

## VIII. THE COMMUNITY PROVIDES INPUT TO THIS NEEDS ASSESSMENT

Manchester key leaders and focus group participants gave careful and thoughtful responses to the interview questions asked during this needs assessment. When asked about the health of the community in general, almost half of focus group participants and key leaders felt that the health of the community was good. However, a larger percent of community participants rated the health of the community as poor compared to key leaders (35% vs.18%). Sixty-one percent of the focus group participants and 48% of key leaders interviewed reported that the general health of the community is about the same as five years ago. However, 18% of key leaders believe that the health of the community has gotten worse over the past five years.

The most commonly mentioned fundamental issues for assuring quality of life of the public during every state of life during the key leader interview process are summarized by six broad categories or factors: prosperity/economic security, access to health care, healthy behaviors, physical and mental health status, physical environment and social environment.

While each of these issues is described separately in the sections following, it is important to note that these emerging themes were discussed in a variety of ways, in many different contexts, and were understood to be dynamic and interdependent to each other; and driven by intentional, values-based efforts that require community leadership.

### WHAT WOULD YOU TALK TO THE MAYOR ABOUT?

If invited to talk to the Mayor about existing and emerging threats to their health and well-being, focus group participants and key leaders would have a lot to say. Issues that focus group participants would discuss include: creating more jobs; integrating mental health services into medical care visits; creating access to dental services for adults without insurance; expanding access to specialty care services, building affordable housing and a more effective transportation system; improving the police force and safety in the neighborhoods; creating better schools; improving snow plowing and trash pick-up; and expanding activities for youth. Participants also would encourage the Mayor to attend more community events and be more accessible to residents.

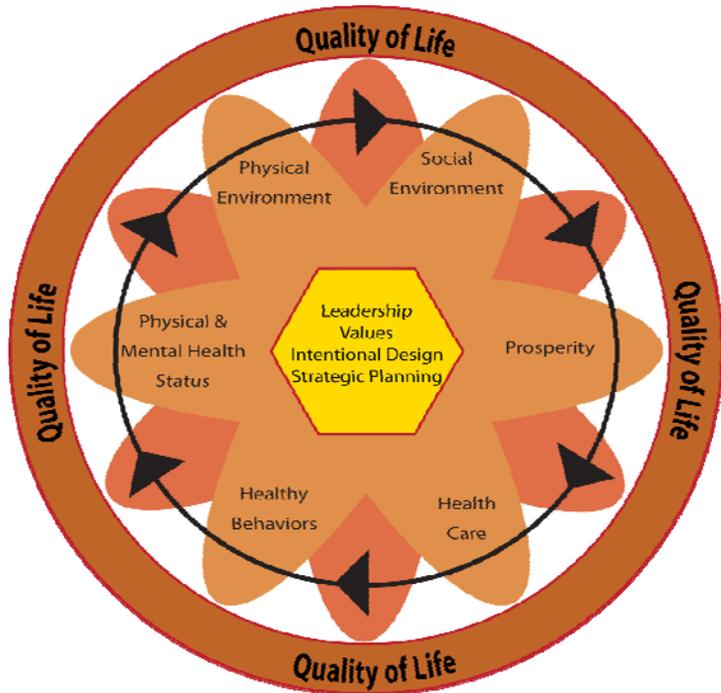
The three most important issues that community leaders would discuss are creating a thriving economy, enhancing access to care and services and improving the health and well-being of the local population through “intentional” community design.

*“A community that listens to the residents and not just the city departments about what needs to be done makes a community a good place to live.”*

# INTENTIONAL COMMUNITY DESIGN AND LEADERSHIP

In its most simple form, described by those interviewed for this assessment for producing a healthy community, is illustrated in the model below. This model puts the strong influence of intentional community design; i.e., leadership, values, and strategic planning in the center as the driver of the processes that influence the determinants known to produce health and enhance the quality of life for all area residents.

A simple way to understand this model is to first think about the major health outcome that we want to maintain or improve in the long-term; i.e., our “measures of success”. In the Manchester model the outcome desired by City residents is “enhanced quality of life” for all. This is summarized by the outermost ring of the model. The major factors identified by Manchester informants as influencing this outcome are health status, healthy behaviors, the physical and social environments in which we live and work; individual and area prosperity, and the health care system.



