2017 Community Health Needs Assessment Final Report

Bringing community voices together.
Executive Summary

A Message from the President

To Our Community,

The Lake Sunapee Region VNA & Hospice 2017 Community Health Needs Assessment (CHNA) has been a valuable and fascinating process involving members of our community from every county we serve and from a wide variety of professions, experiences and areas of expertise. Collaboration such as this has always been and remains vitally important in order to serve the region to the best of our ability. Conducting a periodic CHNA is also an inherent part of our not-for-profit mission, allowing us to take a step back and look more broadly at our place in the overall health delivery system of the region.

I wish to thank LSRVNA staff, Board members and so many from our community for their participation and insights, including the 500+ people who completed the needs assessment survey. I also acknowledge Kelly Murphy from Nonprofit First Responders for consulting with us throughout the CHNA process. Finally, I send sincere gratitude to each and every member of the CHNA Advisory Group for taking a leadership role by reviewing survey questions and response data, suggesting targeted audiences for forums and survey distribution, commenting on the final report content and format, and sharing thoughts on next steps. This input, a chorus of voices from many geographic areas as well as diverse professional and personal backgrounds, was core to the process.

The findings from our CHNA will be incorporated into the agency’s larger strategic planning process as we remain committed to offering services and programs with the greatest impact on overall wellness of our region. I, of course, welcome your ongoing input at any time!

With gratitude,

Jim Culhane
President & CEO

2017 Advisory Group

Catherine Bardier
Resident of Newbury
Director, Wellness & Community Health, New London Hospital

Brenda Burns
Resident of Newport
Executive Director, Sullivan County Nutrition Services

Tim Caldwell
Resident of Lyme
Attorney, Caldwell Law, Lebanon

Janice Cundey
Resident of New London
Community Leader/Retired Nurse

Karen Ebel
Resident of New London
NH State Representative, Merrimack District #5

Donald Eberly, MD
Resident of New London
Board Chair, Lake Sunapee Region VNA & Hospice

George Edson
Resident of Cornish
Community Leader/Retired Business Owner & Realtor

Alice Ely
Resident of Grantham
Executive Director, Public Health Council of the Upper Valley

Shari Goldberg
Resident of Elkins
Associate Professor, Nursing and Public Health, Colby-Sawyer College

Renee Harvey
Resident of Norwich, VT
Attorney, Caldwell Law, Lebanon

Lisa LaBombard
Resident of Lebanon
Senior Benefits Administrator, Hypertherm Inc., Lebanon

David Lantz
Resident of Sunapee
Owner, MJ Harrington Jewelers, Newport

Dawn Ranney
Resident of Newport
Executive Director, Sullivan County United Way

Lisa Richmond
Resident of Claremont
Board Member, Lake Sunapee Region VNA & Hospice

Rob Schultz
Resident of Hanover
Area Director, Granite United Way

Linda Scofield
Resident of Wilmot
Community Leader/Retired CRNA/Volunteer, Lake Sunapee Region VNA & Hospice

Andi Steel
Resident of Windsor, VT
VP of Operations, WorldClinic, New London

Kirsten Vigneault
Resident of Windsor, VT
Director, Community Health Preparedness for Greater Sullivan County, DHMC
Our Organization

Our Mission
Lake Sunapee Region VNA & Hospice provides health care and hospice services for individuals and families in homes and community settings, fostering continuity of care across settings and enabling people to stay in their homes as long as possible.

Who We Are & What We Do
Founded in 1970, Lake Sunapee Region VNA & Hospice (LSRVNA) is a non-profit home health care agency with nearly 200 staff and 90 volunteers. Our competent team of caregivers drives 600,000+ miles annually, spanning Grafton, Merrimack and Sullivan counties in NH. We serve all ages, newborns to seniors, although the largest segment of our patient population is 65+ years of age. On any given day, 625+ patients are on service with LSRVNA.

