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Manchester's primary care safety net "intact but endangered": a call to action, Manchester sustainable access project, a strategic planning initiative of the healthy Manchester leadership council

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Manchester's Primary Care Safety Net
"Intact but Endangered"

A CALL TO ACTION

Manchester Sustainable Access Project

A Strategic Planning Initiative of the
Healthy Manchester Leadership Council

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MANCHESTER SUSTAINABLE ACCESS PROJECT COMMUNITY COALITION MEMBER ORGANIZATIONS

- Catholic Medical Center
- Child Health Services/Teen Health Clinic
- City of Manchester
- City of Manchester Department of Health
- Dartmouth-Hitchcock Manchester
- Easter Seals New Hampshire
- Elliot Health System
- Manchester Community Health Center
- The Mental Health Center of Greater Manchester

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WHAT IS ACCESS TO CARE?

"Access is the timely use of personal health services to achieve the best possible health outcomes."

- Institute of Medicine
Access to Health Care In America, 1993[1]

EXECUTIVE SUMMARY

The City of Manchester (referred to as Manchester or the City throughout this report), the largest urban community in northern New England, has a diverse primary care delivery system that is comprised of both public and private health institutions. Manchester's primary care system has recently been confronting significant economic challenges posed by an increase in demand for health care services and changes in demographic and epidemiological factors.

Manchester residents have poorer health outcomes compared to their state counterparts. This stems in part from the barriers to access to appropriate health care services faced by Manchester's most vulnerable populations. Manchester has experienced a substantial increase in the number and proportion of vulnerable residents, including the uninsured, the underinsured, and Medicaid Enrollees. The health care needs of these residents are great.

Data suggest that the growth of Manchester's most vulnerable populations has outpaced the City's primary care capacity. An increasing number of vulnerable residents are using the community's hospital emergency departments for care that should be obtained at less costly primary care sites. Primary care is often not accessed by these residents because they find the system difficult to navigate and/or they experience socio-cultural, economic, or geographic barriers.

Moreover, a growing number of patients who seek and obtain health care services in the City are unable to pay for the care they receive and their providers are often inadequately reimbursed for the care they provide. As a result, those who do provide care to the vulnerable are being challenged by the financial losses incurred by doing so. For fiscal years 2004–2006, the Manchester Community Health Center (MCHC), Dartmouth-Hitchcock Manchester, Child Health Services, The Mental Health Center of Greater Manchester, and the City's two local hospitals contributed a total of $133,023,926 in uncompensated care to the community.

The Manchester Sustainable Access Project was established to address these important issues now before further consequences are realized. The aim of the project is to develop an economically sustainable system of comprehensive, coordinated primary care for Manchester's most vulnerable populations. This will be accomplished by:

- establishing a community health system strategic planning board to guide the development and maintenance of the integrated primary care network;
- immediately expanding primary care services through the relocation of the Manchester Community Health Center—a Federally Qualified Health Center—to a larger facility and through the development of an additional community-based primary care site in a neighborhood of elevated need;
- developing a care coordination program to improve and stabilize care coordination across major providers of health care; and
- using data to guide the improvement of the community health system.

It is imperative that Manchester's health care leaders work collaboratively to enhance the City's primary care delivery system. With effective organizational collaboration, an integrated community health network that improves the health of the community's diverse population can be successfully created and its potential achieved.

REPORT AIM

In this report, we describe the Manchester primary health care delivery system and summarize the economic stress that it has recently been challenged to address. We present Manchester's changing demographic and economic landscape and the impact that this will continue to have on the City's health care providers, community organizations, and residents in regard to access to primary care services. Finally, we describe our vision of what we believe the community can do to decrease these economic barriers. Specifically, we illustrate our long-term vision for system improvement and then focus on the goals and objectives developed through the *Manchester Sustainable Access Project (MSAP).*

A CALL TO ACTION

As the MSAP moves forward in its work to decrease the economic barriers to primary care access, the project leaders and community have agreed to work collaboratively to enhance the quality and cost effectiveness of the health care delivery system for all vulnerable residents in Manchester.

Manchester is a city in need. It is also a city at the tipping point of great change. The question today for Manchester leaders is not whether the plan described in this document is the perfect solution for addressing the economic barriers that are burdening their community. The question is whether Manchester leaders have the political will to change the paradigm of how we work together. The question is whether we have the will to collaborate and maximize the cumulative resources of local providers to create a delivery system that works for ***all*** area residents and providers - a delivery system that is fiscally sustainable and prevents further loss to the community's health security.

