fact, PolEcon Research (2014) contends that doubling the substance abuse treatment rate in NH to 12% is estimated to result in net benefits to the state of between $83 and $196 million.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), every dollar invested in treatment saves $4 in healthcare costs and $7 in law enforcement/judicial costs. We also know that prevention efforts are even more cost-effective, with an estimated return on investment ranging between $7.40 and $36 per dollar invested, with a medium estimate of $18 (SAMHSA, 2008). Addressing substance misuse in our state and in the Capital Area will save lives and save resources.

GOALS & OBJECTIVES*

GOAL 1.1	**PREVENT AND REDUCE SUBSTANCE MISUSE (INCLUDING ALCOHOL, MARIJUANA, PRESCRIPTION DRUGS) AMONG YOUTH AND YOUNG ADULTS (12-34) IN THE CAPITAL AREA BY 2020.**	***BASELINE & TARGETS:*** • *PAST 30-DAY ALCOHOL USE: high school baseline of 32.0% in 2013 to a decrease in 2015 and 2017 to 24.0% in 2019. Young adult [18-25] baseline [for central 2 region of NH and past 30-day binge use] of 46.0% in 2010-2012 to a decrease in 2015 and 2017 to 38.0% in 2019.* • *PAST 30-DAY USE MARIJUANA: high school baseline of 21.7% in 2013 to a decrease in 2015 and 2017 to 16.0% in 2019. Young adult [18-25] baseline [for central 2 region of NH] of 23.8% in 2010-2012 to a decrease in 2015 and 2017 to 17.0% in 2019.* • *PAST 30-DAY MISUSE RX DRUGS: High school baseline of 7.2% in 2013 to a decrease in 2015 and 2017 to 4.2% in 2019. Young adult [18-25] baseline [for Central 2 region of NH and past year use] of 11.0% in 2010-2012 to a decrease in 2015 and 2017 to 8.0% in 2019.* ***Sources:** YRBS, National Survey on Drug Use and Health (NSDUH)*
Objective 1.1.1	***Access & Availability*** Decrease access to alcohol (among underage population), marijuana and prescription drugs (without a doctor's prescription) among youth and young	***BASELINE & TARGETS:*** • *ALCOHOL: High school baseline of 38.4% in 2013 to a decrease in 2015 and 2017 to 30.0% in 2019.* • *MARIJUANA: High school baseline of 42.6% in 2013 to a decrease in 2015 and 2017 to 35.0% in 2019.* • *RX DRUGS: High school baseline of 14.8% in 2013 to a decrease in 2015 and 2017 to 10.0% in 2019.*

[3] PolEcon Research. November 2014. The Corrosive Effects of Alcohol and Drug Misuse on NH's Workforce and Economy. Retrieved from http://www.new-futures.org/sites/default/files/Summary%20Report_0.pdf on September 30, 2015.

**The majority of baselines and targets have been determined for this priority area. This is because we have a better since of trend data related to the misuse of drugs and alcohol and also have a better understanding of expected scope/saturation of inputs/activities to impact the indicators.*

	adults.	***Source:*** *YRBS*
Objective 1.1.2	***Parental Monitoring & Communication*** a. Increase the percentage of youth and young adults (12-20) who report talking with at least one of their parents or guardians about the dangers of tobacco, alcohol, or other drug use. b. Increase the percentage of youth and young adults (12-20) who report that their parents or other adults in their family have clear rules and standards for their behavior.	***BASELINE & TARGETS:*** • *High school baseline of 49.1% in 2013 to an increase in 2015 and 2017 to 55.0% in 2019.* ***Source:*** *YRBS* ***BASELINE & TARGETS:*** • *High school baseline of 77.9% in 2013 to an increase in 2015 and 2017 to 84.0% in 2019.* ***Source:*** *YRBS*
Objective 1.1.3	***Perception of Risk*** Increase the percentage of youth and young adults (12-34) who think people are at great risk of harming themselves (physically or in other ways) if they…. ➢ have five or more drinks of alcohol (beer, wine, or liquor) once or twice a week; ➢ use marijuana once or twice a week; ➢ take a prescription drug without a doctor's prescription.	***BASELINE & TARGETS:*** • *ALCOHOL: High school baseline of 32.1% in 2013 to an increase in 2015 and 2017 to 40.0% in 2019. Young Adult [18-25] baseline [for Central 2 region of NH] of 27.6% in 2010-2012 to an increase in 2015 and 2017 to 35.0% in 2019.* • *MARIJUANA: High school baseline of 21.6% to an increase in 2015 and 2017 to 30.0% in 2019. Young Adult [18-25] baseline [for Central 2 region of NH] of 10.0% in 2010-2012 to an increase in 2015 and 2017 to 15.0% in 2019.)* • *RX DRUGS: High school baseline of 63.2% in 2013 to an increase in 2015 and 2017 to 70.0% in 2019. No Young Adult [18-25] baseline.* ***Sources:*** *YRBS, NSDUH*
Objective 1.1.4	***Self-Medicating Behavior*** *(Unmet Need for Mental Health Care)* Decrease the percentage of youth and young adults (12-34) who misuse substances for the purposes of "self-medicating."	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by focus groups, key informant interviews, and Key Stakeholder Survey.*
Objective 1.1.5	***Social Determinants of Health*** Increase health equity by creating social and physical environments that promote good health for all across the Capital Area.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by a social vulnerability index and compilation of data sets creating a socioeconomic ranking from the NH Center for Public Policy Studies.*
Objective 1.1.6	***Social Norms*** a. Decrease the discrepancy that exists between perceptions of peer use and actual use of substances among youth and young adults (12-24). b. Increase the perception of peer, parental, and community disapproval for substance misuse among youth and young adults (12-34).	***BASELINE & TARGETS:*** • *Baseline and targets for gap between perception of peer use and actual use to be determined. As measured by focus groups, key informant interviews, and youth survey.* ***BASELINE & TARGETS:*** • *PEER PERCEPTION ALCOHOL: High school baseline of 57.3% in 2013 to an increase in 2015 and 2017 to 65.0% in 2019. PARENT PERCEPTION ALCOHOL: High school baseline of 88.1% in 2013 to an increase in 2015 and 2017 to 92.0% in 2019.* • *PEER PERCEPTION MARIJUANA: High school baseline of 43.2% in 2013 to an increase in 2015 and 2017 to 48.0% in 2019. PARENT PERCEPTION MARIJUANA: High school baseline of 85.0% in 2013 to an increase in 2015 and 2017 to 90.0% in 2019.*