Our overriding goal has always been to help people remain in their own homes. Whether recovering from accident or illness, managing a chronic condition or spending your final days with loved ones in the comfort of familiar surroundings, services are available to meet these diverse needs. We are further committed to offering community-based programs, including support groups, bereavement programs, health fairs and clinics, community education, professional mentoring, respite care and more.

Where We Serve
Lake Sunapee Region VNA & Hospice serves 29 towns within Grafton, Sullivan and Merrimack counties. Our area encompasses 1,131 square miles and includes 96,481 community members.

How We Served You in 2017

| 1,988 | Community members received services |
| 11,279 | Hospice visits |
| 32,185 | Home care skilled visits |
| 65,015 | Hours of personal care time for clients |
| 659,475 | Miles driven to provide services |
When designing the LSRVNA Community Health Needs Assessment (CHNA), we recognized the importance of utilizing a mixed methods approach, including community forums, surveys, and secondary data analysis.

In 2015, Dartmouth-Hitchcock Medical Center, Alice Peck Day Memorial Hospital, Valley Regional Hospital, Mt. Ascutney Hospital and Health Center, and New London Hospital united their efforts and resources to survey community members and review demographics across 19 municipalities, encompassing approximately 70,000 community members. In general, the following needs were identified in each of the hospitals’ service areas:

- Access to enough and affordable health insurance; cost of prescription drugs
- Alcohol and drug misuse, including heroin and misuse of pain medications
- Access to mental health care
- Access to dental health care
- Lack of physical activity; need for recreational opportunities and active living
- Health care for seniors
- Poor nutrition/access to affordable healthy food
- Income, poverty and family stress
- Access to primary health care
- Transportation

Recognizing the validity of the above identified needs, yet striving to avoid duplication of effort or outcomes, our approach was to drill down to elicit input that would help us gain new insights about what makes a healthy community.

The following chart shows how the needs were prioritized within the five-hospital assessment.

More detailed information regarding health issues and priorities, selected service area demographics and health status indicators can be found by accessing the individual 2015 CHNA reports found on each hospital’s website.
Process Overview

With a greater understanding of the general needs identified in the hospitals’ assessment, we launched a process to expose additional gaps, conditions, trends and needs within the lives of community members residing in our 29-town service territory.

Your Circumstances Matter.

Demographic data was collected and analyzed for all 29 towns in our service area. This included numbers available through the US Census Bureau on topics such as population, insurance, vehicles, veterans, disabilities, income, employment and housing. Health status information by county was also included.

Your Voices Matter.

Community Forums were held in Claremont, Lebanon and Wilmot, NH in October 2017. The dialogue we were fortunate to have with a diverse representation of area residents provided unique perspectives and valuable information.

Your Input Matters.

540 surveys were completed from September to December 2017 and included community input from every town in our service area*.

34% of surveys completed from Sullivan County community members.

42% of surveys completed from Merrimack County community members.

19% of surveys completed from Grafton County community members.

* 5% of surveys completed from outside LSRVNA’s service area.
Our Communities

The information contained in this section serves to provide a general summary of health and demographics for LSRVNA’s service area. More detailed data is available in the appendix.