SECTION ONE

THE CITY OF MANCHESTER

– THE QUEEN CITY OF NEW HAMPSHIRE –

LARGEST FLAG IN AMERICA

Workers rally round the flag they made in the mills of the Amoskeag Manufacturing Company in 1914. This Manchester, New Hampshire enterprise produced the 95-by-50-foot (29-by-15-meter) banner that year for a Chicago firm but borrowed it back in the spring of 1916 to lead New York City's "preparedness parade," an 11-hour procession on the eve of the United States' entry into World War I. Hundreds of Amoskeag employees numbered among the 125,000 participants. National Geographic first published this photograph in the October 1917 Issue. That special issue, devoted entirely to flags, was distributed free to thousands of American troops departing for battle in France.[2]

MANCHESTER

The City of Manchester is the largest community in New Hampshire and in northern New England. Manchester reins as the "Queen City" of New Hampshire as it is the largest city but not the state capital. With a total population of 109,364 residents, Manchester represents 8.3% of the state's population of 1,315,000 residents.[3] The City is rich in its diversity and history, which can still be seen today in the unique architecture, museums, culture, and demographics of the region.[4]

Although Manchester is located in a predominately rural and affluent state, it is also an urban community with public health challenges similar to those found in larger cities across the United States. For example:

- Nearly 28,000 of its residents are living below some level of poverty.[5]
- The fastest growing impoverished age group is children under the age of 18 years. In 2006, more than one in four of the City's children were living below 100% of the poverty threshold and more than one in three of the community's student population qualified and were enrolled in free or reduced meals.[3, 6]
- While the City makes up 8.3% of the state's population, it accounts for about fifteen percent (n=16,405) of New Hampshire's Medicaid Enrollees.[3]
- More than 5,000 refugees from all over the world have been resettled throughout the community. Seventy different languages are now spoken in Manchester schools by refugees and immigrants.[7, 8]
- In 2006, over 1,300 unduplicated homeless individuals of all ages were served by the Mobile Community Health Team Project.[9]
- In 2005, close to 78,000 visits were made to the Emergency Departments of Catholic Medical Center and Elliot Hospital. Of those, nearly half were for primary care rather than urgent care needs.[10, 11]
- In 2001, 32% of the patients cared for by the Manchester Community Health Center (MCHC), the City's Federally Qualified Health Center, were uninsured compared to 56% in 2006.[12] Even with federal grant dollars, enhanced Medicaid reimbursement and generous community funds, these dollars are not adequate for sustaining such growth.

A COMMUNITY WITH PROMISE

While the City can be described as a community at risk, it is also a community that holds great promise. With an unofficial motto of "Where History Invites Opportunity," the strength of Manchester is woven in the fabric of its heritage and innovation. One of its greatest strengths is its continued ability to mobilize, collaborate and leverage resources to respond to priority needs. The City's approach to problem-solving and decision making to improve the health of all residents, especially the most vulnerable, has implications for generations to come. These community lessons may also guide other developing cities and towns in New Hampshire who have yet to face these complex and multifaceted challenges, either of the same volume or intensity.

MANCHESTER AND ITS SURROUNDING TOWNS

Manchester, plus the surrounding towns of Auburn, Bedford, Candia, Chester, Deerfield, Goffstown, Hooksett, and New Boston, makes up what is known as the Manchester Health Service Area (HSA). The Manchester HSA has a population of 184,307 persons and represents 14.1% of the state's population and defines the major service area of the two local Manchester hospitals.[3] In 2003, the Manchester HSA experienced 16.4% (n=2,355) of the state's total births and in 2001, 14.5% (n=1,423) of the state's total deaths.[13]

Manchester Health Service Area
Population Projections (Based on 2005 Population Estimates)

	1990	2000	2005 Estimate	2010	2020	2030
Auburn	4,085	4,682	5,122	5,360	5,790	6,170
Bedford	12,563	18,274	20,732	21,810	23,940	25,400
Candia	3,557	3,911	4,165	4,250	4,570	4,840
Chester	2,691	3,792	4,636	4,790	5,220	5,590
Deerfield	3,124	3,678	4,115	4,420	4,780	5,100
Goffstown	14,621	16,929	17,687	18,600	20,260	21,800
Hooksett	8,767	11,721	13,279	14,330	16,360	18,100
New Boston	3,214	4,138	4,880	5,190	5,690	6,160
Manchester	99,567	107,006	109,691	112,400	117,620	121,700
Total Manchester Health Service Area	**152,189**	**174,131**	**184,307**	**191,150**	**204,230**	**214,860**

