LITTLE RIVERS HEALTH CARE

Little Rivers Health Care, Inc.

Community Health Needs Assessment 2021

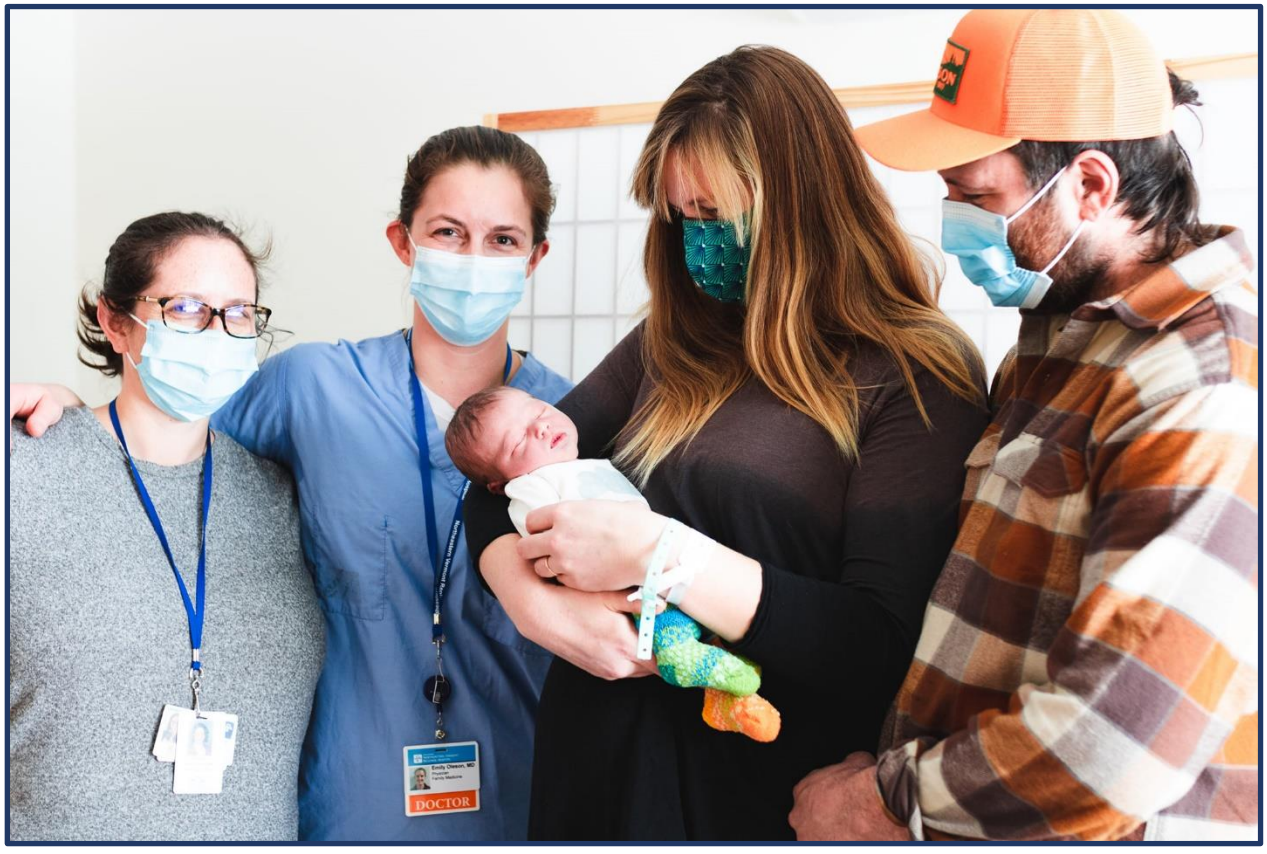

Table of Contents

Introduction

Little Rivers Health Care, Inc. (LRHC) incorporated in July 2003, was awarded Federally Qualified Health Center (FQHC) status in 2006, and is now in its 16th year of operation. Comprehensive primary care services are provided out of our 4 owned clinics in the towns of Wells River, Bradford, East Corinth, and Newbury, and at 1 in-scope behavioral health site, which is Valley Vista in Bradford. In addition, all six schools of the Orange East Supervisory Union are in LRHC's scope of project.