$68,782  
**average median household income**

$24,197  
**average mean Social Security income**

$20,202  
**average mean retirement income**

### HEALTH STATUS INFORMATION BY COUNTY

<table>
<thead>
<tr>
<th>Beneficiaries, Total by County, CMS 2015</th>
<th>Sullivan County</th>
<th>Merrimack County</th>
<th>Grafton County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Medicare Beneficiaries</strong></td>
<td>8,870</td>
<td>25,794</td>
<td>17,322</td>
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<tr>
<td><strong>Health Status</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chronic Heart Failure</td>
<td>825</td>
<td>2,457</td>
<td>1,699</td>
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<tr>
<td>Percentage of Beneficiaries</td>
<td>9.3%</td>
<td>9.5%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>601</td>
<td>2,434</td>
<td>1,617</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>6.8%</td>
<td>9.4%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2,125</td>
<td>6,573</td>
<td>3,939</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>23.9%</td>
<td>25.5%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Asthma</td>
<td>628</td>
<td>1,975</td>
<td>1,158</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>7.1%</td>
<td>7.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>COPD</td>
<td>823</td>
<td>2,471</td>
<td>1,438</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>9.3%</td>
<td>9.6%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Depression</td>
<td>1,538</td>
<td>5,245</td>
<td>2,838</td>
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<tr>
<td>Percentage of Beneficiaries</td>
<td>17.3%</td>
<td>20.3%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,734</td>
<td>5,498</td>
<td>3,314</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>19.5%</td>
<td>21.3%</td>
<td>19.1%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>2,618</td>
<td>10,336</td>
<td>4,909</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>29.5%</td>
<td>40.1%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>1,459</td>
<td>4,883</td>
<td>3,020</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>16.4%</td>
<td>18.9%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>341</td>
<td>1,611</td>
<td>736</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>3.8%</td>
<td>6.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Stroke</td>
<td>304</td>
<td>833</td>
<td>529</td>
</tr>
<tr>
<td>Percentage of Beneficiaries</td>
<td>3.4%</td>
<td>3.2%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

### Aging & Disabilities

Over 50% of the disabled population in these eleven towns are also 65 years and older. These residents have been diagnosed with one or more disabilities, such as hearing, vision, cognitive, ambulatory, self-care and/or independent living.
Our Findings

Four key “themes” or categories bubbled to the surface as a result of the overall CHNA process, including survey responses, conversations at community forums and health data collection from a variety of sources. They are:

**Affordability**

**Personal Accountability**

**Access to Resources**

**Aging with Confidence**

We found it fascinating ... and perhaps somewhat surprising ... that the community voices we heard from focused less on specific services or diseases and more on the concept of creating a better integrated community infrastructure as a way to positively impact health and wellness for our region. Details of these themes are summarized in the following pages.

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**Data Sources**

LSRVNA gratefully acknowledges data analyzed and compiled from the following sources:

- Behavioral Risk Factor Surveillance System, Centers for Disease Control & Prevention
- Centers for Medicare and Medicaid
- Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care
- National Center for Biotechnology Information, U.S. National Library of Medicine
- National Center for Health Statistics, Centers for Disease Control & Prevention
- New Hampshire Department of Health & Human Services
- New Hampshire State Cancer Profiles
- United States Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
- United States Department of Housing and Urban Development

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**The Comprehensive CHNA Final Report**

including all survey results and data, is available in hard copy by request or at:

WWW.LAKESUNAPEEVNA.ORG
**Affordability**

It is no surprise that Affordability immediately rose to the top of all needs identified by community members throughout our service area.

There’s a dollar value attached to daily living, be it health care, our supply of food, property taxes, or how we get to work. Those costs, whether perceived or real, will determine many of our decisions and impact our short and long-term outlooks on life. For community members in our service area, navigating the unknown of one’s health care over the long term and the question of affordability cuts through all income levels, geographic locations, and stages in life. For younger generations, accumulated student loan debt and securing adequate work/housing may compete with the priorities of health and wellness; while our older populations weigh options and barriers to aging at home, securing in-home care when needed, and the cost of daily basic needs and transportation.

**Top Ten Towns**

When considering the most vulnerable populations by geographic location, the towns of Andover, Charlestown, Grafton, Lempster and Washington share a similarity in high residential populations of residents 65 and over below the federal poverty level, Medicaid enrollees, and/or disabled residents.