Source: NH Office of Energy and Planning [14]

SECTION TWO

MANCHESTER'S PRIMARY CARE SYSTEM – IS INTACT –

THE MANCHESTER PRIMARY CARE SYSTEM

The primary health care delivery system in Manchester is as diverse as the population it serves. It is delivered through public and private health institutions that provide a loosely knit system of population-based public health services, social services, and primary, secondary and tertiary care. The major provider institutions include the Elliot Health System (Elliot), Catholic Medical Center (CMC), Dartmouth-Hitchcock Manchester (D-H), Child Health Services (CHS), Teen Health Clinic (THC), the Manchester Community Health Center (MCHC), and The Mental Health Center of Greater Manchester (MHCGM).

A point in common for each of Manchester's health institutions is that each one is a health care charitable trust and eligible for property tax exemptions. Charitable trusts are defined as not-for-profit corporations that are organized to provide health care services and that have fund balances greater than $100,000. In lieu of property taxes, charitable trusts are required to: (1) conduct a community needs assessment that identifies the health needs of the community, and (2) develop a community benefit plan that identifies the activities to be undertaken to address those needs. Finally, every year each health care charitable trust must submit its community benefit plan to the Director of Charitable Trusts of the Attorney General's Office. Thus, by virtue of each organization's mission and vision, as well as state law, Manchester's primary care system organizations share a responsibility to protect and improve the health of the City's population.

MANCHESTER PRIMARY CARE SYSTEM ORGANIZATIONS

Manchester is home to two full service (not-for-profit) hospitals and one Veterans Administration Medical Center.

- The Catholic Medical Center (CMC) is a 330-bed hospital that offers medical-surgical care with more than 25 subspecialties, inpatient and outpatient services, diagnostic imaging, and a 24-hour emergency department. CMC is home to the New England Heart Institute and the Poisson Dental Facility.
- The Elliot Health System (the Elliot) manages a 296-bed hospital that hosts a Regional Cancer Center and one of three existing Neonatal Intensive Care units in New Hampshire. The Elliot, the designated Level II Trauma Center for the Greater Manchester, provides 24-hour critical care services to local area residents.
- The Manchester VA Medical Center is a 25-bed hospital that was a full-service hospital at one time but currently has a stronger focus on long-term care and end-of-life care for veterans.

The following key (not-for-profit) health care organizations serve the community at large and vulnerable populations specifically:

- Child Health Services (CHS) provides comprehensive medical care, social support services, and nutritional consultation to children and youth in the Greater Manchester area who are from low-income families. In addition, it houses a child development clinic that manages behavioral and developmental problems of early childhood. The Teen Health Clinic (THC) that is administered by CHS provides primary health care, nutrition, social support services, and health education to medically underserved adolescents from the Manchester area.
- Dartmouth-Hitchcock (D-H) Manchester provides primary, secondary, and tertiary health care services to all community residents and is backed by the resources of Dartmouth-Hitchcock Medical Center (DHMC) and the Children's Hospital at Dartmouth (ChaD) in Lebanon. This direct link to DHMC and ChaD enables the community to access to specialty services not otherwise available in the Manchester area.

- The Manchester Community Health Center (MCHC) is a federally-qualified community health center (FQHC) providing family-oriented primary care services in the Greater Manchester area for those who lack access to quality health care and/or are underinsured or uninsured.
- The Mental Health Center of Greater Manchester is a non-profit charitable organization that provides an array of psychiatric and substance abuse services.