The providers of LRHC deliver a full range of primary care services to meet the needs of residents of all ages, including oral health, obstetrical care, and behavioral and mental health services. The care they provide to individual patients has been aligned deliberately with the Institute of Medicine's six aims: *to ensure that it is patient-centered, safe, effective, timely, efficient, and equitable.* Our providers are actively involved in various ways to improve the larger system of health care delivery locally and regionally. They also offer a range of alternative healing options including reiki, yoga, tai chi, and Acu-wellness.

On a regular basis, LRHC conducts a Community Health Needs Assessment (CHNA) in order to evaluate the needs of the community with regard to health status, health disparities, socio-demographics, cultural influences, and access to services. These CHNAs are used to guide LRHC's decisions regarding the allocation of resources, the services we offer and the way in which those services are delivered. They also provide a larger view of our community and reveal potential opportunities for synergistic partnerships with other service providers.

Availability of the CHNA

Upon completion of the entire CHNA process, the documents comprising the LRHC CHNA Report will be made widely available in an easily downloadable format on the LRHC website at www.littlerivers.org. A hard copy is also be available by calling Little Rivers Health Care Administration at 802-222-3000 and requesting a copy. This information will be available to community members without the need to have special hardware or software, without payment or fee, or without the requirement of creating an account or being required to provide personally identifiable information.

A Thank You to Our Partners

We would like to thank all our community partners who met with us and provided input into the 2021 Community Health Needs Assessment. In particular, we thank Bi-State Primary Care Association for its generous sharing of statistical data, insight, and advice in preparing this report. We would also like to thank all the agency and independent members of the Upper Valley Unified Community Collaborative for working together with us in conducting the CHNA data collection process.

Objectives

This eastern Orange County Community Health Needs Assessment (CHNA) seeks to accomplish the following:

1. Describe the socio-demographics and health status characteristics of our service area.
2. Examine health disparities due to age, gender, race, ethnic origin, income, education, and insurance status.
3. Describe the perspectives of stakeholders and key informants with regard to access barriers and gaps in service.
4. Explore the impact of state and federal policy and other environmental factors on the health or our target population.
5. Better understand the impact of COVID-19 on our communities.
6. Provide the needed information and insight to update LRHC's strategic planning process.

Methodology

Both primary and secondary sources of data were used for this report. The CHNA process included a review of qualitative data from primary sources, including a community survey's results and findings as described in this report. The community survey, entitled "Eastern Orange Community Health Needs Assessment" was distributed widely and provided information about perceptions of health needs and risk behaviors that have the greatest impact on the community. The survey also indicated the perceptions of the availability or lack of availability of a broad spectrum of resources. The survey was easily electronically accessible via a Survey Monkey link which was circulated through multiple e-distribution lists reaching numerous agencies, organizations, and employers in the LRHC service area. A link directly to the survey was also posted on LRHC's website. Paper surveys and survey collection boxes were not distributed because of COVID restrictions.

Primary source data were derived from:

- Key informant interviews, focus groups, and widely distributed digital surveys that were created on www.surveymonkey.com and distributed with a link. The following stakeholders participated in the completion and distribution to farther reaches of our region:
  - Representatives from local health and human service agencies
  - Clinicians, nurses, and care coordinators from within and outside LRHC
  - LRHC board of directors
  - Behavior health organizations, including Clara Martin Center our areas designated mental healthcare center
  - School staff of Orange East Supervisory Union
  - Vermont Department of Health
  - Consumers
  - Data from patient satisfaction surveys

Secondary sources included:

- *Community Health Rankings & Roadmaps, 2020 Rankings*, published by the University of Wisconsin Population Health Institute
- *2019 Vermont Youth Risk Behavior Survey Report: Orange County*, published by the VT Department of Health
- *VT Household Health Insurance Survey Data Compendium*, published by the VT Department of Health (July 2018)
- The *Healthy Vermonters 2020 Data Explorer*, on the website of the VT Department of Health
- *The Behavioral Risk Factor Surveillance System 2018 Report*, published by the VT Department of Health (January 2020)
- *QuickFacts for Orange County Vermont, on the website of the* US Census Bureau (data estimates were as of 7/1/2019)
- Data from the Vermont Housing Finance Agency, including the *2020 VT Housing Needs Assessment (Chapter 19: Orange County)*
- *Cottage Hospital 2019 Community Needs Assessment* (December 2019)
- *Northeastern Vermont Regional Hospital 2018 Community Health Needs Assessment*
- 2019 Census of Dentists Statistical Report, published by the VT Department of Health (September 2020)
- *Health Care Workforce Census Dental Hygienists, 2019*, published by the VT Department of Health (April 2020)
- *2018 Physician Census Statistical Report,* published by the VT Department of Health (October 2018)
- *The VT Dept of Health COVID-19 Dashboard*, accessed February 2021
- *The Vermont Primary Care Practitioner Workforce 2018 Snapshot*, published by the VT Area Health Education Centers Program
- *UDS Mapper,* accessed February 2021
- *DataUSA: Orange County Vermont,* accessed February 2021
- Vermont Affordable Housing Coalition 2021
- *Local Area Unemployment Statistics,* Vermont Department of Labor (August 2021)
- *2020 State Agricultural Overview,* nass.usda.gov/Quick_Stats/stateOverview.

CHARACTERISTICS OF THE HEALTH SERVICE AREA

Overview of Little Rivers' Service Area

LRHC's 18-town service area in east central Vermont is rural, and according to the 2021 UDS Mapper data, includes: **Bradford, Corinth, Fairlee, Groton, Newbury (which includes the village of Wells River), Ryegate (East and South), St. Johnsbury, Thetford, Topsham, West Topsham, and our neighboring "border" towns in New Hampshire of Bath, Haverhill, Monroe, North Haverhill, Orford, Piermont, Pike and Woodsville,** with a total population of **~22,000**.

Although the overall average density is 42 residents per square mile, roughly a third of them live in villages with the remaining two thirds spread throughout the hills and valleys. Bradford, Vermont is the largest town with a population of 2,619 (Census 2019). While an Interstate highway runs North/South on the VT/NH border, most roads that connect residents to their schools, jobs, and social services are secondary or tertiary. Residents generally stay within the boundaries of the service area and do not routinely travel to the bigger population centers of Hanover, NH / Dartmouth (25 miles south) or Littleton, NH (35 miles northeast) for services, particularly during the winter and "mud" seasons (October-May).

With few other providers in the area, LRHC's target population includes all the residents of the service area, with a special emphasis on the low-income and underserved. The population is comprised predominantly of farmers, tradespersons, service industry workers, seasonal employees, and seniors. Compared to the rest of the country, the overall Vermont population is aging faster; in 2019 the median age of residents was 42.9 years, compared with 38 years nationally. Orange county is even older with a median age of 46.6 years in 2019. In Orange County 22% of the population is over the age of 65 versus 20% statewide.

Regional Characteristics

Orange county is 95.6% Caucasian but has unique cultural attitudes which influence health behaviors and the access and utilization of health care services.

Self-reliance and independence are strongly valued cultural traits among Vermonters. These admirable qualities can become liabilities that hinder many of our residents from pursuing or accepting financial assistance, counseling or other care. Some will resist care until they are in an emergency situation. With regard to behavioral and mental health, this reticence to reach out to others for help is even more deeply ingrained due to the stigma associated with these needs, not to mention the frequent inability or unwillingness to acknowledge a problem even exists. This fierce independence can also contribute to the social isolation already inherent in a rural community due to geography, an isolation that in turn can worsen substance abuse and mental health problems.

Unemployment in this region, as in all Vermont, is relatively low at 3.0% as of August 2021 compared to 5.3% nationwide. Under-employment is more of an issue. A great many jobs involve seasonal work and/or frequent layoffs due to lulls and surges in business. There is no large employer base that offers good benefits. Farming, logging, building trades, small retail and

self-employment are the most common industries, all of which are very vulnerable to changes in the larger economic climate and unforgiving weather.

