# Community Health Worker (CHW) Assessment 2017
# North Country Region

North Country HEALTH CONSORTIUM
NCHCNH.org

## Table of Contents

**Introduction and Methodology of the Community Health Worker Assessment 2017**

The assessment of the Community Health Worker (CHW) role in chronic disease prevention and management in the North Country Public Health Region has been conducted through in-person interviews, telephone interviews and an online survey to gather information (63% response rate). The group represented a broad constituency including leaders in area business, faith-based groups, and health and human service organizations. Additional information includes data from the recent Community Health Needs Assessment by The North Country Health Consortium. The success of the assessment has relied on the established relationships with health care providers and community based organizations in the North Country, and used assessment tools that were customized to address the specific needs of the North Country communities.

The needs assessment includes information pertaining to:

- Understanding of the role of CHWs
- Current practices and barriers related to the integration of CHWs into health care teams and their use in the community for targeted outreach
- Training and technical assistance needs of health care systems and community organizations related to CHWs
- Policies or protocols that incorporate CHWs into teams
- Identified opportunities to incorporate CHWs into chronic disease prevention and management

The following information are summary points of the most recent regional Community Health Needs Assessments(CHNA) conducted between November 2015 and September 2016. The Executive Summary from the CHNA is available in Exhibit A. In Exhibit B are demographic and area health indicators to provide context of the communities in the Northern NH service area of Coos and upper Grafton counties. The secondary data was collected from the U.S. Bureau of the Census, Behavioral Risk Factor Surveillance Survey, County Health Rankings, and the NH State Health Profile and available as benchmark data to see how the area compares to state and national trends. Information from the surveys and secondary data sources are used to evaluate the health of the community, identify high priority health needs, and develop and implement strategies to address the needs of the community.

The *top six serious health issues* in the North Country that were identified by the community assessment surveys were:

- Substance Misuse (includes drugs, opioids, heroin, etc.) (83.9%)
- Obesity/Overweight (79%)
- Alcohol Abuse (74.4%)
- Low-income/Poverty (74%)
- Physical Inactivity (72.9o/o)
- Smoking and Tobacco Use (72.1%)

Key informants in the Community Health Needs Assessment identified the following as challenges in the North Country healthcare system:

- Access to Healthcare

- Affordable Health and Dental Insurance
- Barriers to Healthy Living
- Healthcare Workforce Capacity
- Inadequate Behavioral Health Services

Using this information as a building block for improving health and wellness in the northern NH area alongside the known ca
pacity of Community Health Workers(CHW) across the United states that address these issues, a survey was developed and implemented to gain a better understanding of potential incorporation of CHWs into local health and human services for a comprehensive approach to whole patient care.

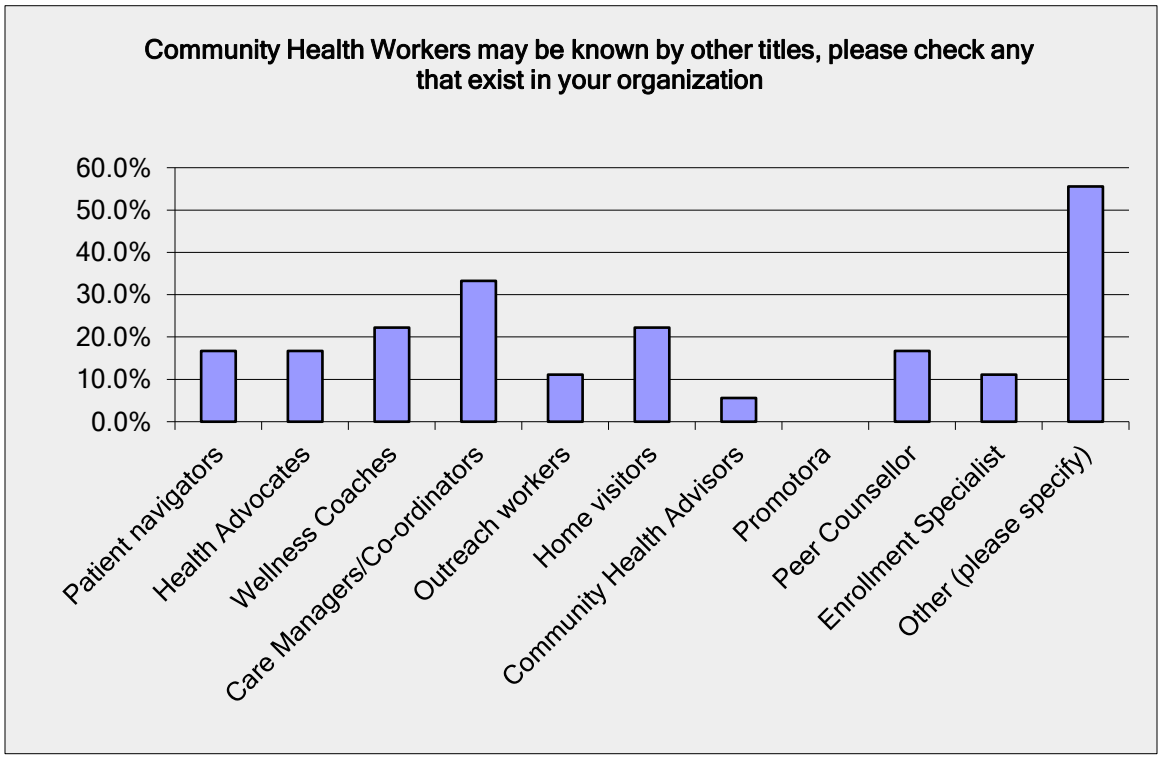
**Community Health Worker Assessment 2017**