		• *PEER PERCEPTION RX DRUGS: High school baseline of 78.5% in 2013 to an increase in 2015 and 2017 to 85.0% in 2019. PARENT PERCEPTION RX DRUGS: High school baseline of 94.5% in 2013 to an increase in 2015 and 2017 to 97.0% in 2019.* ***Source:*** *YRBS*
Objective 1.1.7	***Access to Services*** Increase community knowledge of and access to resources available to address substance misuse across the continuum of care (prevention, intervention, treatment, recovery) among all populations.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by the Key Stakeholder Survey.*

GOAL 1.2	**DECREASE THE NUMBER OF DRUG-RELATED OVERDOSE DEATHS IN THE CAPITAL AREA AMONG ALL AGE GROUPS BY 2019.**	***BASELINE & TARGETS:*** • *Baseline of 29 deaths in the Capital Area in 2014 to a decrease each year to zero drug-related overdose deaths in 2019.* ***Source:*** *NH Office of the Medical Examiner*
Objective 1.2.1	***Access to Services*** Increase community knowledge of and access to resources available to address substance misuse across the continuum of care (prevention, intervention, treatment, recovery) among all populations.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by focus groups, key informant interviews, and the Key Stakeholder Survey.*
Objective 1.2.2	***Access and Availability*** Increase access to and education regarding the use of Naloxone by healthcare providers and community members.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by focus groups, key informant interviews, and the Key Stakeholder Survey.*
Objective 1.2.3	***Lack of Knowledge*** Increase knowledge among community members regarding Good Samaritan law.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by focus groups, key informant interviews, and the Key Stakeholder Survey.*

GOAL 1.3	**PROMPTLY RESPOND TO AND PREVENT HARMS ASSOCIATED WITH EMERGING DRUG THREATS IN THE CAPITAL AREA.**	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by meeting minutes, entries to P-Wits, focus groups, key informant interviews, and the Key Stakeholder Survey.*
Objective 1.3.1	***Assessment*** Increase data collection and monitoring efforts among key stakeholders and sectors to identify and track emerging issues of concern related to substance misuse.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by meeting minutes, entries to P-Wits, focus groups, key informant interviews, and the Key Stakeholder Survey.*
Objective 1.3.2	***Capacity Building*** Increase the capacity of key stakeholders and sectors to identify, proactively address, and respond to emerging issues of concern related to substance misuse.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by meeting minutes, entries to P-Wits, focus groups, key informant interviews, and the Key Stakeholder Survey.*

Objective 1.3.3	***Planning & Implementation*** As emerging issues arise, follow the Strategic Prevention Framework to develop and implement appropriate, research-based strategies to address concerns.	***BASELINE & TARGETS:*** • *Baseline and targets to be determined. As measured by meeting minutes, entries to P-Wits, focus groups, key informant interviews, and the Key Stakeholder Survey.*

STRATEGIC APPROACH

Strategy 1: ***Systems change, advocacy, policy & planning***	**Strategy 2:** ***Awareness & education***	**Strategy 3:** ***Direct evidence based/research informed programming***	**Strategy 4:** ***Environmental change***
• Advocate for sectors to consider impacts on misuse of drugs and alcohol when making policy decisions. • Advocate for laws and policies that support a full continuum of services to address the misuse of drugs and alcohol. • Work with sectors, particularly schools, to develop comprehensive policies and procedures to encourage healthy environments and behaviors. • Integrate primary care, mental health care, and substance abuse prevention, treatment and recovery support, including integrated data collection, training, and services. • Support youth advocates through the Capital Area	• Develop social marketing campaigns that provide simple, consistent messaging to be used across all key community sectors to increase perception of risk of substance misuse and improve social norms in the community. • Implement responsible opioid prescribing workshops. • Increase provider use of the Prescription Drug Monitoring Program to identify and address problems related to prescription drug misuse. • Develop and implement resource materials for community sectors to be able to effectively prevent and respond to substance misuse concerns. • Provide education and training to key	• Develop and implement Substance Use Disorder first aid training and curriculum. • Implement Project Success/Student Assistance programs in area middle and high schools. • Support Community-/Problem-Oriented Policing to address complex community concerns, including the misuse of drugs and alcohol, with a focus on connecting residents to available services and supports when possible. • Implement and evaluate "Life of an Athlete" in area high schools. • Support the implementation of evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) in a wide range of health care	• Promote and support local "Take-Back" events and permanent boxes to encourage safe and regular disposal of unused prescription medications.