The 2020 State Agriculture Overview reports that there are 6,800 working **farms** in Vermont. In 2017 Orange County accounted for 7% of the state's agriculture; 38% is cropland, 13% is pastureland, 44% is woodland, and 5% is other.

Migrant and seasonal workers are common to our farms, as are foreign workers who stay 2-3 years at a time to work at local dairy farms. In our area, most of these workers are from Mexico and speak very little or no English. It is difficult to obtain numbers of this population because of fear of deportation, even among those with work papers, but recent estimates suggest there are over 2,000 in Vermont. This same fear also inhibits seeking attention for injuries and illnesses among these workers, let alone routine care. Farm workers work as long as the light permits during the growing season; 10–16-hour days are typical. In terms of work safety, agriculture consistently ranks as one of the most dangerous occupations. Hazards include repetitive strain, working with dangerous equipment, and exposure to toxic pesticides and other chemicals, to list a few. In addition to occupational illnesses and injuries, these workers are especially at risk for depression due to their isolation and separation from loved ones.

Poverty has been identified as a major barrier to health care access and utilization in our area, as well as to health self-management. It impacts an individual's access to transportation, secure stable housing or ability to maintain Internet and telephone services. These issues all impact an individual's ability to make and attend appointments, as well as follow through on a health care plan. According to 2019 estimates cited in the US Census Bureau's *QuickFacts* for Orange County Vermont, the average per capita income here ($31,697) is below the state average of $34,577. 9.4% of the area's residents are living below the Federal Poverty Level, but it should be noted that this is misleading because **Vermont livable wages need to be taken into account.** Federal poverty guidelines as applied to Vermonters understate the effect on the ability to afford basic essentials and health care in this state due to the relatively high cost of living. The VT median income is significantly below what is considered a livable wage in Vermont. Although the Vermont minimum wage is higher than the national average at $11.75/hour, it is still less than the livable wage of $13.39 per hour estimated by the Vermont Legislative Joint Fiscal Office, which is needed to afford to meet basic needs of state residents. The State of Vermont Office of the State Treasurer said that the cost of living increases as of January 1st, 2021 reflects a 1.60 % change from the June 30, 2018 inflation rate.

The issue of **generational poverty** must also be addressed if one is to even begin to understand the challenges some of our residents face with regard to accessing health care services. This type of poverty, unlike situational poverty, is even more about culture than it is about money. It involves individual behaviors, group mores, personal power and control over one's situation. To address it effectively requires confronting many uncomfortable truths regarding political and economic structures and even human exploitation. Those caught in its net are of necessity anchored in the here and now, trying to survive one day at a time. Their choices are driven by immediate need and what has been described as "the tyranny of the moment." This effects both

physical and mental health, but behavioral health issues in particular are likely to be considered a low priority if indeed they are even recognized.

Lack of transportation hinders many patients from seeking health care when they need it in our area. This subject comes up consistently at meetings of health and human service providers and is identified as a major barrier to access to care for those who need the care most. Even for those patients with some access to transportation, many travel 20+ miles to their health appointments, which in a rural, hilly region with many unpaved roads, this can easily take 30-45 minutes. There is no mass transit and the two local bus services have limited schedules and routes at this time. Taxi service is available in some areas but expensive and limited as well. A car is beyond the means of many (5% in our area have no access to a vehicle at all), and some, especially the elderly, do not drive. Others are fearful of driving in snow (which can cover roads in many areas for up to 5 months out of the year), and a significant number in the community have had their licenses revoked as a result of DUI/DWI infractions. Those who do have cars often struggle to afford maintenance, fuel and insurance.

Affordable housing is a widespread problem in this area because of low wages and few low-cost housing options. Vermont has a greater percentage of affordable and available rental homes for extremely low-income households than the national average, but the state still faces an affordable housing shortage, which impacts families with the lowest incomes more severely. In Vermont, there are 18,813 extremely low-income households, but only 9,200 affordable rental homes available to them. Approximately 64% of extremely low-income households in Vermont are severely cost-burdened and at risk of homelessness. This data was collected prior to the COVID-19 crisis, and the pandemic has exacerbated challenges facing low-income households. (Vermont Affordable Housing Coalition).