A model, such as the one depicted above, is very important to a community for mapping out the data elements to be collected in a needs assessment, for summarizing the data, and for bringing diverse stakeholders to the planning table to address the critical issues for improvement identified by the data and information gathered. For example, using the model to ask the question of who is responsible for each major determinant of health quickly brings community leadership and residents to the conclusion that we all are responsible because not one of us can address these multi-faceted and interrelated issues alone.

Embedded within their responses, participants of both key leader and focus groups identified community design as essential to drive community health improvements. Community design is a high-level concept that links directly to each of the identified issues and, therefore, provides a framework for beginning to address these issues in a comprehensive and integrated way. It represents a community intervention that is based on unique knowledge of a particular community, requires reflection, and applies available resources to foster economic growth and community development. It will be important to consider establishing the conditions that foster the generation of social capital as well as carefully avoiding disruption of existing social networks and established structures.<sup>130</sup>

*...Communities are built on existing networks and evolve beyond any particular design, the purpose of the design is not to impose a structure but to help the community develop.<sup>131</sup>*

The concept of community design includes intentional development of places, programs, and policies that cultivate and maintain a local environment that fosters access to health care and other services, physical and social safety, and that fosters and supports healthy behaviors and prosperity.

*“Many of the agencies in Manchester work in silos rather than addressing the community as a whole.”  
(Patrick Tufts – CEO, Heritage United Way)*

This issue was discussed by several leaders in the context of both health care and social service agencies. One leader questioned whether the City needed so many individual organizations focused on these services or if the City would be better served by stronger collaboration as a way to use resources more effectively and decrease fragmentation.

The key leaders emphasized the need for strong proactive leadership. It was noted as a weakness that the highest position in the City (the position of Mayor) was only a two-year elected appointment. As in state government, this short-term approach to leadership does not work well for solving long-term community issues. Additionally, several leaders felt that businesses and residents need to have a stronger voice in City government.

Leaders also talked about the infrastructure of education in general and about the need to enhance funding for education for healthy lifestyles, the local transportation system, and improvement of neighborhood recreational environments.

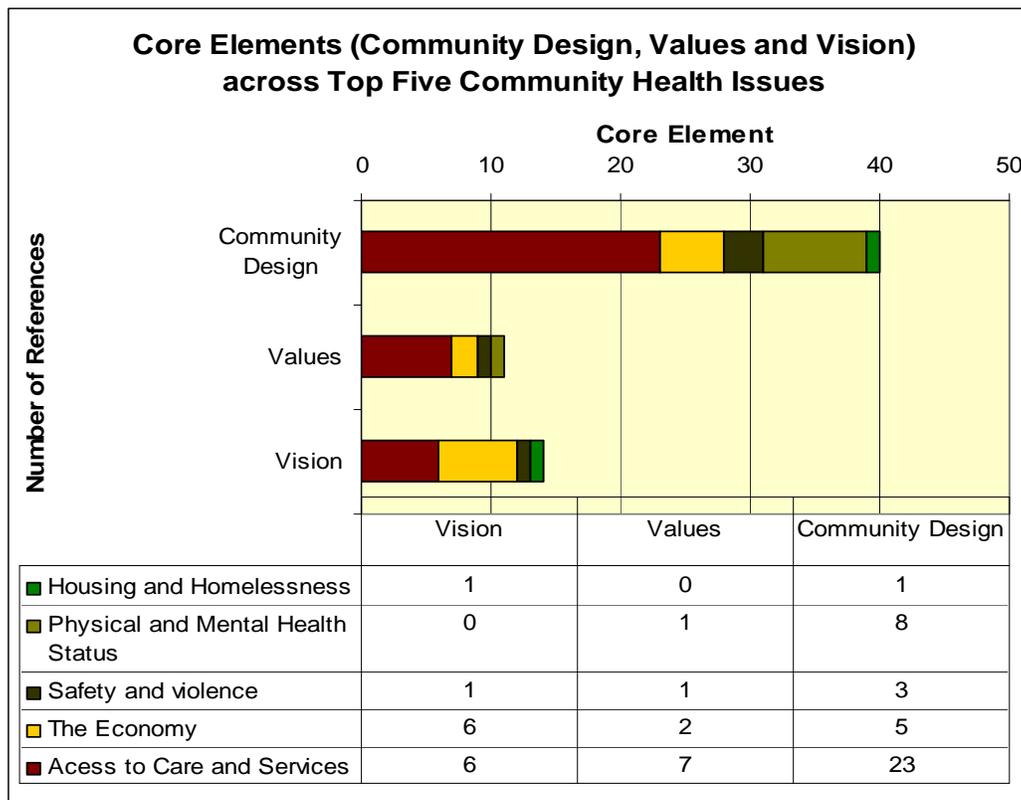
## COMMUNITY DESIGN

The conception of community design that grew out of the analyses of the focus group and key leader data includes intentional development of places, programs, and policies that cultivate and maintain a local environment that fosters access to health care and other services, physical and social safety, and that fosters and supports healthy behaviors and prosperity as depicted by the simple community design model.