Strategy 1: ***Systems change, advocacy, policy & planning***	**Strategy 2:** ***Awareness & education***	**Strategy 3:** ***Direct evidence based/research informed programming***	**Strategy 4:** ***Environmental change***
Youth Councils. • Follow the Strategic Prevention Framework as a planning process (assessment, capacity-building, planning, implementation, evaluation, cultural competency, sustainability).	community stakeholders regarding the use of Naloxone and laws and policies, such as the Good Samaritan law.	settings, including primary care and emergency or urgent care.	

Focus Area 2: Access to Comprehensive Behavioral Health Services

BACKGROUND

Behavioral health care encompasses a broad range of coordinated mental health and addiction services. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health "refers to mental/emotional well-being and/or actions that affect wellness."[4] Behavioral Health Access and Affordability was identified as one of the top five priority health needs in the 2015 Capital Region Community Health Needs Assessment. When asked about the top priorities to improve, Capital Area residents identified drug use, alcohol use, and mental health problems as the top three choices.[5] Mental health issues and substance use were repeatedly identified as concerns by respondents in the telephone survey, online survey, focus groups, and stakeholder interviews.

The Capital Area has statistically significantly higher rates of mental health condition inpatient discharges per 100,000 people (453.2) than the NH state average (373.0) (NH DHHS Hospital Discharge Data Collection System, 2009). The Capital Area also has higher mental health condition emergency department visits and observation stays per 100,000 people (1745.6) compared to NH state average (1511.6) according the same data source. Additionally, substance abuse-related emergency hospital discharges, age-adjusted per 10,000 population (82.3) are significantly higher than the NH state average (68.3).[6]

According to the Behavioral Risk Factor Surveillance Survey (BRFSS, 2012), 12.3% of Capital Area adults report that there were 14 to 30 days within the past 30 days during which their mental health was not good, compared to 11.6% of adults statewide reporting the same. Among adolescents, 24.5% of Capital Area high school aged youth report within 12 months prior to the survey that they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, compared to 25.4% statewide (YRBS, 2013). Just over 15% of Capital Area adolescents report they seriously considered attempting suicide within the previous 12 months, compared to just over 14% statewide (YRBS, 2013). YRBS data also associates suicide attempts with higher likelihood of recent substance misuse. Additional data within the region supports the existence of shared risk factors related to substance misuse, mental health, and suicide.

Barriers that impact access to comprehensive behavioral health care services in the Capital Area include affordable insurance coverage and a lack of awareness concerning available resources and services

[4] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). National Behavioral Health Quality Framework. Retrieved from http://www.samhsa.gov/data/national-behavioral-health-quality-framework/ on September 30, 2015.
[5] Concord Hospital. (2015). Capital Region Community Health Needs Assessment.
[6] NH DHHS Hospital Discharge Data Collection System, 2003-2007.

and/or how to access those services. These needs, identified by Capital Area Public Health Network stakeholders, were echoed in the findings of the hospital needs assessment. Affordability was determined to be the primary barrier to obtaining needed health care and understanding insurance and the healthcare system was identified consistently throughout numerous community listening sessions, focus groups, and written and online surveys.[7]

Behavioral health integration is defined by the World Health Organization (WHO) as, "The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system."[8] Integration provides for the systematic coordination of general and behavioral health care to provide the best possible outcomes for people with multiple healthcare needs.

GOALS & OBJECTIVES*

GOAL 3	**IMPROVE ACCESS TO A COMPREHENSIVE, COORDINATED CONTINUUM OF BEHAVIORAL HEALTH CARE SERVICES IN THE CAPITAL AREA BY 2020.**	***BASELINE:*** • *89.1% of Capital Area adults report having "any health care coverage" in 2012.* • *Ratio of population to mental health care providers in Merrimack County is 364:1 in 2014.* ***Sources:*** *BRFSS, NPI Registry*
Objective 3.1	***Insurance*** Increase access to affordable insurance coverage.	***BASELINE:*** • *13.7% of Capital Area adults reported they could not see doctor because of cost in 2012.* • *89.1% of Capital Area adults report having "any health care coverage" in 2012.* • *51.0% of Capital Area adults have a health insurance plan through employer, 16.2% have Medicare, 4.4% have Medicaid, and 5.4% have a plan purchased on own.* ***Sources:*** *BRFSS*
Objective 3.2	***Integrated system of care*** a. Increase access to behavioral health supports in primary care settings.	***BASELINE:*** • *91.5% of Capital Area adults have one or more personal doctors or health care providers in 2012.* • *# of embedded behaviorists are on primary care staff at Concord Hospital /Capital Region Family Health Center.* ***Sources:*** *BRFSS, Endowment for Health*
	b. Decrease rates of emergency room visits or hospitalizations that could have been prevented.	***BASELINE:*** • *82.3 per 10,000 population (age-adjusted) rate of substance abuse-related emergency hospital discharges in the Capital Area in 2003-2007.* • *1745.6 per 100,000 people rate of mental health condition emergency department visits and observation stays in the Capital Area in 2009.* • *Rate of preventable hospital stays in Merrimack*