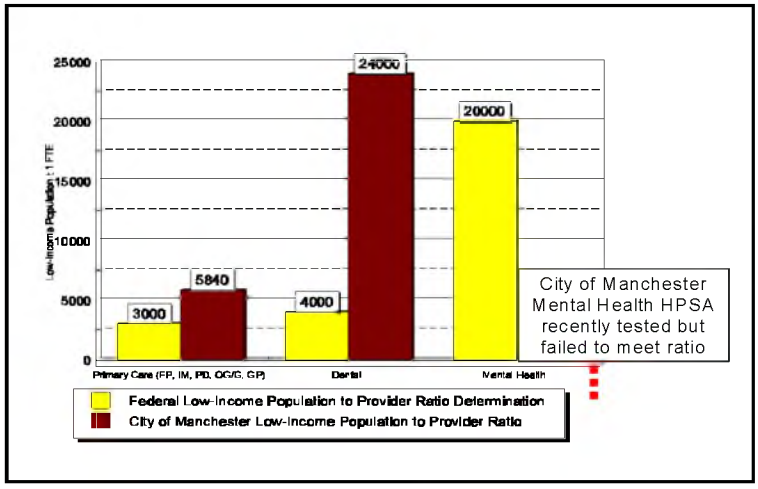
HEALTH PROFESSIONAL SHORTAGE AREAS

The capacity of the Manchester health care delivery system is limited by the number and type of facilities able to serve its growing population and by the numbers of providers available and/or willing to serve low-income residents. The federal government has recognized the need to increase the capacity of primary care providers in Manchester through its designations of professional shortage areas in the City, designations that provide incentives (i.e., loan forgiveness programs) for providers to practice in these areas.

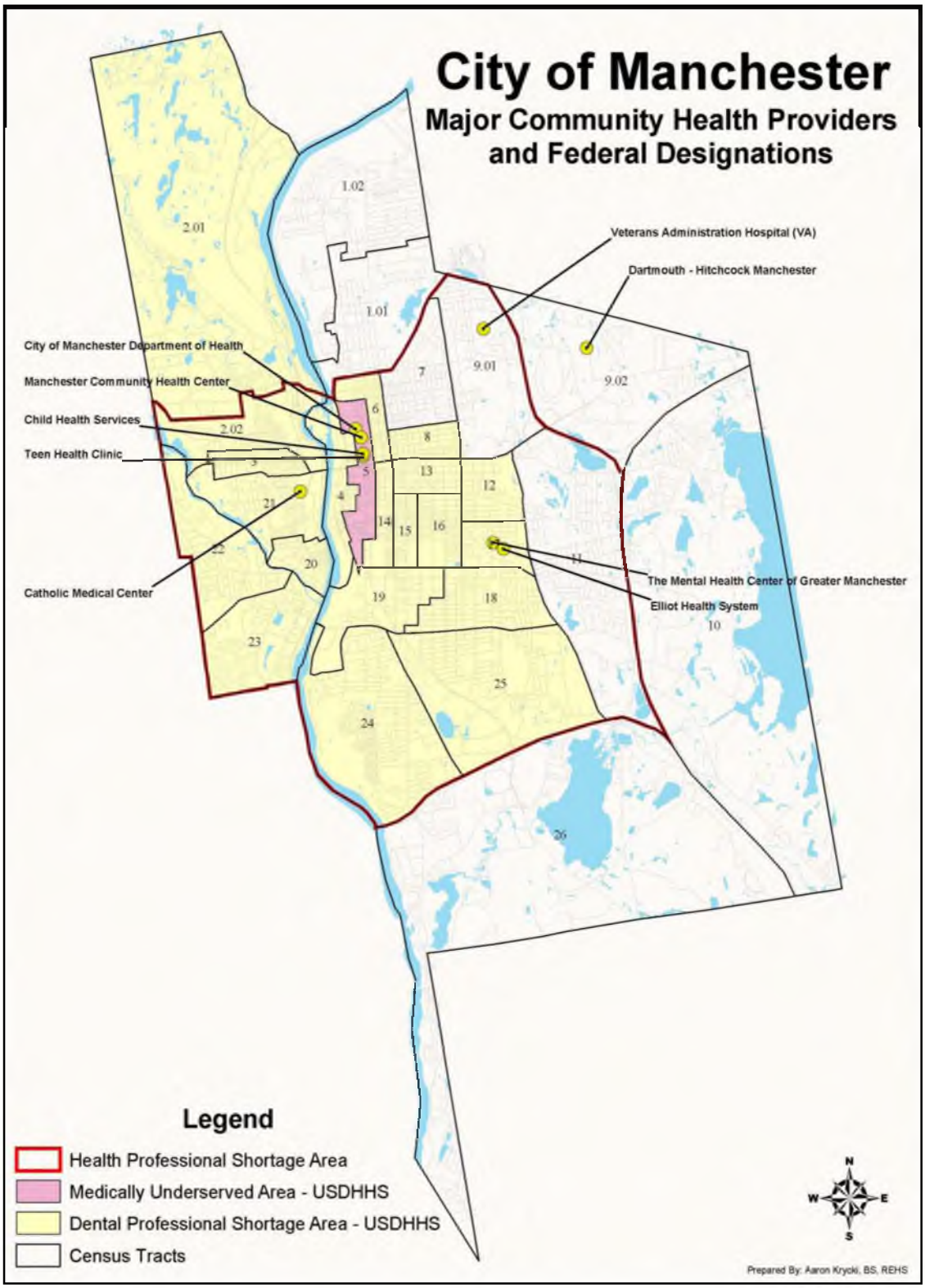
In 2002, Manchester's ratio of primary (medical) care providers to underserved populations was one provider for every 5,840 residents. The ratio proposed by federal guidelines for adequate primary care is one provider for every 3,000 residents. Thus, using this federal standard as a benchmark, twenty-three out of twenty-eight census tracts in Manchester have been federally designated as Health Professional Shortage Areas (HPSA).