Content analysis of responses to the first three open-ended questions revealed that community design was discussed by a substantial majority of key leaders (80%) and all of the focus groups, and cut across all dimensions of the community design model. Elements of community design included transportation, community involvement, fostering socialization, recreation and the physical environment, education, and revitalization. Each of these factors are linked to the development of social capital, which has been linked to positive health outcomes.<sup>132</sup>

Participants discussed elements of community design when they described what makes a community the best place to live. They identified gaps or weaknesses in community design in discussions of the main issues facing the community. They also mentioned elements of community design in their recommendations for the mayor. Although it touched each dimension, community design was discussed in most depth in terms of access to care and services and the economy. The figure below

depicts connections between the core elements of community design and the top five health issues identified by focus group participants and key leaders.



## VALUES

Meaningful community design is values-based and requires leadership for mobilization. It includes the concept of social capital, which refers to “...the institutions, relationships, and norms that shape the quality and quantity of a society's social interactions... Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together.”<sup>133</sup>

Values were mentioned by the majority of focus groups and key leaders, and were discussed in conjunction with physical and mental health status, safety and violence, the economy and access to care and services. Included in the category of values were: collaboration, community involvement, family and community orientation, personal responsibilities, pride and values, and religion. Pride and values were mentioned within six focus groups and three key leaders. Family and community orientation were also raised both by focus groups and key leaders. With regard to family and community orientation, focus groups identified the importance of affordable family activities and availability of health care and health care coverage for all, and saw the need to develop and sustain an infrastructure that promotes family and community-oriented lifestyles. Key leaders mentioned the importance of putting children at the center of all the City does.

Community involvement was raised only within focus groups. One participant stated, “...*a community that listens to the residents and not just the City departments about what needs to be done would make a great community to live in.*”

East Side residents spoke at length about people helping other people. Several participants who live in the same neighborhoods spoke of the kindness they see daily and wish that that behavior was exhibited everywhere. They mentioned the value of community involvement as a source of gratification and generosity:

One participant told a story about how after they began participating in the neighborhood watch group, they began reaching out to people across the community, and making small voluntary gestures to help City employees with snow and trash removal just to make their jobs a little easier.

On the other hand, a participant from another focus group noted a decrease in people taking care of their homes, which she attributes to lack of landlord involvement. This lack of landlord involvement was also identified as a problem by key leaders, and tied to housing, safety and violence, and physical activities as they relate to safety and violence.

Among key leaders, business leaders made the most references to values, discussing pride and values, and community and family values as important. Only key leaders specifically mentioned personal responsibility, religion, or ethnic culture as important community affiliations and sources of community values.

## **LEADERSHIP AND VISION**

Integral to community design is leadership and vision, which together form the engine that drives positive community level change. Community design is what is needed to make all of it work. Community design represents a community-based and community-focused intervention that reflects/embodyes/fosters community empowerment.<sup>134</sup>

Twelve participants across both groups spoke about vision, leadership and quality of life. Vision was discussed in conjunction with housing and homelessness, safety and violence, the economy, and access to care and services. Most often, vision was mentioned in relation to leadership.

Focus group members mentioned that they would like to see more involvement by community leaders at community events. Focus groups that raised issues related to vision included the uninsured, ethnic minorities, frail elders, refugees, people with mental health issues, and East and West Side residents.

Key leaders identified a need for stronger leadership within the community as well. One leader mentioned a specific leadership role of advancing opportunities for community residents such as advocating for the development of bike paths, rail trails, recreational outlets and health care.

## SPECIFIC COMMUNITY HEALTH ISSUES

The following section of this chapter provides an analysis of the health issues identified by a majority of focus groups or key leaders. These issues include access to care and services, the economy, safety and violence, physical and mental health status, and housing and homelessness. The figure below outlines the top ranking issues and the number of sources identifying each issue.