[7] Concord Hospital. (2015). Capital Region Community Health Needs Assessment.
[8] World Health Organization (WHO). (2008). Integrated health services: What and why?. Technical Brief No. 1, 2008. Retrieved from http://www.who.int/healthsystems/service_delivery_techbrief1.pdf on November 30, 2015.
**Targets to be determined by the workgroups, once we have a better understanding of the scope/saturation of expected inputs/activities and resources available to impact the indicators.*

		County is 50 per 1,000 Medicare enrollees in 2012. ***Sources:*** *BRFSS, NH DHHS Hospital Discharge Data Collection System*
Objective 3.3	***Services*** a. Increase awareness of available services across the continuum of care. b. Increase the number of services across the continuum of care to address unmet needs.	***BASELINE:*** • *Baseline to be determined. As measured by meeting notes, continuum of care assessment, focus groups, key informant interviews, and a key stakeholder survey.*

STRATEGIC APPROACH

Strategy 1: ***Systems change, advocacy, policy & planning***	**Strategy 2:** ***Awareness & education***	**Strategy 3:** ***Direct evidence based/research informed programming***
• Support policies that increase access to insurance coverage, including Medicaid, employer-based insurance and plans offered through the marketplace. • Identify and develop key components of a comprehensive system of care for behavioral health services. • Develop systems and protocols that support Primary Behavioral Healthcare Integration.	• Promote information and referral resources among providers and within communities.	• Develop and implement Mental Health and Substance Use Disorder first aid training and curriculum.

Focus Area 3: Educational Achievement

BACKGROUND

It is well known that healthier students are better learners and achieve better educational outcomes. Research clearly shows that health factors such as physical activity and nutrition, as well as overall health status influence students' motivation and ability to learn.[9] However, research also clearly and definitively shows that "better educated individuals live longer, healthier lives than those with less education, and their children are more likely to thrive."[10] Additionally, "more schooling is linked to higher incomes, better employment options, and increased social supports that, together, support opportunities for healthier choices."[11] Even when income and health care insurance status are controlled for, the affect of one's level of educational achievement on health outcomes such as length of life and quality of life remain significant.

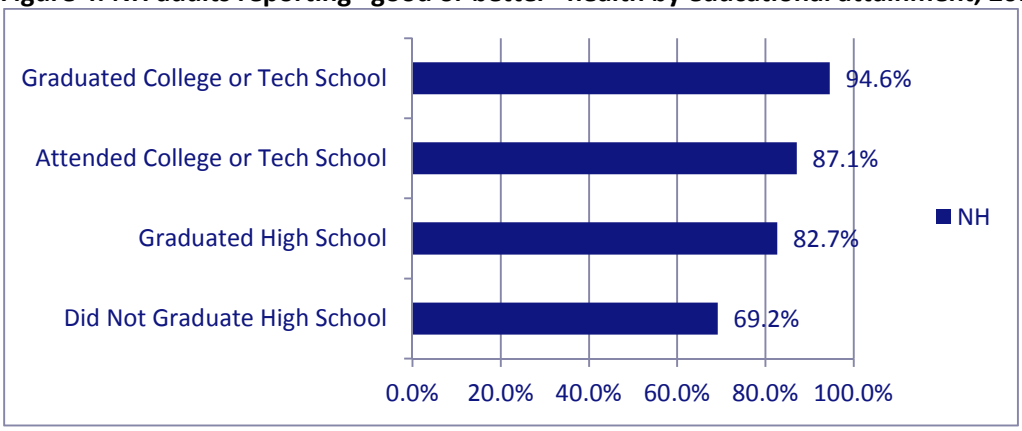
Educational achievement status can also influence multiple generations, with evidence showing an impact of maternal and parental education on children's health. Alarmingly, children whose mothers graduated from college are twice as likely to live past their first birthday.[12] In addition, according to the same study from the Center on Society and Health (2014), on average, college graduates live nine more years than those who dropout from high school.

Additional benefits gained from educational attainment include higher income, which in turn, also leads to positive health outcomes. It is estimated that for each additional year of schooling, annual income increases by approximately 11%.[13] Better educated workers are able to endure economic downturns, such as recessions, more effectively than their less educated counterparts. Therefore, it is in our best interest to advocate for high quality, accessible educational opportunities for all residents, from childhood to adulthood.

As shown in the following chart, NH residents with higher educational attainment are more likely to report being in "good or better health" than residents with less education.

[9] Basch, C. (2011). Healthier students are better learners: A missing link in school reforms to close the achievement gap. Journal of School Health. 81-1.
[10] Robert Wood Johnson Foundation. (2015). County Health Rankings & Roadmaps. Why is education important to health? Retrieved from http://www.countyhealthrankings.org/our-approach/health-factors/education on November 30, 2015.
[11] Robert Wood Johnson Foundation. (2015). County Health Rankings & Roadmaps. Why is education important to health? Retrieved from http://www.countyhealthrankings.org/our-approach/health-factors/education on November 30, 2015.
[12] Center on Society and Health. (2014). Education: It matters more to health than ever before. Richmond: Center on Society and Health, Virginia Commonwealth University (VCU); 2014.
[13] Egerter S, Braveman P, Sadegh-Nobari T, Grossman-Kahn R, Dekker M. (2011). Education and health. Princeton: Robert Wood Johnson Foundation (RWJF). Exploring the Social Determinants of Health Issue Brief No. 5.