<table>
<thead>
<tr>
<th>% of Residents 65 and Older Below the Federal Poverty Level by Town</th>
<th>% of Medicaid Enrollees by Town</th>
<th>% of Disabled Residents by Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andover 15.8%</td>
<td>Claremont 27.8%</td>
<td>Grafton 24.9%</td>
</tr>
<tr>
<td>Canaan 13.5%</td>
<td>Newport 26.5%</td>
<td>Andover 18.6%</td>
</tr>
<tr>
<td>Grafton 13.2%</td>
<td>Grafton 20.0%</td>
<td>Newport 18.1%</td>
</tr>
<tr>
<td>Charlestown 9.6%</td>
<td>Lempster 19.5%</td>
<td>Claremont 17.5%</td>
</tr>
<tr>
<td>Lempster 9.1%</td>
<td>Charlestown 19.4%</td>
<td>Lempster 17.4%</td>
</tr>
<tr>
<td>Langdon 7.9%</td>
<td>Danbury 16.3%</td>
<td>Lebanon 17.1%</td>
</tr>
<tr>
<td>Wilmot 7.5%</td>
<td>Washington 15.4%</td>
<td>Danbury 16.7%</td>
</tr>
<tr>
<td>Washington 6.8%</td>
<td>Unity 15.2%</td>
<td>Goshen 16.0%</td>
</tr>
<tr>
<td>Lebanon 6.5%</td>
<td>Enfield 14.9%</td>
<td>Charlestown 15.1%</td>
</tr>
<tr>
<td>Enfield 6.2%</td>
<td></td>
<td>Salisbury 14.9%</td>
</tr>
</tbody>
</table>

38% of surveyed community members were unable to obtain assistance for non-routine health issues due to affordability of the care.

33% of surveyed community members cited financial challenges to obtain affordable prescription drugs.

10% of survey responders have intermittently or regularly skipped taking their prescribed medication, or delayed getting a prescription filled, due to the expense.

**Community Voices**

“More financial assistance for those that don’t qualify for Medicare/Medicaid.”

“Affordable health care!”

“We need more affordable insurance. I’m terrified of the future when I stop or slow down with work.”

“To make it less expensive to have devices such as eye glasses, hearing aids and dentures on limited incomes.”

“I have avoided going to the cardiologist for an annual echo and other tests due to the huge deductible. When I last went to the cardiologist, I paid almost $900 out of pocket.”

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Health Insurance Status in LSRVNA Service Area

- Medicaid, as of 10/3/17
- MediCARE
- Private Health Insurance, all ages
- NO Health Insurance, all ages

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% of Medicaid Enrollees by Town: NH Department Health & Human Services, October 3, 2017

% Disabled Residents and % of Residents 65 and Older Below Federal Poverty Level: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
Personal Accountability

We found it fascinating that Personal Accountability (“a willingness to accept responsibility for one’s actions”) came up quite frequently in our survey responses, enough so that we assigned it its own category in this final report.

Many respondents acknowledged that choices around better health (such as exercise, eating habits and sleep) were “within their control.” In addition, the concept of “taking responsibility” can be applied to more than just healthy lifestyle choices. It is part of a growing trend for people to take a more proactive role in their health, to not necessarily always or immediately “do what the doctor says” but rather to gather information, ask questions, have conversations with medical professionals and loved ones and then decide what is right for you, whether that is related to healthy living, medical interventions or choices at end-of-life. How do we continue the conversation about choices that impact quality of life?

The use of yoga and tai chi increased from 5.8% in 2002 to 10.1% in 2012. 10.1%

If you could change one thing that you believe would contribute to better health for YOU, what would that change be?

34% of surveyed community members cited weight less, exercise more and change eating habits

24% of surveyed community members cited work less, sleep more, handle stress better, organize my life

<table>
<thead>
<tr>
<th>Adults, ages 18 &amp; Over</th>
<th>Sullivan County</th>
<th>Merrimack County</th>
<th>Grafton County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed with High Blood Pressure</td>
<td>9,968</td>
<td>29,734</td>
<td>16,670</td>
</tr>
<tr>
<td>% Choosing No Medication</td>
<td>27.8%</td>
<td>23.7%</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

BRFSS 2006-2012, Centers for Disease Control and Prevention

71% of adults over age 18 reported daily SUPPLEMENTAL USE, equating to over 170 million Americans taking supplements. The Top 5 supplements: Multivitamin, Vitamin D, Vitamin C, Calcium, and Vitamin B, according to a 2016 Council for Responsible Nutrition (CRN) survey

63% of adults have not completed an ADVANCE DIRECTIVE, according to a 2017 University of Pennsylvania study

Community Voices

“I appreciate what my parents did to make the transitions easier for them and me.”