The average home cost is rising throughout the state. In December 2018 the average home cost was $237.48K compared to $274.36K in December 2020. A new report from the National Low Income Housing Coalition (NLIHC) found that Vermont's "housing wage" – the hourly wage Vermonters must earn to afford a two-bedroom home at fair market rent (FMR) – is $22.78. The average renter in Vermont earns $13.40 an hour, which is $9.38 less than the housing wage. The average renter can afford just $697 a month for their housing costs without spending more than 30% of their income, while the median apartment rental cost in Orange county is $847 per month and the state median cost is $945 per month. Taken together, Vermont has the 6th largest affordability gap for renters in the country. (Vermont Affordable Housing Coalition).

Our providers and school nurses report that homelessness is much worse than we have been able to quantify, especially with regard to those who are part of a growing subculture of what is known as "couch surfers," individuals and families who stay with friends and family members for short periods of time and then move on. These essentially homeless individuals are much more difficult to reach and keep connected to care for obvious reasons.

More details regarding regional demographics are illustrated in the following table:

Regional Demographics Compared to the State

Measure	Orange County (OC) or Upper Valley (UV)	Vermont	Statistically significant: Higher/lower/similar
Population			
Population (2019)	28,892	623,989	
High school graduation	91.8%	92.7%	
Bachelor's degree	29.1%	38%	Lower
Persons <5 years old	18.1%	18.3%	
Female persons	49.8%	50.6%	
White alone, not Hispanic/Latino	95.6%	92.6%	
Hispanic/Latino	1.4%	2%	
Veterans	2,047	36,988	
Foreign born	2.1%	4.7%	Lower
Persons per household	2.3	2.3	
Living in the same house 1 year ago	90.4%	86.7%	
Language other than English spoken at home	3.4%	5.8%	Lower
Living with a disability under 65	12.9%	10.6%	
Civilian labor force	66.4%	65.4%	
Connectivity			
Household with a computer	87.7%	89.9%	
Households with broadband internet	79.1%	81.5	
Transportation			
Mean travel time to work	27.1 minutes	23.3 minutes	
Commuting in a car alone 30+ minutes	43%	31%	Higher
Income			
Household income	$60,925	$61,973	Less

Persons in poverty	9.4%	10.2%	Fewer
Population per square mile	42.1	67.9	Less
Unemployment (VT Dept. of Labor)	2.4%	3.0%	Similar
Children in poverty youth <18 years living in poverty	13%	12%	Similar
Severe housing problems – households have at least one of 4 problems – overcrowding; high costs; lack of kitchen facilities; lack of plumbing facilities	16%	17%	Similar
Homeless individuals	23 (22 adults; 1 child)	1110	
Median monthly rental	$847/month	$945/month	Less
4-person median family income (HUD 2020)	$74,400	$79,000	Less
Households (type: owner w/ mortgage) are paying 50%+ of income on housing costs	15%	13%	Similar
Households (type: owner w/o mortgage) are paying 50%+ of income on housing costs	11%	10%	Similar
Households (type: renter) are paying 50%+ of income on housing costs	23%	25%	Similar

Access to Health Care Services

In 2018, 97% of Vermont residents indicated they have a primary source of **health insurance**. This accounts for approximately 604,800 persons. Despite this encouraging statistic, in reality, most plans now available to Vermonters are high deductible plans, whether or not they are labeled as such. Those whose income is below 136% of the FPL qualify for Medicaid, but now most everyone else must purchase health insurance through the state health exchange, Vermont Health Connect (VHC). Although there are federal and state subsidies adjusted to income and household size to help offset the premium costs, the patient still pays the first-dollar out-of-pocket costs, which are from $1,250-$5,000 for single plans and $2,500-$10,000 for 2-person and family plans except for the 2 plans with the highest monthly premiums. This poses a hardship for a great many of our patients.