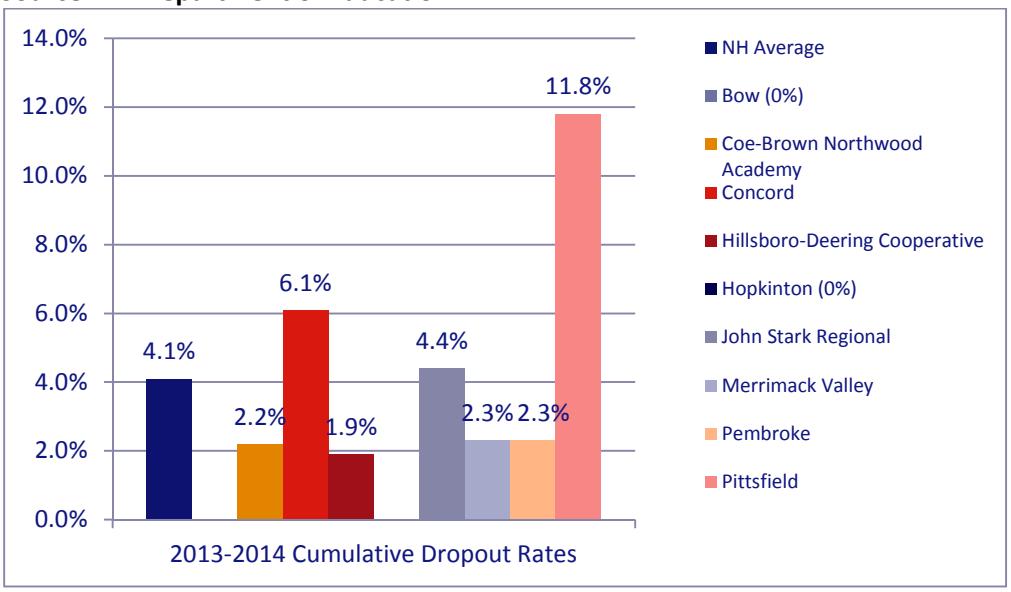
Figure 4. NH adults reporting "good or better" health by educational attainment, 2010. Source: BRFSS.



At particular risk for educational, and therefore health disparities are vulnerable populations, including those living in poverty or with low socioeconomic status (SES). Research shows that despite growing graduation rates, gaps still exist among these populations. National Kids Count data from 2015 looked at NH 4th graders who scored below proficient reading level and within that group, compared those who are eligible for free/reduced school lunch (74%) with those who are not eligible for free/reduced school lunch (46%). This discrepancy outlines the disparity that negatively impacts people living with low SES.

High school dropout rates for the Capital Area tend to be lower than NH state average, but vary across our geography, as demonstrated in the chart below. This illustrates another potential association with living in a high risk community and being at risk for poor educational outcomes.

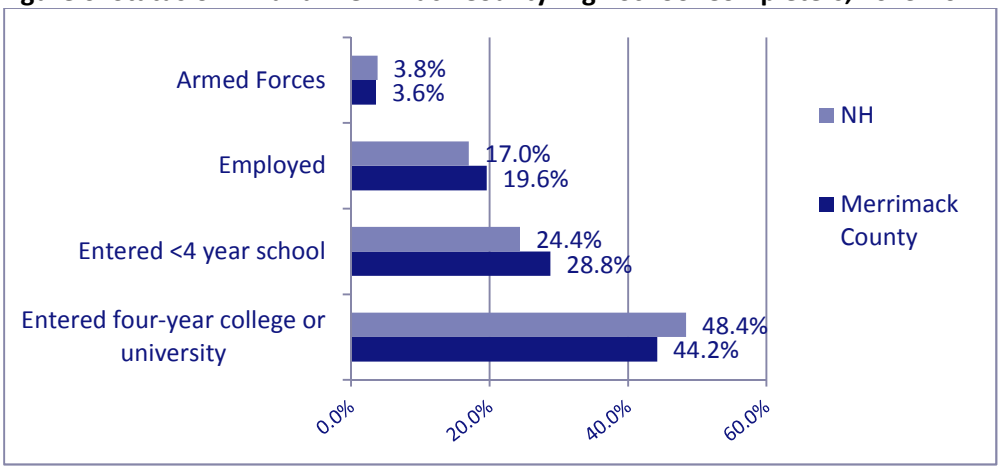
Figure 5. "4-Year Cumulative" Dropout Rates[14] among NH and Capital Area schools, 2013-2014. Source: NH Department of Education.



[14] Cumulative Rates = 1 - (1 - annual rate)^4. This formula applies the annual rate to a progressively declining base population. The cumulative rate represents the percentage of current students who will early exit or drop out before reaching graduation if the annual rate does not change. This rate is not applicable to Charter Schools due to high migration.

On average, the Capital Area fares quite well when compared to NH concerning many protective factors that influence pursuit of higher education upon high school graduation. Surprisingly, however, high school completers from Merrimack County are less likely to enter a four-year college or university compared to the average NH student. In Merrimack County, out of those who completed high school in the 2013-2014 school year, approximately 44.2% have entered four year colleges and universities, 28.8% have entered "less than four year" schools, 19.6% are employed, 3.6% are in the armed forces, and the remaining are either unemployed or status is unknown. Comparisons with NH state averages are shown in the chart below.

Figure 6. Status of NH and Merrimack County High School Completers, 2013-2014.