“Getting away from the screens - not on cell phone, computer, etc.”

“Allowing myself to set goals I can actually reach while most of my time is needed to take care of my spouse. I need to keep from doing too much else and spend more energy on finding calm in our lives and time to properly rest.”

“Need to lose weight. More my change than anyone else’s. Easy recipes for healthier eating, crockpot ideas. Not always time to make healthy food.”

“Oh, well, that's easy ... that's all down to me and making the time and/or sacrificing time elsewhere to commit to my own health needs. I need to see doctors more frequently and stay on track. I truly am my own worst enemy in this regard, while I bend over backwards to help my friends and family with these same issues!”
Accessibility, what you need and when you need it, is an invisible barrier that challenges individuals, families and communities throughout our service area on a daily basis.

As affordability is a financial challenge to obtain needed resources, accessibility points to resources out of our reach, or maybe not in existence at the time of need. When asked, people most often point to the need for "more" of something, to obtain the need differently, or a simple lack of knowing where to get the help. Accessibility challenges should be seen as an opportunity to reinvent, to infuse creativity, to identify a more efficient and productive way of meeting the needs of our community members. It’s not enough to say, "We tried that." As a community, we must listen to the needs of our neighbors in the spirit of collaboration and solution-building, breaking down those invisible barriers.

Survey respondents indicated they need ...

Transportation Options
- Senior Housing
- Home Care Services
- Exercise Facilities

Community Events
- In-home Caregivers
- Addiction Treatment Help
- Community/Parish Nursing Services

Walking & Biking Trail Systems
- Active aging in place cooperative support
- Doctors & Walk-in Care Centers
- Help to seniors & self-contractors to understand health care options

Communication about available resources
- Coordination of existing health care resources
- Mental Health Services & Faster Access

What health screenings, education, information or services are lacking in your Community?
(based upon survey respondents)