Twenty-one census tracts in Manchester have also been designated as Dental Health Professional Shortage Areas (DPSA) due to the low provider (dentist) ratio to resident population. In addition, although the City has no Mental Health Professional Shortage Area designations (MPSA) at the time of publication of this report, we expect that this designation will be made in the near future. The map on the following page illustrates these designations.

City of Manchester Health Care Professional Shortage Area Designation Ratios, 2002



Source: NHDHHS: Office of Rural Health [15]



Source: NHDHHS: Office of Rural Health [15]

SECTION THREE

MANCHESTER'S PRIMARY CARE SYSTEM
– INTACT BUT ENDANGERED –

Manchester's Primary Care System is Stressed

Manchester's primary care delivery system is stressed. The number and proportion of Medicaid Enrollees, underinsured, and uninsured populations (including refugee, immigrant, and homeless populations) living in the Manchester area have grown substantially over the past several years. The current health care system has become inadequate for meeting the needs of these local residents in a sustainable way.

Contributing to the fragility of the City's primary care delivery system are the following factors: (a) Manchester residents are not as healthy and have poorer health outcomes compared to all other New Hampshire residents. (b) Barriers to primary care medical services are associated with economic factors as well as with the physical and social infrastructure of Manchester (e.g., rising poverty rates, poor housing, and lack of transportation). (c) Barriers to oral health care are associated with the lack of an oral health program and/or infrastructure for the City's most vulnerable populations. (d) There is an inefficient distribution of care burden across the provider population (i.e., some primary care providers do not provide primary care access to new Medicaid or uninsured residents; while at the same time the community emergency departments are seeing rising numbers of area residents for primary care). (e) Rising uncompensated care costs of providing primary care is threatening the economic viability of local providers.

Manchester Residents Are Not As Healthy as Their State Counterparts

Manchester residents, in almost every instance as described in the table on the next page, have poorer health outcomes compared to their neighbors who live outside of the City and throughout the rest of New Hampshire. For example, rates of premature mortality (death before the age of 75 years), heart disease mortality, and infant mortality in Manchester are higher compared to the average rates of mortality from these same causes across all other communities in the state. Likewise, rates of hospitalization for conditions that might have been prevented had primary care been available on a regular basis (e.g., hospitalization for asthma and diabetes) are also substantially higher compared to the rest of New Hampshire.

Health Outcomes – Manchester Residents Compared to All Other New Hampshire Residents