Other factors that improve school readiness, thus impacting educational achievement, include access to high quality, affordable early childcare education, pre-kindergarten and full-day kindergarten. Merrimack County has fewer childcare slots per 100 children (138.6) than the NH state average (151.0).[15] In the Capital Area, the following communities are the only ones that currently offer full-day kindergarten programs, according to the NH Department of Education (2014-2015): Andover, Hillsboro-Deering Cooperative, Hopkinton, Kearsarge Regional, Merrimack Valley, Pembroke, Pittsfield, and Washington.

GOALS & OBJECTIVES*

GOAL 4	**IMPROVE COMMUNITY HEALTH BY INCREASING THE NUMBERS OF YEARS AND QUALITY OF EDUCATION ACHIEVED BY YOUTH AND ADULTS IN THE CAPITAL AREA BY 2020.**	***BASELINE:*** *92% of Merrimack County residents over age 25 have at least a high school education, 33.3% have a Bachelor's degree or higher, 29.8% have some college or Associate's degree, an 29.0% have High School degree or GED.* ***Sources:*** *American Community Survey, 2013.*
Objective 4.1	***Accessibility*** Increase opportunities for high quality and accessible education for all residents from	***BASELINE:*** • *8 school districts in the Capital Area currently offer full-day kindergarten as of December 2015.* ***Source:*** *NH Department of Education (NH DOE)*

[15] NH Kids Count Data Book. (2010-2011). Child Care Licensing. Data set has several limitations. See source for details.

**Targets to be determined by the workgroups, once we have a better understanding of the scope/saturation of expected inputs/activities and resources available to impact the indicators.*

	early childhood to adulthood.	
Objective 4.2	***School, college & career readiness*** Improve school, college and career readiness among children, youth, and young adults.	***BASELINE:*** • *Baseline to be determined. As measured by High School GPA, SAT scores, rates of remediation courses, other assessment tools.*
Objective 4.3	***Socioeconomic status disparities*** Improve graduation rates among low-income and/or high-risk populations.	***BASELINE:*** • *Cumulative, 4 yr dropout rates in the Capital Area range from 0% to 11.8%.* ***Source:*** *NHDOE*

STRATEGIC APPROACH

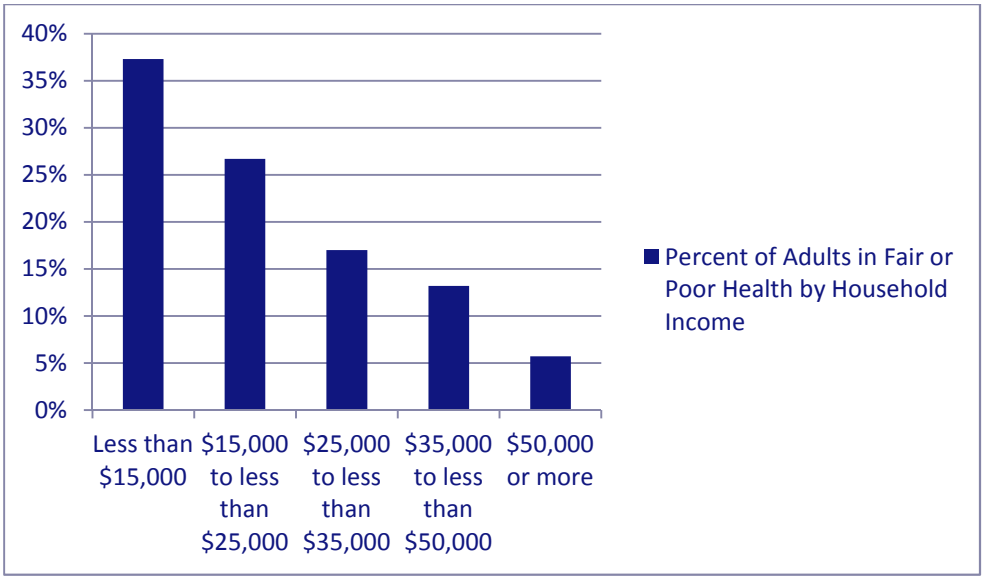
Strategy 1: ***Systems change, advocacy, policy & planning***	**Strategy 2:** ***Awareness & education***	**Strategy 3:** ***Direct evidence based/research informed programming***
• Advocate for universal full-day kindergarten and universal pre-kindergarten programs to improve reading and mathematics achievement.	• Promote existing educational programs, including early childhood, high-school completion and out of school time academic programs, particularly those that are easily accessible to low-income and high-risk populations. • Raise awareness among key sectors and the general public concerning the impact of educational achievement on health outcomes.	• Support and implement early childhood education programs that address literacy, numeracy, cognitive development, socio-emotional development, and motor skills. • Support and implement high school completion programs for students at high-risk for non-completion.

Focus Area 4: Economic Wellbeing

BACKGROUND

According to the County Health Rankings and Roadmaps report, social and economic factors are not only the largest single driver of health outcomes, but also significantly influence health behaviors, the second greatest influence on health and longevity.[16] The relationship between income and health is not only based on the fact that income allows individuals to purchase quality medical care, but income also provides an array of options for healthy lifestyle choices. People living in poverty are more likely to have limited access to healthy foods, safe neighborhoods, employment options, and quality schools. What's even more alarming are the health outcomes for the wealthiest in our society compared to the poorest among us. Income inequality is extremely harmful to one's health and can actually result in a shorter lifespan. According to a 2011 report, people in the highest income bracket live six full years longer than people in the lowest income bracket.[17] The chart below demonstrates this relationship between NH adults who report being in fair or poor health and household income.