<table>
<thead>
<tr>
<th>Service</th>
<th>Claremont</th>
<th>Newport</th>
<th>Hanover</th>
<th>Lebanon</th>
<th>Enfield</th>
<th>New London</th>
<th>Charlestown</th>
<th>Andover</th>
<th>Grafton</th>
<th>Sunapee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>14.5%</td>
<td>13.2%</td>
<td>12.7%</td>
<td>11.2%</td>
<td>10.8%</td>
<td>10.3%</td>
<td>10.2%</td>
<td>9.7%</td>
<td>9.2%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Pediatric care</td>
<td>13.1%</td>
<td>12.3%</td>
<td>11.8%</td>
<td>10.3%</td>
<td>9.9%</td>
<td>9.6%</td>
<td>9.5%</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12.5%</td>
<td>11.7%</td>
<td>11.2%</td>
<td>9.7%</td>
<td>9.3%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.0%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>11.9%</td>
<td>11.1%</td>
<td>10.6%</td>
<td>9.1%</td>
<td>8.7%</td>
<td>8.4%</td>
<td>8.3%</td>
<td>7.8%</td>
<td>7.3%</td>
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<td>Cholesterol</td>
<td>11.4%</td>
<td>10.6%</td>
<td>10.1%</td>
<td>8.6%</td>
<td>8.2%</td>
<td>7.9%</td>
<td>7.8%</td>
<td>7.3%</td>
<td>6.8%</td>
<td>6.4%</td>
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<tr>
<td>Medication management assistance</td>
<td>10.9%</td>
<td>10.0%</td>
<td>9.5%</td>
<td>8.0%</td>
<td>7.6%</td>
<td>7.3%</td>
<td>7.2%</td>
<td>6.7%</td>
<td>6.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>9.4%</td>
<td>8.6%</td>
<td>8.1%</td>
<td>6.6%</td>
<td>6.2%</td>
<td>5.9%</td>
<td>5.8%</td>
<td>5.3%</td>
<td>4.8%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Parenting</td>
<td>8.9%</td>
<td>8.1%</td>
<td>7.6%</td>
<td>6.1%</td>
<td>5.7%</td>
<td>5.4%</td>
<td>5.3%</td>
<td>4.8%</td>
<td>4.3%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>8.4%</td>
<td>7.6%</td>
<td>7.1%</td>
<td>5.6%</td>
<td>5.2%</td>
<td>4.9%</td>
<td>4.8%</td>
<td>4.3%</td>
<td>3.8%</td>
<td>3.4%</td>
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<tr>
<td>Eating disorders</td>
<td>7.9%</td>
<td>7.1%</td>
<td>6.6%</td>
<td>5.1%</td>
<td>4.7%</td>
<td>4.4%</td>
<td>4.3%</td>
<td>3.8%</td>
<td>3.3%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Eating healthy</td>
<td>7.4%</td>
<td>6.6%</td>
<td>6.1%</td>
<td>4.6%</td>
<td>4.2%</td>
<td>3.9%</td>
<td>3.8%</td>
<td>3.3%</td>
<td>2.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Emergency preparedness</td>
<td>6.9%</td>
<td>6.1%</td>
<td>5.6%</td>
<td>4.1%</td>
<td>3.7%</td>
<td>3.4%</td>
<td>3.3%</td>
<td>2.8%</td>
<td>2.3%</td>
<td>1.9%</td>
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<tr>
<td>Active living</td>
<td>6.4%</td>
<td>5.6%</td>
<td>5.1%</td>
<td>3.6%</td>
<td>3.2%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>2.3%</td>
<td>1.8%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Home safety assessment</td>
<td>5.9%</td>
<td>5.1%</td>
<td>4.6%</td>
<td>3.1%</td>
<td>2.7%</td>
<td>2.4%</td>
<td>2.3%</td>
<td>1.8%</td>
<td>1.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Health insurance</td>
<td>5.4%</td>
<td>4.6%</td>
<td>4.1%</td>
<td>2.6%</td>
<td>2.2%</td>
<td>1.9%</td>
<td>1.8%</td>
<td>1.3%</td>
<td>0.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Telemmedicine</td>
<td>4.9%</td>
<td>4.1%</td>
<td>3.6%</td>
<td>2.1%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>1.3%</td>
<td>0.8%</td>
<td>0.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>4.4%</td>
<td>3.6%</td>
<td>3.1%</td>
<td>1.6%</td>
<td>1.2%</td>
<td>0.9%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Caregiver support &amp; respite</td>
<td>3.9%</td>
<td>3.1%</td>
<td>2.6%</td>
<td>1.1%</td>
<td>0.7%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Alzheimers/Dementia support</td>
<td>3.4%</td>
<td>2.6%</td>
<td>2.1%</td>
<td>0.6%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mental health</td>
<td>2.9%</td>
<td>2.1%</td>
<td>1.6%</td>
<td>0.1%</td>
<td>0.0%</td>
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</table>

% of Residents with No Access to a Vehicle by Town

- US Census Bureau, 2012-2016
- American Community Survey 5-year Estimates
Access to Resources

**Key Community Resources**
identified by forum participants
- CAP (Community Action Program)
- Churches/Clergy
- Council on Aging/Senior Citizen Councils
- Family
- Friends & Neighbors
- Hospitals
- Meals on Wheels
- Physicians
- Senior Centers
- ServiceLink
- Town Offices
- VNA's

A tremendous barrier in times of personal need can be a lack of awareness, especially as someone ages. When asked the places to access information when seeking services for older adults, such as home delivered meals, caregiver services, home repairs, or social activities, survey respondents overwhelmingly chose local senior centers as their “go to”...