**Summary of Findings***

**Key findings from the Community Health Worker Survey:**

- 90% of all respondents are very to extremely interested in learning about CHWs.
- 95.5% see CHWs as relevant to their organizational needs, with 4.5% stating CHWs may not be relevant.

Many organizations are already using CHWs in their organization. However they may be given different titles:




Other titles include:

- Non-licensed social worker
- Home meal delivery coordinator
- Social Workers
- Peer Support Specialist
- Family Support Coordinators
- Behavioral Health Workers
- Certified Recovery Support Workers CRSW
- Social Workers
- Medical social worker

*Respondents could choose more than one answer

50% of all respondents stated they could “absolutely” imagine CHWs integrated into their organization and all others said it could be possible.

**Primary Focus of a CHW:**

| What would you see as a Community Health Worker's primary focus? | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Client/Community Education | 72.7% | 16 |
| Outreach | 40.9% | 9 |
| Resource Provision/Service Access | 50.0% | 11 |
| Support Groups | 18.2% | 4 |
| Other (please specify) | 18.1% | 3 |

*respondents were allowed to choose multiple answers

Other specified answers (18.1%) included:

- Breast and Cervical Cancer Program,
- Behavioral Health,
- and a focus on decreasing patient readmissions.

In-home visitation availability by CHWs to work with clients was stated as a benefit to 68% of respondents with another 27% stating it may be a benefit.

**Technical Assistance needed for CHW incorporation into organizations varied:**

| What kind of technical assistance would your organization need to incorporate a CHW into your team? | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Administrative | 27.3% | 6 |
| Policy and Procedures | 36.4% | 8 |
| Funding sources to support the position | 81.8% | 18 |
| Quality Improvement | 18.2% | 4 |
| Incentives | 9.1% | 2 |
| Other (please specify) | 18.2% | 4 |

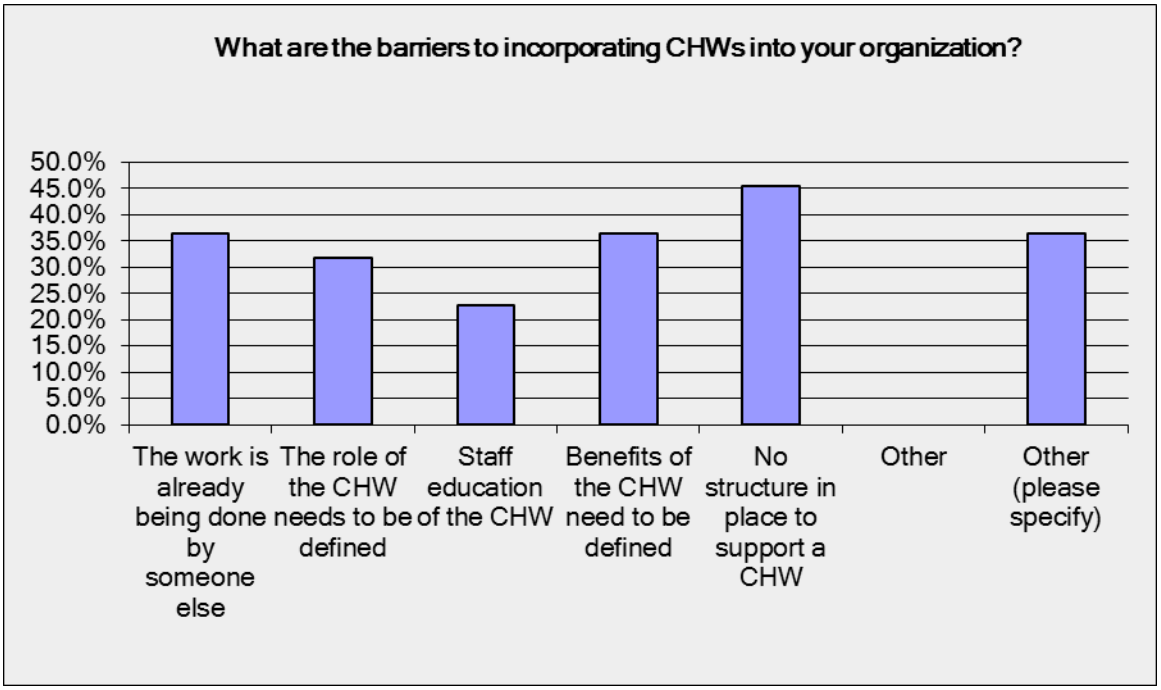
*respondents were allowed to choose multiple answers