RANKING OF ISSUES BY SOURCES		
FOCUS GROUPS (N=13)	RANKING	KEY LEADERS (N=19)
Access to care and services (n=13)	1	Access to care and services (n=15)
The economy (n=12)	2	The economy (n=11)
Safety and Violence(n=6) / Physical and Mental Health Status (n=6)	3	Safety and Violence (n=10)
	4	Physical and Mental Health Status (n=9)/ Housing and homelessness (n=9)

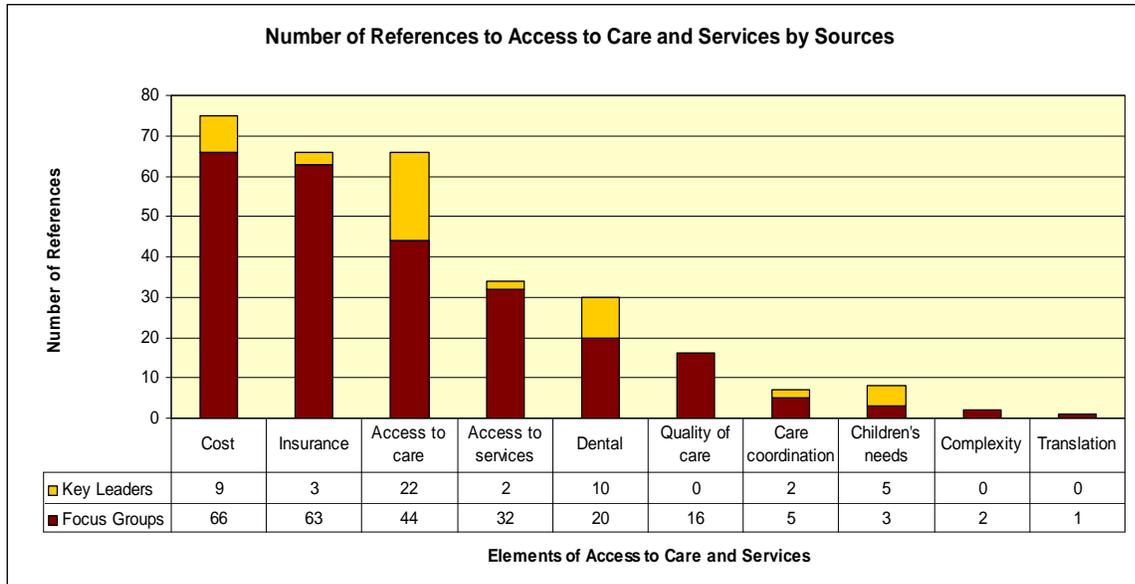
### ACCESS TO CARE AND SERVICES

Access to care and services ranked as the top issue across focus group participants and key leaders. Access to care and services includes issues related to cost, insurance, dental, quality of care, and children’s needs, to name a few. These types of issues were raised within each focus group and mentioned by a majority of key leaders. Analysis revealed, however, important differences between the two groups.

*“This community delivers care in a fragmented manner. The solution is not just about how many offices or providers you have or how many hours your practice is open... the solution is to be more innovative and find better ways to collaborate.”*

*(Steve Paris, Medical Director, Dartmouth-Hitchcock - Manchester)*

The cost of care was identified within more focus group sessions than key leader interviews. Similarly, divergent views emerged between focus groups and key leaders regarding the importance of access to services. Insurance was also identified with greater frequency among focus groups than key leaders. Quality of care was explicitly identified only by focus groups, as was interpretation. The following figure depicts for the numbers of references by sources for each identified element of access to care and services.