- **Local senior center (71.7%)**
- **Physician or health care professional (60.9%)**
- **Family or friend referral (60.7%)**
- **Internet (53.7%)**
- **Hospital/other health care agency (49.5%)**
- **Local government office (18.2%)**
- **Faith-based organization (18.3%)**

**Community Voices**

- “We need elderly day care options.”
- “More help with getting needed IDMs, walker, ramp. Limited, long wait, much paperwork, run around, stress.”
- “Our community needs a care coordinator to connect all the health care dots.”
- “Better walkability, more sidewalks.”
- “How can we integrate institutions even more and build trust?”
- “More information about services that are available and how to access them.”
- “We need an actual clinic or access to doctors who are not affiliated with a hospital, so you can go and get a quick prescription without having to go to the ER.”
- “Housing options depend on the kind of zoning in [each] town. Need to make changes [to zoning] to accommodate the elderly.”
- “A house for seniors to live with in-house nursing. This way they can stay in the town where they live and be with their life long friends and family.”
- “No matter how many great opportunities there are for receiving food or exercise or other social activities, it won’t matter if no one can actually get there. Transportation is a huge issue.”
- “We need an actual clinic or access to doctors who are not affiliated with a hospital, so you can go and get a quick prescription without having to go to the ER.”

“When asked the top 3 sources for accessing health information, survey respondents cited a doctor, the internet and friends/family, far exceeding all other sources.
Aging with Confidence

While we know that our population is aging rapidly, what our assessment reflected clearly was a growing concern about Aging with Confidence.

Approximately 10,000 baby boomers turn 65 every day, a trend that began in 2011 and will continue through 2030, according to the Pew Charitable Trust. In 2016, 14.5% of the total U.S. population and 15.8% of New Hampshire’s population was 65 and older. Within our service area, more than 17,000 community members are 65 years and older, and 4,416 of our neighbors are living alone. Aging confidently in one’s home or community encompasses a wide variety of variables, including:

- a reliable source of income;
- social and community interactions to avoid isolation;
- a plan for transportation when independence is no longer an option;
- open, transparent communication with family to reduce anxiety and stress;
- awareness of community resources for assistance with all aspects of daily life; and,
- a plan (and finances) to address any safety and maintenance home renovations and repairs.

When just one of these variables becomes unreliable or is eliminated, stress and anxiety can take a tremendous toll on our aging population.

<table>
<thead>
<tr>
<th>Top 10 Towns with % of Residents 65 years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>New London</td>
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<tr>
<td>Newbury</td>
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<tr>
<td>Washington</td>
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<tr>
<td>Acworth</td>
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<tr>
<td>Wilmot</td>
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<td>Newport</td>
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<td>Andover</td>
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<td>Sunapee</td>
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<tr>
<td>Sutton</td>
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<tr>
<td>Bradford</td>
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</table>

US Census Bureau, 2012-2016 America Community Survey 5-year Estimates

Participants attending the three area community forums also voiced concerns for the elderly to unknowingly become victims to predators and scams. Questions were raised about who responds in a non-emergent time of need and what happens when it’s time to surrender their driver’s license or car. Participants also recognized the critical need to maintain friendships, relationships and involvement in social programs to stay engaged in life.

13% of survey respondents cited experiencing needs around aging in a safe and supportive environment.
Aging with Confidence

When asked about the importance of staying in their homes and communities, well over 70% of community members answered very or extremely important. While there are financial and health-related challenges to aging at home, an often-overlooked result is isolation.

In more rural communities within our service area, public transportation is a tremendous challenge. When family and friends are distant, a senior can face extended periods of time with no social interaction or stimulation.

If you could change one thing that you believe would contribute to better health FOR YOU, what would that change be?

Age Comment

85+ More support for home & yard care
Access to my back door in winter

70-84 Someone to exercise regularly with me at home
I’d get a “First Alert”
More outdoor activity locally
A place to walk in the winter months
A place and a ride for one hot meal a week and people to socialize with

60-69 Family who hasn’t forgotten me
Create an elderly tax deduction
Access to affordable housekeepers

Community Voices

“My daughter and I may have to care for each other.”

“I live in a mobile home with a bathtub which I do not use. I feel like an accident waiting to happen because of difficulty getting in and out of the shower...need it taken out and a shower pan installed. No funds for this.”

“A way for elderly to go to events and someone to drive, or change a light bulb, start a lawn mower, help if you fall but not injured, check on in a storm...i.e. Like a good neighbor.”