Other answers (18.2%) included:

- Not part of organization’s mission.
- Regulation.
- CHWs are already part of the team.

Lack of funding for education/initial course fees.

**Barriers for the use of CHWs correlated to the necessary Technical Assistance:**

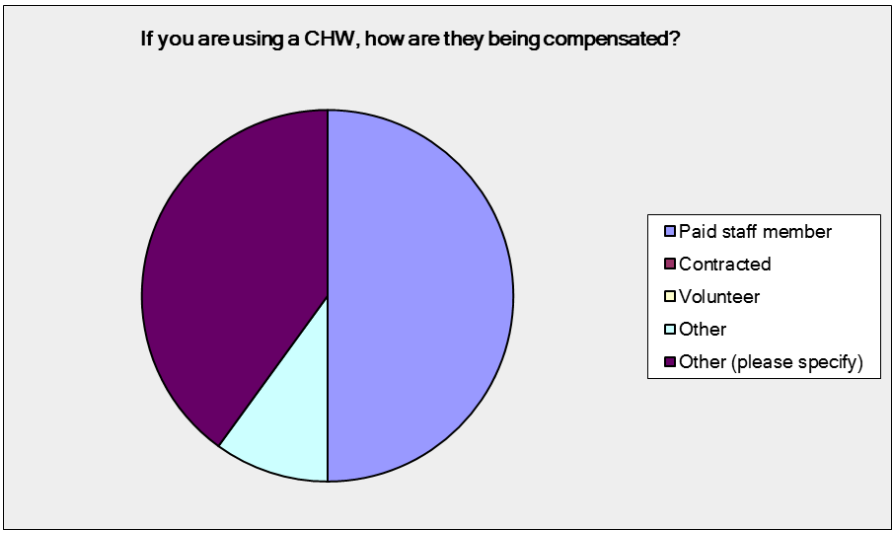



Other barriers (36.36%) noted:

- A Volunteer CHW may work, but need to have a job responsibility.
- Bureaucracy re: insurance/reimbursement.
- Funding - State Agency.
- Peer support already in place.
- Not enough personnel.

**CHW Compensation:**

.



It was stated that 50% of workers currently used with roles similar to CHWs are being funded as a paid staff member and 40% are grant/temporarily funded. The remaining 10% are not funded.

**Other comments from CHW survey respondents:**

- "Essential if we are trying to support elders in their homes."

- "Social worker acts as the community health worker, not all senior center sites have this capacity. Need to work on reducing the stigma of senior centers so more people have access to the resources."

- "Community Health Workers can be helpful in providing more case management and more investigation than we are able with our high case loads."

## Conclusion and Dissemination Plans

The survey was delivered to individuals representing local health and human service providers, faith-based community representatives and social service organizations. In some cases, this was the first opportunity to share Community Health Worker(CHW) roles and capabilities. The American Public Health Association " A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy." Once the definition of the Community Health Worker was clarified, a majority (90%) stated their interest in potential integration of CHWs is very high.

The CHNA data show consistent themes that directly reflect a need to address the social determinants of health, the primary role of Community Health Workers and complement the information gained through the surveys process.

The dissemination of assessment findings will occur in several ways. The North Country Health Consortium Board of Directors is made up of the leadership of North Country stakeholder organizations. These include all of the regional Federally Qualified Health Centers, all of the regional Critical Access Hospitals, the community mental health center, home health agencies, long-term care facilities, tri-county community action programs, and several other social service organizations. The assessment findings will be reviewed by the Board at a monthly meeting, and program progress will be discussed quarterly. Assessment findings will be reported at a quarterly CHW Coalition Meeting, and posted on the NCHC web site. Results will be shared with the Department of Health and Human Services, as requested. A press release will be disseminated to local media that describes the role of CHWs, results of the survey, and CHW training opportunities.