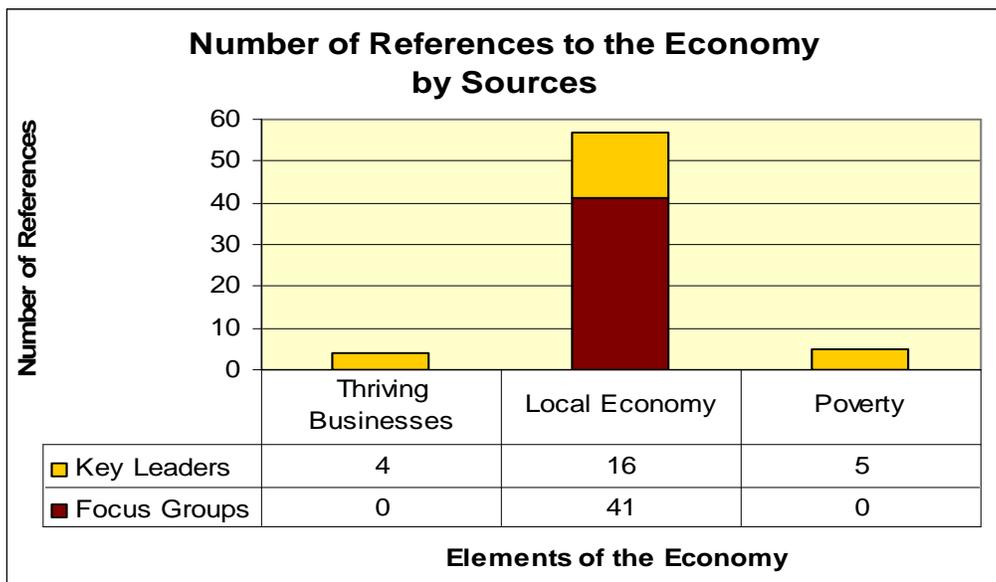
Focus groups mentioned each identified element, while key informants discussed a narrower range of issues. In addition, the only topic raised by the majority of key leaders was access to care, while access to care, access to services, cost of care, insurance, and quality of care were discussed within a majority of the focus groups. The issue of access to care was raised with greater frequency among focus group members than key leaders, suggesting that it is a salient theme for individuals and families across demographic groups.

Among focus groups, mentions of access to services (day care centers, grocery stores, food stamps, mobility aids for the disabled, therapy, and social centers) was fairly evenly spread, with teens, elders and caregivers mentioning with the greatest frequency. Bosnian and Bhutanese refugees identified access to care, insurance and cost of care, and care coordination, suggesting a need to more closely examine the needs of this group. In addition to the Bosnian and Bhutanese refugee groups, care coordination was raised with higher frequency among residents of the East Side, those with mental health issues, and the chronically ill.

Participants were concerned about whether they would be able to afford health care if they were laid off or when they retired. In a few focus groups, participants who were out of work said that it was very difficult to afford COBRA. For almost all of the participants, except participants who were on Medicaid and Medicare, health insurance was linked to either their job or their spouse's job. Within the group of key leaders, access to services was mentioned only by those from outside of the City of Manchester. This group also mentioned access to care, cost and insurance, and dental services as needs. Conversely, only key leaders from within the City mentioned children's health needs and care coordination as important issues. Key leaders' remarks about access to care varied widely. There was concern about a lack of primary care providers and a need to expand the services of the community health centers. Other leaders identified a lack of specialists. In contrast to focus group participants, no key leaders mentioned quality of care, complexity or translation as issues related to access to care and/or services.

## THE ECONOMY

In addition to access to care and services, the issue of the economy was raised by a majority of focus groups (92%) and key leaders (58%). Although it emerged as the second most important issue for both groups, differences existed in how the two groups related the economy to health issues. The graph below depicts the numbers of references by sources for each identified element of the economy.



Focus groups discussed the economy in terms of job security, personal finances, lack of affordable housing, foreclosures, and cost of insurance (which they tied to job security). Several focus group participants discussed their experiences with shifting health care benefits, even when they have kept their jobs. Among focus groups, the highest number of mentions regarding the economy was made by refugees, the uninsured, residents of the West Side, people with mental health issues, and caregivers of children.

Many of the focus group participants had recently been laid off or were worried they would soon be laid off. For participants who had recently been laid off, many found it difficult to navigate the public assistance office. Some participants recounted stories of being denied benefits on numerous occasions even though they had no job and no way to support themselves and their families. Participants wanted to talk with the Mayor about the need to increase eligibility to residents to public assistance programs including job training programs.

The downturn in the economy and the rising rates in poverty in the City are of real concern to area leadership. They understand that the people whom they are trying to serve are losing their jobs, benefits, health insurance, and when unable to pay their mortgages – their houses. Leadership assumes that poverty, especially for children and the elderly will worsen in the upcoming years.