Most residents have private health insurance (53%). Around one in five have Medicare (19%) or Medicaid (22%). Three percent indicate they are uninsured. The proportions of Vermonters with each type of insurance has not changed statistically since the last survey in 2014. Since 2000, the proportion of Vermonters with private insurance has decreased from 60% to 53%. The proportion of those who are uninsured has also decreased (from 8% to 3%). The proportion of Vermonters with Medicare (14% to 19%) or Medicaid (16% to 22%) has increased. 4% of residents in Orange County are uninsured.

Health care workforce is a significant concern in Vermont, as it is across the country. Primary care, oral health, and behavioral and mental health services are all seeing shortages in workforce, and Orange County, which of course has a direct impact on access. The following table lays out some statistics that highlight the challenges faced in Orange County in particular:

Measure	**Orange County (OC) or Upper Valley (UV)**	**Vermont**	**Statistically significant: Higher/lower/similar**
Residents with a personal health care provider	83%	86%	Similar
Ratio of primary care population to FTE provider	2,400-3,000:1	1,437:1	Worse
Adults who have had a routine doctor visit in last 12 months	74%	76%	Similar
Those with medical health plan coverage	89%	92%	Similar
Uninsured <65 years	6%	6%	Similar
Residents who did not visit a doctor due to cost	10%	8%	Similar
Households with military coverage	6.6%	2.7%	Highest in the state
Households that report going to a private doctor's office or practice when sick or needing medical attention	52.7%	64.9%	Lower
Households that report going to a health center	18.6%	19.3%	Similar
Households that report going to a hospital outpatient department	15.8%	7.2%	Higher
Households that report going to a VA clinic	6.1%	1.7%	Higher

Households that report that they usually go to a private doctor's office or group practice for routine or preventive care	54.4%	67.7%	Lower
Households that report going to a health center for preventive care	18.9%	19.1	Similar
Households that report going to a hospital outpatient department	14.5%	6.5%	Higher
Households that use a VA clinic for outpatient services	6.4%	1.7%	Higher
Households that report that it takes 5 minutes or less to travel to their usual place for routine medical care	7.9%	15%	Lowest in the state
Households that report that it takes 31-40 minutes to travel to their usual place of care	10.3%	3.7%	Higher
Households report it taking 41-50 minutes	10.5%	3.7%	Higher
Households reported going to ER b/c it was more convenient	6.4%	18.4%	Lower
Households said it was b/c their doctor's office told them to go	4.6%	20.1%	Lower

Health Status and Health Disparities

Income level and access to care affect health habits and overall health. Lower income Vermonters report significantly higher rates of depression and chronic disease, are more likely to be obese, engage in regular physical activity less and smoke significantly more. State health disparities data have not been updated since 2010 and are therefore not reported here, although those older studies indicated a clear correlation between income levels and health status. The more updated statistics below indicate that Orange County is tracking similarly to state averages.

Medical Conditions

Measure	Orange County (OC) or Upper Valley (UV)	Vermont	Statistically significant: Higher/lower/similar
Adults with arthritis	30%	28%	Similar

Adults with asthma	12%	12%	Similar
Adults diagnosed w/ Cancer	7%	8%	Similar
Adults diagnosed w/ Skin Cancer	7%	7%	Similar
Adults w/ CVD	8%	8%	Similar
Adults w/ COPD	6%	6%	Similar
Adults with Diabetes	10%	9%	Similar
Adults with HTN	27%	25%	Similar
Adult obesity w/ BMI>30 KG/m^2	28%	26%	Similar
Adult obesity w/ BMI>30 KG/m^2	28%	26%	Similar

VT Dept of Health COVID-19 Dashboard

Measure	Orange County (OC) or Upper Valley (UV)	Vermont	Statistically significant: Higher/lower/similar
Cases as of 10/18/2021	1,228	37,519	
Cases per 10,000 as of 10/18/2021	423.5	601	Lower

Recreation and Physical Health			
Access to Locations for Physical Activity	52%	76%	Lower
Physical inactivity no leisure time physical activity	21%	19%	Similar
Adult obesity w/ BMI>30 KG/m^2	28%	26%	Similar
Poor physical health	14%	12%	Similar
Premature death years of potential life lost before age 75	6,400	6,300	Similar
Teen births per 1,000 females	11	12	Similar
Adults who report high risk HIV transmission behaviors	8%	6%	Similar