**Exhibit A**

## Community Health Needs Assessment
## Executive Summary

As part of the 2016 North Country Regional Community Health Needs Assessment, 181 community leaders and 528 community members were surveyed to gather information about health status, health concerns, unmet health needs and services, and suggestions for improving health in the community.

*Key findings from the Community Survey:*

The *top six serious health issues* in the North Country that were identified by the community assessment surveys were:

- Substance Misuse (includes drugs, opioids, heroin, etc.) (83.9%)
- Obesity/Overweight (79%)
- Alcohol Abuse (74.4%)
- Low-income/Poverty (74%)
- Physical Inactivity (72.9o/o)
- Smoking and Tobacco Use (72.1%)

The *top six serious health concerns* for the North Country that contribute to the most serious health issues were identified to be:

- Drug Abuse (84%)
- Lack of Dental Insurance (79%)
- Cost of Prescription Drugs (78%)
- Lack of Physical Exercise (75%)
- Cost of Healthy Foods (74%)
- Alcohol Abuse (72%)

Community members identified the following *programs, services or strategies to improve the health of the community:*

- **Access to Healthcare and Services**: Need urgent care facilities; weekend and evening availability for urgent care beyond emergency departments; addiction treatment and supports as well as Suboxone prescribers; access to mental health services, including psychiatrists and child development specialists; continuum of care services for mental health and substance misuse, appropriately addressing the social determinants of health; in-home supports for children with emotional and developmental needs; expanded healthcare workforce, including primary care providers, actual MDs/DOs, dermatologists, pediatricians, functional medicine, specialists, and internal medicine; need a naturopath care giver; access to more affordable prescription medications; access to more affordable dental services, especially for the uninsured; more community-based services for seniors; assistance with navigating the marketplace; more safety net services for low-income families; COPD and cardiac rehab; local cancer care; more of a focus on preventative care versus sick care; better in-home care for elderly by qualified individuals; more police to help

combat the drug abuse problems in the region; access to on-call nurses; develop more homeless shelters out of vacant buildings; better insurance benefits that cover gym memberships and decrease other out-of-pocket costs;
need exchange programs; more patient education classes at hospitals; hospice house; free diabetes classes; medical art therapy programing; autism services, such as OT and ABA therapy, and more funding to support parents who are paying for these services; palliative care outpatient clinic; and weight loss services.

- **Environment/Economy**: Better public transportation options; opportunities for families to have fun; less fast food; more affordable housing; lower taxes for homeowners; better paying jobs that provide benefits, especially health insurance; varied exercise programs; affordable rec programs for kids; more programs and activities for middle age group; more safe places to walk, cross-country ski, and organized events; more recycling; more 5K races or community run/walks; enhance walking areas to entice residents to walk; more community recreation centers; more businesses and social activities; access to more affordable fresh and healthy food; more integration between agencies and institutions; more healthy dining options; better handicapped accessibility universally; support services for the elderly to age in-place; more jobs and industry; more farm to table programs; more spaces for community gardens; more inclusive activities for people with disabilities; more outdoor gatherings, such as outdoor movies or music and treasure hunts; access to indoor walking space; develop initiative for retaining young people in the region; create a pedestrian walkway that connects to shops and services; offer extended hours for water aerobics, water jogging, and low-impact aerobics for adult at local rec center; library expansion to include cultural offerings and plant swaps; dedicated bike lanes; adult organized sports; continue to develop technology infrastructure; expand volunteer opportunities for teens; affordable bus trips for seniors to different areas and places of interest; and public health challenges, such as community-wide walking challenge; lower cost childcare.

- **Education:** Mental health and substance abuse prevention education in school, especially young children; better promotion of community activities and events that are open to the public; intensive primary and secondary prevention education programs; parenting classes; education for healthy lifestyles for all ages; more holistic health groups and education; cooking classes for local food pantry and community meals participants; reduce stigma associated with addiction; on-going health seminars; better education for police and healthcare providers who interact with people with mental illness or substance abuse issues; education around cost-effective ways to eat healthy; teen cooking classes; create hotline for food, cooking, and shopping to assist people trying to learn better eating habits; community forums, public radio, and TV spot ads for promotion of education and activities; life skills education for teens; community education on food allergies; education for elderly regarding Medicare choices, when to register, and how to prepare for nursing home placement; structured health education in schools; hygiene education in schools; well-advertised support groups for drug abuse assistance and help; one-on-one outreach to individuals living in poverty or victims of substance abuse to develop a sense of self-worth and coping skills and an opportunity to become a visible member of the community; and community food drives with nutrition education.