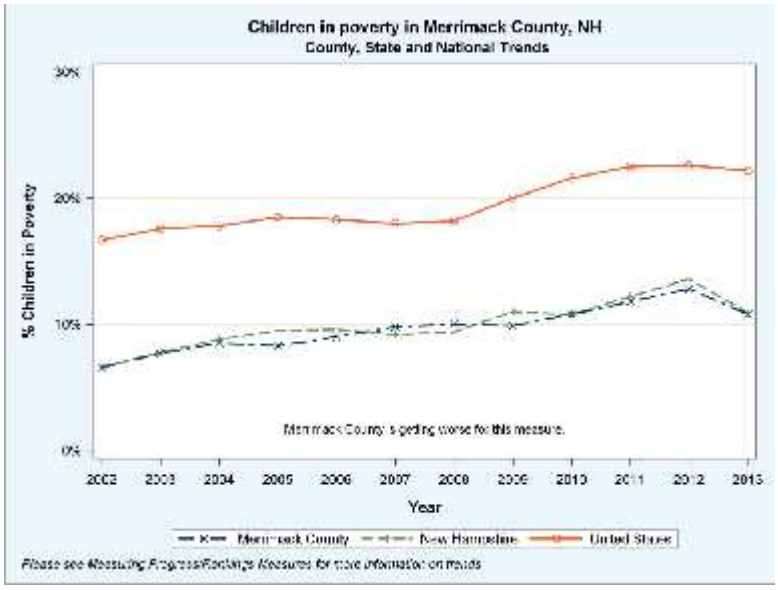
Figure 7. Percent of NH Adults in Fair or Poor Health by Household Income. (2011-2012). Source: BRFSS.



Unfortunately, our must vulnerable populations, including children, are most at-risk for negative health outcomes associated with poverty. In fact, early poverty can result in developmental damage to young children, with IQ at age five correlated more closely with family income than other known influences such as maternal education, ethnicity, and living in a single female-headed household.

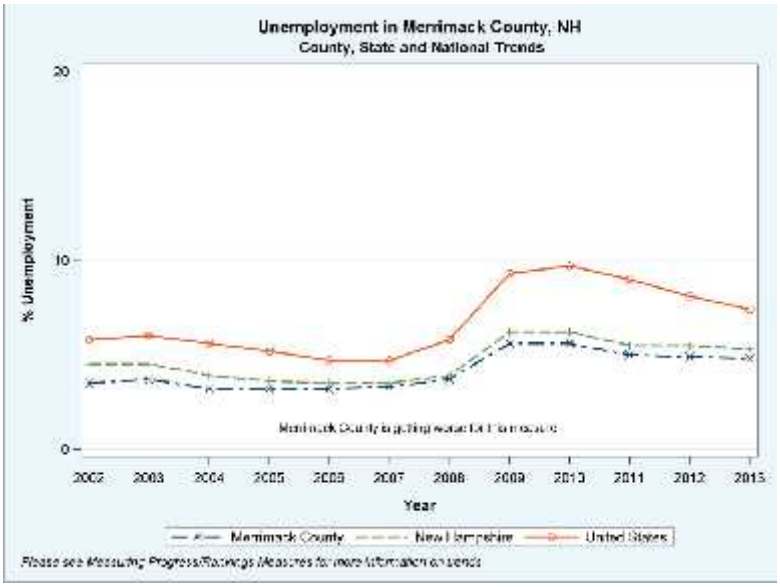
[16] Robert Wood Johnson Foundation. (2015). County Health Rankings and Roadmaps. Retrieved from www.countyhealthrankings.org on November 15, 2015.
[17] Braveman P, Egerter S, Barclay C. *Income, wealth and health*. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 4.

Figure 8. Children in poverty in Merrimack County. (2002-2013). Source: US Census.



According to the County Health Rankings and Roadmaps report, 11% of children in Merrimack County are living in poverty and this indicator is getting worse over time. The percentage of children living in poverty in NH is also 11% and in the United States is higher at 21%.

Figure 9. Unemployment in Merrimack County. (2002-2013). Source: County Health Rankings.



Another factor that influences income and health is unemployment. People who are unemployed are 54% more likely to be in poor or fair health than individuals who are employed.[18]

These individuals are also more likely to suffer from a number of poor health conditions, including stress, high blood pressure, heart disease, and depression.[19] In the Merrimack County region, unemployment rates are worsening over time, though still lower than NH and the United States overall.

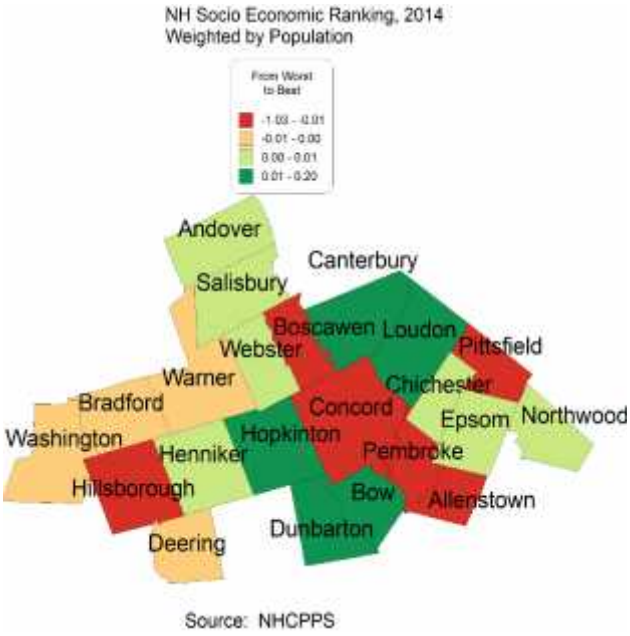
In the Capital Area, we have particular communities at risk based on social vulnerabilities, including poverty, low income, an unemployment. The NH Center for Public Policy Studies created a socioeconomic ranking for the Capital Area, based on the following indicators:

- Percent of Pop 25 and older with BA or better
- 2012 Median HH Income
- 2012 Poverty Rate
- 2012 Households with Food Stamps
- Medicaid Members as a % per Pop
- Low to Moderate Income Percentage
- Elementary Per Pupil Expenditures 2011/12
- 2013TaxRate
- Ratio of House Price to Income 2012
- Poverty Under 18
- Poverty 65 plus
- 2013 grad rate

[18] An J, Braveman P, Dekker M, Egerter S, Grossman-Kahn R. *Work, workplaces and health*. Princeton: Robert Wood Johnson Foundation (RWJF); 2011. Exploring the Social Determinants of Health Issue Brief No. 4.

[19] Robert Wood Johnson Foundation. *Stable jobs = healthier lives*. New PublicHealth blog. January 14, 2013. Accessed November 15, 2015.

Figure 10. NH Socio Economic Ranking, 2014. Source: NH Center for Public Policy Studies.



This ranking shows the communities within the Capital Area that are most vulnerable to risk factors, such as low income and poor education, which negatively impact health behaviors and health outcomes. Highlighted in red, with the lowest ranking, include:

- Allenstown
- Boscawen
- Concord
- Pembroke
- Pittsfield
- Hillsborough

It is incumbent upon our Public Health Network and region to help increase the financial capability of residents, while also working to decrease the impact of socioeconomic disparities on health status.

GOALS & OBJECTIVES*

GOAL 5	**IMPROVE COMMUNITY HEALTH BY PROMOTING ECONOMIC WELL-BEING FOR INDIVIDUALS, FAMILIES, AND COMMUNITIES IN THE CAPITAL AREA BY 2020.**	***BASELINE:*** • *9.5% of individuals in Merrimack County are living in poverty in 2014.* • *11% of children in Merrimack County are living in poverty in 2014.* *Source: American Community Survey, US Census*
Objective 5.1	***Asset development*** a. Increase access to economic opportunities and assets for low-income individuals and families.	***BASELINE:*** • *8,867 tax returns in Merrimack County received the Earned Income Tax Credit (EITC) in 2013.* • *2,355 tax returns in Merrimack County received the Child Tax Credit (CTC) in 2013.*
	b. Increase "financial capability"[20] of residents.	***BASELINE:*** • *3.6% of Merrimack County households do not have a checking or savings account in 2011.* • *17.9% of Merrimack County households that have a checking and/or savings account that have used alternative financial services in the past 12 months in 2011.* • *Other baselines to be determined. As measured by financial knowledge and skills, financial behavior and attitudes, and financial status.*
	c. Decrease the percentage of households experiencing "asset poverty."[21]	***BASELINE:*** • *15.8% of Merrimack County households are without sufficient net worth to subsist at the*

[20] "Financial Capability" is defined as "the capacity, based on knowledge, skills, and access, to manage financial resources effectively." Source: Exec. Order No. 13530 (2010).

[21] "Asset Poverty" is defined as the percentage of households without sufficient net worth to subsist at poverty level for three months in absence of income. Source: Corporation for Enterprise Development (CFED).

		poverty level for three months in the absence of income in 2011. • *29.9% of Merrimack County households are without sufficient liquid assets to subsist at poverty level for three months in the absence of income in 2011.* ***Sources:*** *Assets & Opportunity Scorecard, American Community Survey , FDIC National Survey of Unbanked and Underbanked Households, Brookings Institute EITC Interactive Database, Internal Revenue Service*
Objective 5.2	***Socioeconomic status disparities*** Decrease impact of socioeconomic status disparities on health status.	***BASELINE*** • *The ratio of household income at the 80th percentile to income at the 20th percentile in Merrimack County is 4.1 from 2009-2013.* • *Socioeconomic ranking in Capital Area ranges from -1.03-0.20.* ***Sources:*** *American Community Survey, NH Center for Public Policy Studies Socioeconomic Ranking*

STRATEGIC APPROACH

Strategy 1: ***Systems change, advocacy, policy & planning***	**Strategy 2:** ***Awareness & education***	**Strategy 3:** ***Direct evidence based/research informed programming***
• Work with local businesses to implement policies and practices to improve workplace productivity, retention, advancement, and financial stability for employees. • Advocate for policies and laws that advance economic opportunity, particularly among disenfranchised populations.	• Raise awareness among key sectors and the general public concerning the impact of economic wellbeing and socioeconomic disparities on health outcomes. • Encourage the integration of asset building and financial capability into social services and programs for low-income and vulnerable populations.	• Train social service providers to assist their clients in addressing short and long-term financial barriers that impact health and wellness. • Assist individuals and families in accessing the Earned Income Tax Credit (EITC) and other relevant financial resources.

**Targets to be determined by the workgroups, once we have a better understanding of the scope/saturation of expected inputs/activities and resources available to impact the indicators.*