Violent Crime:	19 per 100,000 population	129 per 100,000 population.	Lower
	Behavioral Health		
Poor mental health days within last month	4.1	3.4	Similar
Injury deaths per 100,000	84	83	Similar
Rate of suicide per 100,000	11.6	18.3	Similar
Adults who reported poor mental health	15%	12%	Higher
Adults w/ depressive disorders	26%	21%	Higher
	Lifestyle		
Adult smoking	14%	14%	Similar
Adults who use smokeless tobacco	4%	3%	Similar
Adults who report excessive drinking binge or heavy drinking	18%	19%	Similar
Adults who report driving after marijuana use (of those who report currently using marijuana	41%	23%	Higher
Children in single-parent homes	30%	30%	Same

Oral Health

The need for more access to dental services is widespread across Vermont, but it is especially dire in our east central Vermont service area where there are fewer than half the number of dentists per number of residents than the state average, according to the *Vermont Department of Health 2019 Census of Dentists Statistical Report.* There are only 2 dental practices in the Bradford area, neither of which is accepting new patients, one is looking to retire in the near future, and both have historically had to severely limit the number of Medicaid and uninsured patients. While those with insurance and of more stable means can travel to more populous areas 30-60 minutes away to find a dentist, a large number of our neighbors don't have the means to do so, either due to lack of transportation and/or money or other social determinants of health. This is especially challenging for those with Medicaid coverage or no insurance at all since many dentists do not accept these patients at all.

Poor oral health has a ripple effect on a great many other factors that influence health, well-being, and financial stability. Periodontal disease can result in complications of pregnancy,

diabetes, heart disease and stroke. Dental infections can lead to lost productivity and/or time from work and overuse of pain medication. Tooth loss can impact nutrition, self-esteem, and even the ability to get a job, especially in a service industry where there is interface with the public and a friendly smile is considered a job requirement. Dental pain and infection also result in unnecessary emergency room utilization and surgery, costing individuals and taxpayers.

2017 East Orange Supervisory Union Youth Risk Behavior Survey (YRBS) Compared to 2019 Orange County and Vermont YRBS

In Orange county 91.8% of students graduate from high school as compared to 92.7% in the state and 29.1% have a bachelor's degree as compared to 38% in the state. There can be skepticism or a suspicion toward those with higher education. Our school nurses report a high rate of resistance among children and parents to information that challenges their beliefs, especially with regard to behavioral health issues. There is lack of recognition that many aspects regarding their situations can be improved because so many around them share the same problems. Affordable quality childcare is virtually unavailable for many, impacting their ability to work outside the home, attend classes, or schedule health appointments. A great many in our community have communication problems despite the fact that English is their native language. Poor language skills make articulation of needs difficult and frustrating. This can manifest itself as behavioral issues or reluctance to share concerns about physical or mental health issues.

Measure	OC (2019)	Vermont (2019)	Statistically significant: Higher/lower/similar
High school graduation	91.8%	92.7%	Similar
Bachelor's degree	29.1%	38%	Lower

HIGH SCHOOL

Measure	OESU (2019)	OC (2019)	Vermont (2019)	OESU vs. VT Statistically significant: Higher/lower/similar
Students who were in a physical fight in the past year	23%	23%	18%	Higher
Students who carried a weapon on school property in past 30 days	5%	7%	5%	Similar

Students who were electronically bullied in past year	20%	21%	16%	Higher
Students who report that someone has ever done unwanted sexual things to them	22%	22%	18%	Higher
Students reporting doing something to purposely hurt themselves without wanting to die in the past year	24%	22%	19%	Higher
Students who reported ever trying cigarette smoking	27%	27%	22%	Higher
Students reported ever using inhalants	7%	10%	7%	Similar
Students ate breakfast at least 5 days in past week	45%	48%	54%	Lower
Students who have a physical disability, emotional problems, or a learning disability	33%	34%	30%	Similar
Students who described their grades as mostly As and Bs	77%	71%	78%	Similar
HS students who report that they are most likely going to attend a 4-year college, community college, or tech school after high school	59%	70%	78%	Lower
Students who report not participating in any afterschool activities	37%	41%	34%	Higher
Students who strongly agree or agree that in their community they feel like they matter to people	49%	54%	58%	Lower