*Key findings from the Key Informant Survey:*

The *top five serious health issues* in the North Country, as identified by key informants, were:

- Substance Misuse (drugs, opioids, heroin, etc.) (94%)
- Alcohol Abuse (91%)
- Obesity/Overweight (90%)
- Mental Health Problems (89%)
- Low-income/Poverty (85%)

Key informants identified the following as *challenges in the North Country healthcare system:*

- **Access to Healthcare**: Healthcare costs are prohibitive; transportation to needed medical treatment and services remains a barrier for residents; long travel distances to specialists; low incomes families need services but lack the necessary resources; and Medicaid transportation assistance is cumbersome with the spenddown requirements.

- **Affordable Health and Dental Insurance**: High deductibles and co-pays; premiums are too costly; many North Country residents lack health insurance; health insurance plans are inadequate and won't cover all of the services that an individual ultimately needs; lack of dental insurance in the region; lower reimbursement limits the number of tests that providers can order; and conflicting recommendations between the government and expert recommendations for care.

- **Barriers to Healthy Living**: Healthy food is costly; cost of medications and prescription drugs; high cost for exercise and wellness classes and activities; lack resources for teaching parenting skills to families; lack of community service opportunities; lack of education regarding healthy living and other determinants of health for low-income families; smoking and other unhealthy behaviors lead to chronic illnesses that become costly and disabling, therefore have an impact on the economy; access to dental care; obesity; need to shift the mindset to prevention versus treatment; and the current alcohol and drug dependence.

- **Healthcare Workforce Capacity**: Lack providers in the region; the high turnover rates for primary care and specialists affects patient relationship; lack of jobs for spouses of providers who want to work in the region; communication among the healthcare workforce remains problematic, especially between hospitals and primary care; expanded hours for healthcare services is needed, but facilities lack the resources to pay for the additional staffing; patients' ability to pay for services affects workforce and the ability to hire; and difficult to attract and retain qualified, quality providers.

- **Inadequate Behavioral Health Services**: Inadequate behavioral health treatment and resources, including for mental health, alcohol, and substance use treatment; stigma associated with treatment; providers need to take a "whole-person" approach; better processes for referral as current wait times for treatment are not acceptable; need more behavioral health workforce; and adequate coverage for services in insurance plans.

Key informants identified the following *new or existing programs or services that could be implemented or enhanced to improve the health of the residents in the North Country:*

- **Education**: Adult education around fitness; evening and summer classes offered at schools for adults, including sewing, gardening, Spanish, basket weaving, etc.; healthy eating seminars; more programs for adults; more educational programs on drug misuse; invest in local workforce to create opportunities for advancement; increased educational opportunities for healthcare positions; parenting programs; free or low-cost nutrition education; community education programs to teach how to shop and cook healthy meals; raise awareness of services that are available in the region, as many are unaware and may be traveling longer distances for services; and offer "how to recognize mental health issues" workshops; education on home economics.

- **Expanded Services**: Including substance abuse and mental health services; drug and alcohol abuse treatment centers; more veteran's services; add Certified Health Educators into school curriculums as well as health, physical, and mental health programs; more physical activities for seniors; half-way house for those struggling with addiction; cardiac ' rehab; early screening for disabilities; mobile preventative services and testing unit to go to communities to provide care; providers offer house calls for seniors; develop a cancer treatment center and a diabetes center; more narcotics support groups; make alternative healthcare options available; smoking cessation programs; local cancer treatment; more public health dentistry; local laboratory services included in insurance (Anthem) network; outpatient clinic open 7 days a week; better outreach for services across the board; recovery supports, including workers and housing; adult dental services; continuity of care services upon discharge; increase screening for suicide; dermatology; a mental health respite program to help those in need or crisis stabilization; and employ Community Health Workers.

- **Enhanced Environment**: Better walking options, including walking trails and better sidewalks; funding to expand community recreation center facilities and services; indoor walking areas; better public transportation and accommodations for those with behavioral health issues; more grocery stores with affordable options; farm-to-table initiatives; workplace integration of health improvement incentives and initiatives; free or low-cost exercise classes; set community health improvement goals; increase physical activities for all ages; institute fitness challenges; and start walking groups and create bike-friendly roads.

**Exhibit B**

## Northern NH Data and Documented Health Indicators

The NCHC service area is located in mountainous terrain and there is reliance upon winding secondary roads that impede travel within the service area as well as to transportation routes outside the service area. Passage is further restricted by the harsh northern New England winters that can complicate travel for five months of the year. Regardless of the time of year, travel from the vast majority of points within the service area to the population centers, requires a significant time commitment. The closest tertiary facility, Dartmouth Hitchcock Medical Center is located over 90 miles away. Public transportation means are nearly non-existent with the exception of the local Community Action Program. Personal transport is costly and requires time away from work and a reliable vehicle to handle the distances and road conditions.