*In the case of children “no one seems to look to the future – we are the wealthiest country in the world but can’t seem to change the course of failure for kids who are living in poverty”.*

*(Fred Rusczyk, Director, Child Health Services)*

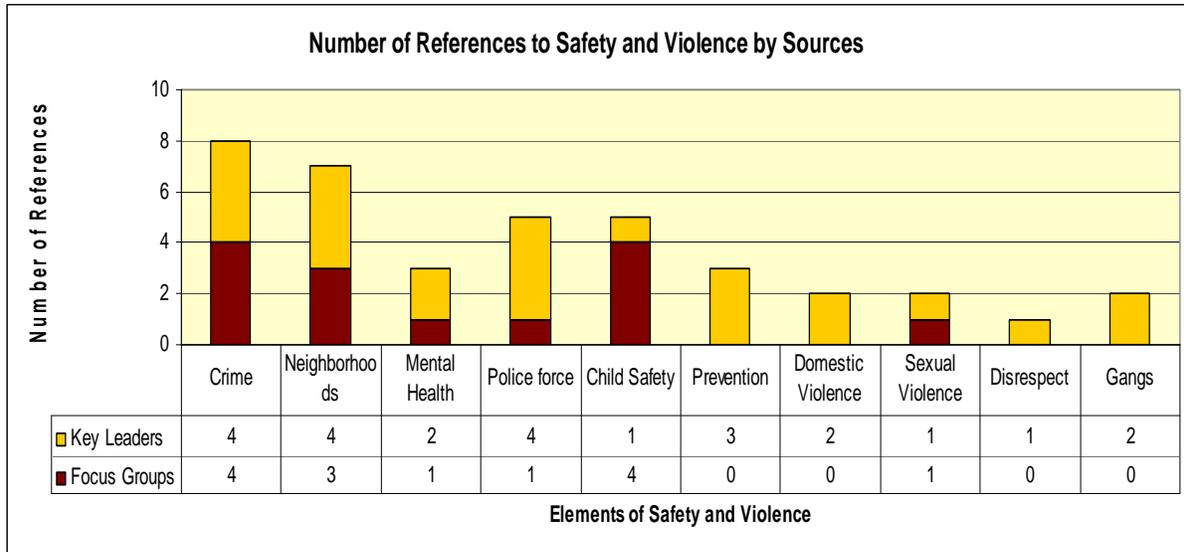
Only key leaders discussed thriving businesses as an important issue or explicitly mentioned poverty. Leaders discussed the effects of economy from a higher level, mentioning how the economic downturn has stressed City budgets and businesses as well as families and individuals. One leader expressed a need for responsibility from surrounding wealthy towns, and his concern that the existing New Hampshire tax structure will not allow the City to survive.

The issue of thriving businesses was raised mostly in descriptions of what makes a best community and included supporting an environment that attracts new and diverse businesses. One business leader mentioned that he was pleased with the economic activity in Manchester over the past ten years, in terms of business and universities and colleges. However, he also mentioned that at the end of the work day people returned home to surrounding communities. He felt that making more high-end housing available would benefit the local economy. Leaders discussed poverty in terms of its broad effects on health, education, and lack of a tax base to support services, particularly for children and the elderly. One leader spoke of a need to improve the quality of life for the poorest in order for the City to make progress.

Comments regarding the importance of the economy included a reference to the current nature of the problems. For example, one leader stated, *“If you had asked six months ago, it would not even have been on the radar, so it is truly a sign of the times.”* On the other hand, a different leader reflected on a recent time of similar economic downturn citing the closing of the mills in the 1960s and 1970s, *“When you look at the people in the community and their ability to be resilient, people in Manchester will come out of this economic downturn stronger provided the infrastructure doesn’t collapse.”*

## **SAFETY AND VIOLENCE**

Safety and violence were mentioned by a greater percentage of key leaders and with greater frequency than focus group participants. Of the participants that mentioned issues of safety and violence, equal numbers of focus groups and key leaders raised the issues of crime and safe neighborhoods. The following graph illustrates the numbers of references by sources for each identified element of safety and violence.



Focus groups made the most references to crime, the police force, and neighborhood safety, identifying increasing street violence and a need for more policing. Several focus group participants expressed concern or anxiety about the lack of safe places for children to play. Although most of the references were to problems facing families or individuals, focus groups also identified the importance of safe neighborhoods to an ideal community. In addition, focus group participants mentioned that they value police efforts to work with residents, keeping them informed about issues. One focus group member related an incident when the police notified the agency where she works about a sex offender moving into the neighborhood. The focus groups that raised the most concerns regarding safety and violence were teens, Veterans, and residents of the West Side.