Students who reported texting or emailing while driving in past 30 days	34%	30%	35%	Similar
Students reporting binge drinking in last 30 days	21%	12%	15%	Higher
Students who were physically active at least 60 min per day on 5+ days in past week	46%	50%	46%	Similar
Students who played video games or used a computer 3+ hours per day	52%	43%	48%	Higher

KEY FINDINGS

Summary of Key Findings from Primary Sources

Focus groups conducted in 2021 with the parties listed on page 4. Each focus group was presented with the following questions to address, with some minor differences based on the audience:

1. What are the main barriers people in our communities face with regard to health and safety?
2. What forms of assistance would help people in our communities achieve more stability and self-sufficiency?
3. What specific health conditions (include physical, mental, dental) seem to be prevalent in our area?
4. What top priorities should we be addressing?
5. What are the top challenges you as a service provider face?
6. What have you found works best with clients/patients when helping them meet their needs?

Collectively, the groups identified the following highest priority areas on which to focus with regard to gaps between available resources and community need: (Please note that these are not necessarily listed in order of priority due to the difficulty quantifying responses across the focus groups)

1. Access to oral health/dental care
2. Mental/behavioral health/substance use treatment
3. Care coordination/healthcare system navigation
4. Chronic disease management

5. Prescription drug affordability
6. Wellness supports

The above 6 clinical needs are also closely related to and influenced by the following social determinants of health:

1. Lack of transportation
2. Lack of safe and affordable housing
3. Food insecurity
4. Lack of internet connectivity
5. Sustainable employment

Please see Appendix A for detail of responses.

Summary of Key Findings from Secondary Sources

Areas where needs in our local service area were higher than state average:

1. Access to dental care
2. Overuse of hospital in-patient services
3. Adult obesity
4. Stroke death rate
5. Poverty/low-income rates
6. Transportation
7. Access to internet
8. Rate of depressive disorders
9. Tobacco use
10. Marijuana use
11. Youth survey findings-rates higher than state's:
    a. Physical fighting
    b. Electronic bullying
    c. Unwanted sex
    d. Purposeful self-harm
    e. Smoking
    f. Use of inhalants
    g. Not feeling they matter

Secondary source data has been presented within this document and additional detail is attached in Appendix B.

Study Limitations

The findings of this assessment were in alignment with expectations and general observations from those who work most closely with patients. However, every study has its limitations and the ones identified with this study include:

1. Many data points from secondary sources were not available on a town-by-town basis and not as specific to our service area as would have been preferred. This is particularly an issue with respect to access issues due to a Critical Access Hospital with owned primary care practices on the western side of Orange County.
2. Stakeholder reports were anecdotal and not based on quantitative data from the participating health and human service agencies.
3. The weighting of issues was difficult in terms of impact versus incidence and access. This was beyond the scope of this study but deserves further inquiry in the future.
4. Because secondary data came from multiple sources and not necessarily derived from the same years, assumptions regarding correlation and certainly causality should not be made.

Recommendations

It is of note that the primary source data are by and large supported by objective secondary data sources. Given the mission and resources of LRHC, and with the strong collaborative work this organization does with community partners, the following high priority areas have been identified as important areas of focus for LRHC in our services area for the upcoming years:

1. Increase access to dental care
2. Expand capacity for mental/behavioral health/substance use disorder services
3. Enhance chronic disease management and prevention
4. Enhance care coordination services to include more patient navigation assistance
5. Work with area partners to better address transportation needs
6. Develop food access program
7. Collaborate on transportation access initiatives
8. Collaborate on affordable housing initiatives

Given the assets and strengths of the many excellent service providers in our area, along with the strong culture of collaboration, LRHC is in an excellent position to make a significant impact on the above priorities over the next few months and years. This study will inform our strategic planning process and influence the funding opportunities for which we apply.