The geographic isolation of the NCHC service area is further evidenced by the fact that the area has a population density of 6.2 persons per square mile, which qualifies it as a sparsely population rural area. The United States Department of Agriculture has also defined Coos County, New Hampshire, as a frontier county by Economic Research Service typology.

According to the US Census Bureau, the 2015 population estimate in Coos County is 31,212, lower than the population of 33,052 in 2010.[1] The median age in Coos County is 47.9 years, compared to 43.9 in New Hampshire. Median household income in Coos County in 2010-2015 5-year average was $42,407[2], while the statewide median income was $64, 230.[3][4]

**The following table displays the 2016 County Health Rankings Health Outcomes and Health Factors Data for Coos County, New Hampshire[4]**

| | Coos County | Error Margin | Top US Performers* | New Hampshire | Rank (of 10) |
|---|---|---|---|---|---|
| **Health Outcomes** | | | | | **10** |
| ***Length of Life*** | | | | | 9 |
| Premature death | 7,200 | 6,100-8,300 | 5,200 | 5,400 | |
| ***Quality of Life*** | | | | | **7** |
| Poor or fair health | 14% | 14-15% | 12% | 13% | |
| Poor physical health days | 3.5 | 3.4-3.7 | 2.9 | 3. | |
| Poor mental health days | 3.7 | 3.6-3.8 | 2.8 | 3.6 | |
| Low birth weight | 6% | 7-9% | 6% | 7% | |

[1] http://www.census.gov/quickfacts/table

[2] http://www.nhes.nh.gov/elmi/products/cp/documents/coos-cp.pdf

[3] http://www.city-data.com/city/Grafton-New-Hampshire.html

[4] County Health Rankings http://www.countyhealthrankings.org/app/new-hampshire/2016/county/snapshots/007

| | | | | | |
|---|---|---|---|---|---|
| **Health Factors** | | | | | **10** |
| ***Health Behaviors*** | | | | | **10** |
| Adult smoking | 19% | 18-19% | 14% | 18% | |
| Adult obesity | 30% | 27-33% | 25% | 27% | |
| Food Environment Index | 8.0 | | 8.3 | 8.4 | |
| Physical Inactivity | 26% | 24-29% | 20% | 21% | |
| Access to exercise opportunities | 66% | | 91% | 84% | |
| Excessive drinking | 18% | 17-19% | 12% | 19% | |
| Alcohol-impaired driving deaths | 18% | 6-32% | 14% | 33% | |
| Sexually transmitted infections | 193.2 | | 134.1 | 236.2 | |
| Teen births | 28 | 24-32 | 19 | 16 | |
| | **Coos County** | **Error Margin** | **Top US Performers*** | **New Hampshire** | **Rank (of 10)** |
| ***Clinical Care*** | | | | | **10** |
| Uninsured | 16% | 14-18% | 11% | 13% | |
| Primary care physicians | 860:1 | | 1,040:1 | 1,060:1 | |
| Dentists | 1,980:1 | | 1,340:1 | 1,430:1 | |
| Mental Health Providers | 750:1 | | 370:1 | 390:1 | |
| Preventable hospital stays | 60 | 54-66 | 38 | 46 | |
| Diabetic monitoring | 92% | 85-99% | 90% | 90% | |
| Mammography screening | 65% | 58-73% | 71% | 70.% | |
| ***Social & Economic Factors*** | | | | | **2** |
| High school graduation | 82% | | 93% | 88% | |
| Some college | 55% | 50-60% | 72% | 68% | |

| | | | | | |
|---|---|---|---|---|---|
| Unemployment | 5.8 | | 3.5% | 4.3% | |
| Children in poverty | 23% | 16-29% | 13% | 13% | |
| Income inequality | 4.3 | 4.0-4.7 | 3.7 | 4.2 | |
| Children in single-parent households | 38% | 32-44% | 21% | 28% | |
| Social associations | 12.8 | | 22.1 | 10.3 | |
| Violent crime | 143 | | 59 | 181 | |
| Injury deaths | 80 | 67-94 | 51 | 59 | |
| ***Physical Environment*** | | | | | **1** |
| Air pollution - particulate matter | 10.6 | | 9.5 | 10.5 | |
| Drinking water violations | yes | | no | | |
| Severe housing problems | 16% | 14-19% | 9% | 16% | |
| Driving alone to work | 80% | 77-83% | 71% | 81% | |
| Long commute- driving alone | 23% | 21-26% | 15% | 38% | |

*90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data

The table below displays and compares selected socioeconomic and demographic characteristics of the 18+ population in the Coos County, the state of New Hampshire and the United States.