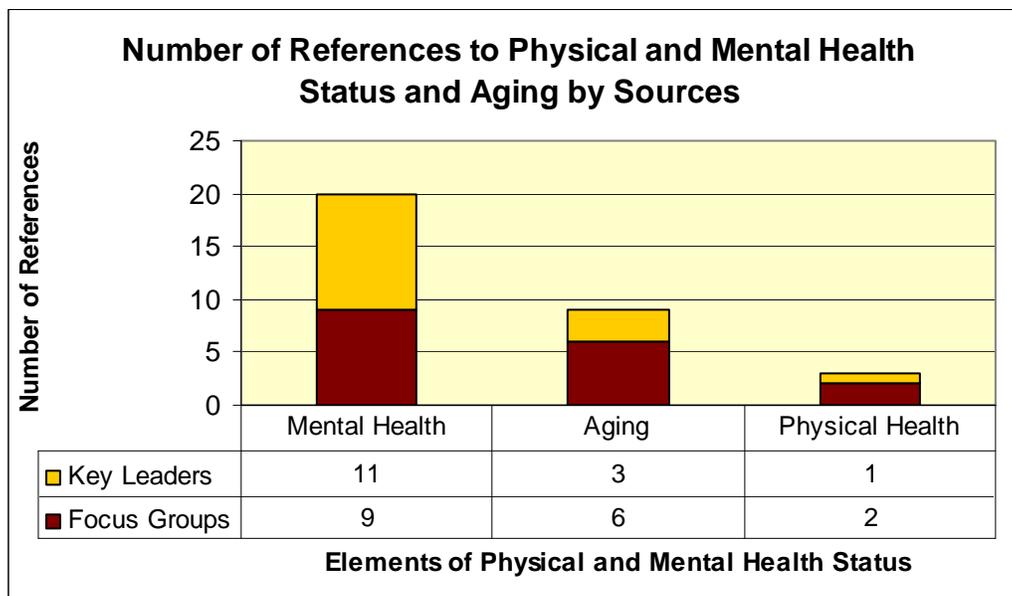
Focus group participants credited police Chief David Mara, “who isn’t afraid to be criticized”, with decreasing gang activity. Another participant spoke about how the YWCA provides support to women affected by domestic violence. Other participants were pleased with the self-defense courses offered to women by the police department. However, several participants stated that drugs remain a problem along with the violence associated with it.

*“We have sneakers banding from the wires which is a sign of drug and gang activity in the neighborhood.”*

Key leaders mentioned crime, neighborhood safety, and mental health with the greatest frequency. Only key leaders explicitly mentioned domestic violence, gangs, safe housing, and prevention of violence. Key leaders suggested that both mental health and drug use issues were correlated with higher crime rates. One key leader described a shift in the types of crimes occurring in Manchester, “...fewer car thefts and house break-ins, but more rapes, assaults, murders...”

## PHYSICAL AND MENTAL HEALTH STATUS

Health status ranked as the fourth greatest issue facing individuals, families, and the community. It emerged as an issue among more key leaders than focus groups. Aging and mental health issues were each raised by three focus groups. However, mentions of mental health issues were greater than aging. Among key leaders, mental health was mentioned the most. Aging was also mentioned, but by far fewer key leaders. The graph below depicts the numbers of references by sources for each identified element physical and mental health status and aging.



Among focus group participants, people with mental health issues and frail elders made the most mentions regarding health status. Other focus groups that identified physical and mental health status issues included the disabled, caregivers of children ages 2 to 12 years old, Bosnian and Bhutanese refugees, and racial ethnic minorities. The majority of key leaders who discussed physical and mental health status issues were responsible for organizations within the City.