“I am not determined to stay in my own home, and I do not want to be a burden to my child.”

“I built my home 12 years ago with the thought to accessibility. A room on the first floor that could be used as a bedroom if necessary; stairs wide enough for a lift, garage on the same level as the entry; shower all tile with no curb so it would accommodate a wheelchair. All this is great, but one potential issue is what if I can’t drive at some point?”

More senior housing, [is needed]. There is a waiting list, many people are forced to stay in houses that are too big & expensive.”

“I have a parent who doesn’t make plans, and just hopes everything works out.”

“We need an Elder Check-In, like a neighborhood watch. So many elders are isolated and not connected to services, increasing their risk of depression and misusing meds.”

“We have a small coffee club that replaces family, that’s at least 2 hours away.”

“If I could figure out how to voice my concerns about family issues without offending my wife and starting an argument so that we could problem-solve more effectively, that would greatly reduce my stress.”
Our Final Thoughts

It is our hope that many individuals and organizations will find this report an informative and useful tool for planning and collaborative purposes. Though we as an organization can’t address every issue, we can work with community partners on those needs where we can have the greatest impact. Collaboration is already an important part of our work at LSRVNA and will only become more so as we move forward.

COLLABORATIONS

- We participate in the Wellness Connection, a group developed by New London Hospital that is currently working on initiatives that support healthy eating, active living and stress reduction.

- We partner with several area organizations to promote conversations and education around end-of-life issues and advance directives, so that people have plans in place before a crisis occurs.

- Fall Prevention is another important initiative, and we are currently working with Dartmouth-Hitchcock Population Health, Lebanon Fire Department, Dartmouth Centers for Health and Aging, and the Public Health Council of the Upper Valley on a pilot project to decrease falls among the residents at Quail Hollow.

- We participate in the Greater Sullivan County Public Health Network, which is coordinating a number of health and wellness projects.

- We have agency representation on the Board of the Kearsarge Area Council on Aging (COA), serving the senior population in nine local communities. COA is a hub for social interaction, volunteerism, lifelong learning and healthy aging, and a source for referrals to other organizations.

- We are at the table with other agencies as well, working to improve how we deliver services to our community in a more seamless and accessible way in areas including mental health, substance abuse and emergency preparedness.

The goal for us all is to have greater success in improving wellness in our region by looking at health more as a system that incorporates every aspect of our lives. As LSRVNA updates its strategic plan in 2018, the findings of the 2017 CHNA will be an invaluable guide.

Jim Culhane, President & CEO

Advisory Group insights

“I think you clearly and accurately depict the voices and opinions expressed in the forums I attended. There are factors identified that fall into the broader arena of societal reform ... there are also several issues that we as an institution can help improve on a local level.”

“Probably the most important effect of this report is to focus the public’s attention on the magnitude of needs so we can join together and embark on the harder task of trying to solve them.”

“LSRVNA has done a wonderful job presenting and highlighting the issues facing our community. Our job has been, and will continue to be, assisting those in need by eliminating barriers that prevent them from enhancing their way of life. Somehow we need to reach out to people more on their own turf to make information-sharing easier and more effective.”

“As soon as the final product is complete, I will meet with our member agencies and provide this very important survey to them as a guide for moving forward. You have provided us with a very valuable tool and I look forward to working on formulating solutions with our partner agencies.”

“Communities about every 15 to 20 years develop their Master Plans for the future. In general, Master Plans are updated every five years as things change in that community. Master Plans encompass all things the community will need, for example, housing, transportation, access to health care to name a few. The information in this CHNA is what communities, specifically the Planning Board and Town Managers, need in order to develop parts of their Master Plan.”

“We all must try to better combine our resources to solve problems ... to have a plan that is broader than focusing on isolated issues. For me, the results of this CHNA only serve to reinforce this approach.”

The comprehensive CHNA final report, including all survey results and data, is available in hard copy by request or at: WWW.LAKESUNAPEEVNA.ORG