***18+ Population Demographics and Socioeconomic Indicators – Geographic Comparison[5]***

| Variable | Coos County | New Hampshire | United States |
|---|---|---|---|
| **18+ population** | 82% | 79% | 77% |
| **65+ population** | 20% | 14% | 15% |
| **75+ population** | 9% | 6% | 6% |
| **Median age** | 47 years | 42 years | 37 years |

[5] 2010- 2013 Behavioral Risk Factor Surveillance Survey, CDC BRFFS and NH Health WRQS web site, Institute for Health Policy and Practice, University of New Hampshire. Data for US, US Census web site, American Community Survey, 2013.

| Variable | Coos County | New Hampshire | United States |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Did not finish high school** | 15% | 9% | 13% |
| **High school graduate or higher** | 87% | 92% | 86% |
| **Bachelor's degree or higher** | 18% | 34% | 29% |
| **Currently employed** | 48% | 61% | 58% |
| **Out of work 1 year or more** | 2% | 3% | 4% |
| **Current unemployment rate** | 9% | 7% | 6% |
| **Income less than $15,000 per year** | 15% | 7% | 12% |
| **Income $15,000-$25,000** | 22% | 13% | 18% |
| **Income $25,000-$35,000** | 18% | 10% | 12% |
| **Income $50,000+** | 30% | 53% | 44% |
| **Median household income** | $41,985 | $64,916 | $53,046 |
| **Families at or below 100% of FPL in last 12 months** | 13% | 9% | 11% |
| **Population 18-64 at or below 100% FPL** | 12% | 8% | 13% |
| **Population 65+ at or below FPL** | 10% | 6% | 9% |

The 18+ population accounts for 82 percent of the total population of the service area. As may be ascertained from this table, the Coos County population 18+ is a larger percent of the total population than the population in the state as a whole or nationally and the 65+ population is substantially larger. The data in this table reflect an area population that is not only older but also has less income and less education that the populations of the state and nationally. Before the age of 65, the Coos County population is evenly divided between males and females. However, by age 65, females account for over 11 percent of the population whereas males account for approximately eight percent. In the rest of the state, 65+ females comprise eight percent of the population while 65+ males comprise five percent of the population.

The Coos County population is homogeneous with over 97 percent indicating their race as Caucasian. The state of New Hampshire reflects a population that is 94 percent Caucasian, one percent African American, two percent Asian, two percent Hispanic, and one percent other.[5]

Life expectancy in the US stands at almost 79 years – an increase of over 20 years since the 1950s. Longer life also means increases in the numbers of diseases affecting the population, especially the over 65 population. Many of these diseases are chronic diseases and include cardio-vascular disease, hypertension, diabetes, respiratory diseases and others. Although these

[5] US Census web site, American Community Survey, 2013-2014.

diseases affect people of all age ranges, patients over 65 tend to have more than one chronic diseases or co-morbidities. More than 65 percent of Americans 65+ and 75 percent of those 80+ have multiple chronic diseases.

The table below reflects a Coos County population that suffers from chronic diseases at rates that are, in most cases, higher than those for New Hampshire and the rest of the country. In addition, this population reflects higher rates of unhealthy behaviors such as smoking, overweight and obesity as well as leading less active lives than the populations in the state and in the country.

***Chronic Diseases – Geographical Comparison[7]***

| Risk Factor | Coos County 18-64 | Coos County 65+ | NH 18-64 | NH 65+ | United States 18-64 | United States 65+ |
|---|---|---|---|---|---|---|
| **Diabetes** | 8% | 24% | 7% | 22% | 6% | 20% |
| **Hypertension** | 27% | 63% | 24% | 61% | 24% | 61% |
| **Angina or Coronary Artery Disease** | 4% | 15% | 2% | 13% | 2% | 13% |
| **Heart Attack** | 4% | 12% | 2% | 12% | 3% | 13% |
| **Stroke** | 1% | 6% | 1% | 7% | 2% | 8% |
| **Overweight (Obese)** | 34% (33%) | 43% (28%) | 34% (28%) | 39% (39%) | 34% (27%) | 40% (26%) |
| **Smoking** | 23% | 9% | 19% | 7% | 17% | 9% |
| **Physical Activity in last 30 days** | 75% | 58% | 82% | 69% | 76% | 67% |

The following table reflects an area with greater risk for premature death and one that suffers from chronic diseases at rates substantially higher than New Hampshire and, in many cases, the United States.