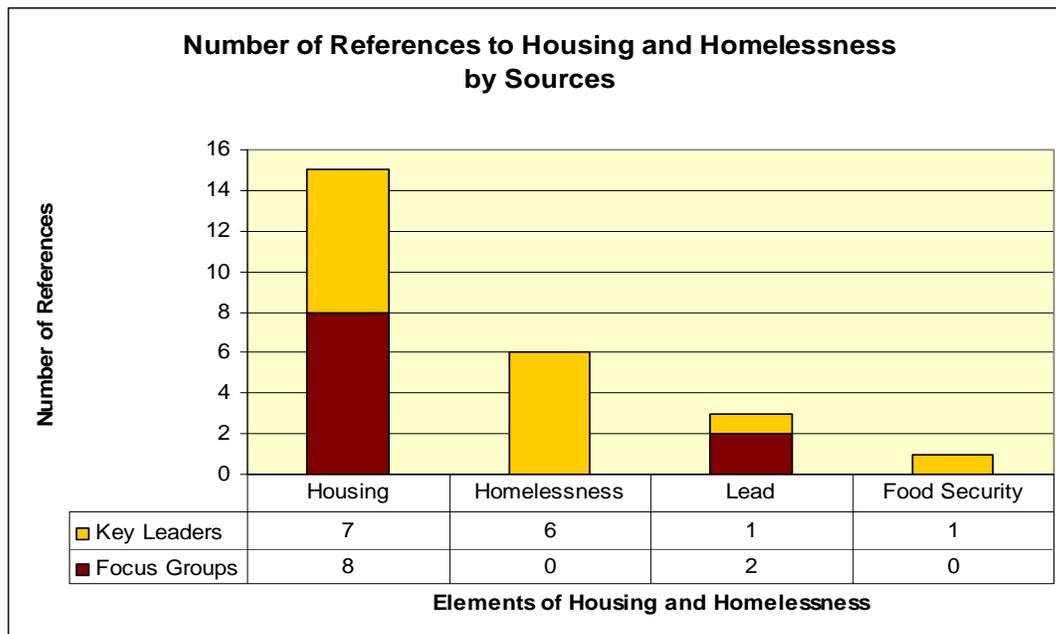
Focus group participants mentioned autism, diabetes and mental health in general. Much of the discussion around mental health issues was tied to access to care. Participants talked about insurance cuts related to mental health benefits and the costs of medication. They also talked about a lack of tolerance within the community for people with mental illness. Participants specifically mentioned a need for mental health specialists within the school system and a need to train police in managing mental health issues.

Key leaders discussed a broader array of health issues than focus group participants. Specifically, their discussion included mentions of depression, schizophrenia, anxiety, Lyme Disease and drug and alcohol addiction. They mentioned the interrelationship between mental and physical health, and the limited availability of Medicaid services for people with mental illness. One provider noted the “soaring referrals” for state-funded programs for the severely and chronically mentally ill. Key leaders mentioned the pervasive influence of mental illness, linking it with community violence and the economy in terms of resources needed for mental health services.

Aging was raised with far less frequency. Key leaders mentioned a lack of elderly housing and barriers to transportation among the elderly. One leader specifically recognized a need to increase prevention stating, *“Older people living independently are less likely to call for help in general and wait until the last minute when their medical needs become a real emergency.”* Another key leader identified an issue among the aging population specific to loss of retirement and financial resources related to the declining economy. These concerns were echoed by focus group participants. They were concerned about their futures as they age, many of them concerned about their continued ability to live independently within the community. One focus group mentioned increased isolation with aging and identified a need for more community-based activities for the elderly population.

## HOUSING AND HOMELESSNESS

Housing and homelessness was identified as an issue among more key leaders than focus groups. The graph below depicts the numbers of references by sources for each identified element of housing and homelessness.



Focus group participants identified a lack of safe and affordable housing. Participants identified health concerns related to housing such as lead exposure which they linked to their children’s learning disabilities, and “serious headaches from [their] home”. Participants also mentioned frustration with inefficiencies of “DHHS” when they applied for housing support, and identified a need for more Section VIII housing. They also felt that there was a lack of information about where to turn for housing-related problems. Housing issues were raised within focus groups of refugees and people with mental health issues.

Leadership from Manchester as well as from the surrounding towns described the lack of access to affordable housing, including housing for the elderly. They expressed their concern that an

abundance of workforce housing might attract to the area only those on the lower end of the socio-economic scale.

Key leaders discussed the pervasive effects of lack of adequate housing; one leader identified the lack of adequate housing stock as the most important issue facing the City, linking it to poor quality of life and health problems such as communicable disease. Focus group participants identified a lack of safe and affordable housing, specifically citing inadequate living conditions and high costs of rent. One leader summed up the housing issue stating that two issues interplay when we grapple with the issue of housing – income and cost.

*“People need to be able to have good housing and earn enough to pay for housing OR our housing just costs too much. Manchester is one of the most expensive places to live in the state.”*

*(Maureen Beauregard, Executive Director, Families in Transition)*

Only key leaders discussed homelessness as an issue. They recognized it as a problem particularly among children younger than 18 years old and linked it to mental health issues. Leaders also recognized that it is difficult to know the prevalence of homelessness because many people are living on an itinerant basis with friends or relatives, and in some cases multiple families are sharing crowded living conditions. Another leader felt that some of the people who are currently labeled as “homeless” would not be homeless if housing were more plentiful or of higher quality, or more easily accessible and affordable.