**Regional, State and National Comparison of Health Status Indicators[8]**

| *Indicator* | *Coos County* | *NH State Rate/Percent* | *National Benchmark Rate/Percent* |
|---|---|---|---|
| **Premature Mortality (Under 65 Years)[9]** | 234.7 | 180.1 | 10 |
| **Percent Elderly (65 & older)** | 19.4% | 12.0% | 12.4% |
| **Age Adjusted Diabetes Prevalence** | 11.1% | 7.1% | 6.5% |
| **Percent Overweight** | 38.6% | 36.5% | 35.8% |
| **Percent Adult Obese** | 31% | 25.8% | 25% |

| | | | |
|---|---|---|---|
| **Asthma Prevalence** | 15.6% | 11.4% | 9.1% |
| **Hypertension Prevalence** | 36.7% | 30.6% | 30.8% |
| **Heart Attack Prevalence** | 7.4% | 4.1% | 4.4% |
| **High Cholesterol Prevalence** | 43.6% | 38.7% | 38.3% |
| **Low birth weight** | 6.3% | 7.6% | |
| **Currently smoking** | 22.8% | 16.9% | 17.3% |
| **Heavy alcohol use risk factor** | 6.1%% | 6.4% | 4.9% |
| **Always wear seat belt** | 73.3% | 81.1% | |
| **General Health Status** | | | |
| **Fair** | 15.3% | 9.9% | 12.4% |
| **Poor** | 4.9% | 3.8% | 3.8% |

[7] 2011-1013 Behavioral Risk Factor Surveillance Survey, CDC BRFSS web site and New Hampshire HealthWRQS web site. Institute for Health Policy and Practice, University of New Hampshire.

[8] Data in this table were obtained from the 2011 Behavioral Risk Factor Surveillance Survey at the NH Health WRQS web site and the US Center For Disease Control web site.

[9] Per 100,000 population

[10] No data available

**Exhibit C**

Community Health Worker Assessment Survey (Survey Monkey web-based tool)

## Community Health Worker

**A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/ link/ intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.**

**A Community Health Worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.**

***This assessment is for information gathering and subject matter knowledge only. If you have any questions about this survey, please contact Francine Morgan at 603-259-3700 ext 232 or FMorgan@nchcnh.org***

1. After reading the description above, how interested are you in learning more about Community Health Workers?

- Extremely interested
- Very interested
- Moderately interested
- Slightly interested
- Not at all interested

2. How relevant is Community Health Workers to your organizational needs?

- Extremely relevant
- Very relevant
- Somewhat relevant
- Not so relevant
- Not at all relevant

3. Community Health Workers may be known by other titles, please check any that exist in your organization

- [ ] Patient navigators
- [ ] Health Advocates
- [ ] Wellness Coaches
- [ ] Care Managers/Co-ordinators
- [ ] Outreach workers
- [ ] Home visitors
- [ ] Community Health Advisors
- [ ] Promotora
- [ ] Peer Counsellor
- [ ] Enrollment Specialist
- [ ] Other (please specify)

4. Are any of the above positions required to be licensed/certified, i.e. RN, MSW, etc?

- ( ) Yes
- ( ) No

5. In previous question, if a license/certification is required, please indicate what type

6. Can you imagine Community Health Workers integrated into your organization?

| Never | Unlikely | Maybe | Possible | Absolutely |
|---|---|---|---|---|
| ☆ | ☆ | ☆ | ☆ | ☆ |

7. What would you see as a Community Health Worker's primary focus?

- [ ] Client/Community Education
- [ ] Outreach
- [ ] Resource Provision/Service Access
- [ ] Support Groups
- [ ] Other
- [ ] Other (please specify)

8. Who would the CHW work with primarily?

- [ ] Existing Clients
- [ ] New Clients
- [ ] Healthcare Providers
- [ ] Other
- [ ] Other (please specify)

9. Often, Community Health Workers visit clients in their home to gain a comprehensive situational awareness and to better accommodate client needs. Would this aspect be of benefit to your clients?

- ( ) Yes
- ( ) No
- ( ) Maybe

10. What kind of technical assistance would your organization need to incorporate a CHW into your team?

- [ ] Administrative
- [ ] Policy and Procedures
- [ ] Funding sources to support the position
- [ ] Quality Improvement
- [ ] Incentives
- [ ] Other
- [ ] Other (please specify)

11. What are the barriers to incorporating CHWs into your organization?

- [ ] The work is already being done by someone else
- [ ] The role of the CHW needs to be defined
- [ ] Staff education of the CHW
- [ ] Benefits of the CHW need to be defined
- [ ] No structure in place to support a CHW
- [ ] Other
- [ ] Other (please specify)

12. If you are using a CHW, how are they being compensated?

- ( ) Paid staff member
- ( ) Contracted
- ( ) Volunteer
- ( ) Other
- ( ) Other (please specify)

13. Please add any other comments

14. Name of Contact

15. Title of Contact

16. Organization

17. Date survey taken

| | MM | DD | YYYY | hh | mm | AM/PM |
|---|---|---|---|---|---|---|
| Date / Time | / | / | | : | | - |