	Manchester	Manchester Health Service Area	All Other NH Without Manchester	New Hampshire
Premature Mortality Rate per 100,000 Population <Aged 65 Years, 2003-2005	230.9 *	197.6	176.9	180.9
Heart Disease Mortality Rate Per 100,000 Population, 2003-2005	299.4 *	219.5	193.8	197.2
All Cancer Mortality Rate Per 100,000 Population, 2001-2003	191.7	182.4	189.1	189.0
Infant Mortality Rate Per 1000 Live Births, 2003-2005	6.0	5.1	5.0	5.1
Percentage of Births With Late or No Entry Into Prenatal Care, 2001-2003	2.3%	1.8%	3.1%	3.0%
Percentage of Low Birthweight Births Per Total Births, 2001-2003	7.3% *	6.8%	6.3%	6.4%
Teen Birth Rate Per 1000 Births to Females Aged 15-19, 2003-2005	38.6 *	25.1	18.0	19.5
Percentage of Adults Aged 18 or Over Reporting Overweight or Obese, 2005	63.6%		56.2%	60.7%
Percentage of Adults Aged 18 or Over Reporting Current Smoking, 2005	28.3% *		19.7%	20.4%
Inpatient Hospitalization for Asthma, 2003-2005	149.7 *	112.8	74.8	80.8
Inpatient Hospitalization for Diabetes Mellitus, 2004	146.6 *	115.9	105.9	108.8
Inpatient Hospitalization for Unintentional Injuries, 2003-2005	452.6 *	420.6	404.8	409.1
Suicide Mortality Rate Per 100,000 Population, 2003-2005	13.2	12.2	11.0	11.2
Inpatient Hospitalization for Mental Disorders, 2003-2005	694.2 *	542.7	485.1	502.4
Inpatient Hospitalization for Alcohol Dependence Syndrome, ICD9 Codes 303.0-303.9, 2003-2005	306.7 *	223.2	211.1	218.3
Rate of HIV Infection Per 100,000 Population, 2003-2005	6.7 *		1.8	2.2
Rate of AIDS Cases Per 100,000 Population, 2003-2005	8.3 *		1.9	2.7
Rate of Chlamydia Per 100,000 Population, 2003-2005	293.0 *		118.6	133.3

Source: NHDHHS [16]
Note: All mortality rates are age-adjusted.
* denotes statistically significant differences between Manchester and all other NH residents

MANY BARRIERS TO PRIMARY CARE ACCESS EXIST

Manchester fairs poorly compared to New Hampshire on ***every*** indicator proposed by the federal government as being reflective of, or correlated with population barriers to access to health care.

Indicators Associated with Barriers to Primary Care Services – Manchester Compared to New Hampshire –

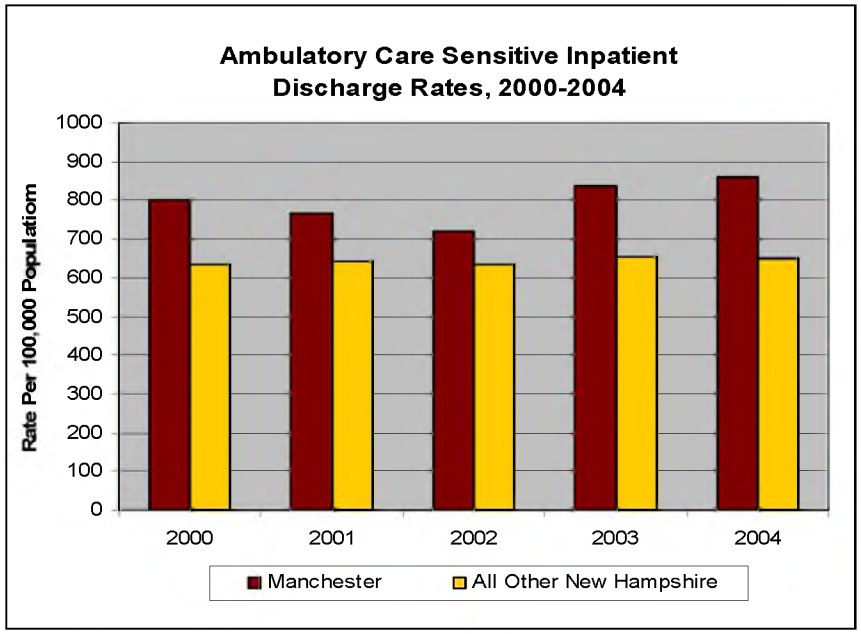
	City of Manchester	New Hampshire
Total Population, 2005	109,308	1,272,486
Percentage of Population Living Below the Poverty Threshold, 2005	12.9%	7.5%
Percentage of Population Living Below 200 Percent of the Poverty Threshold, 2000	25.9%	18.9%
Federal Poverty Level for a Family of Four, 2000	$17,050	$17,050
Unemployment Rate of Civilian Labor Force, 2005	5.8%	4.8%
Basic Needs and Livable Wage for a Family of Four, Both Parents Working, 2005	$50,031	$48,625
Median Household Income, 2005	$50,404	$56,768
Percentage of Persons Aged 25 and Older With Less Than a High School Education, 2005	15.7%	10.1%
Percentage of Population Aged 5 Years or Older Who Speak a Language Other Than English, 2005	18.7%	8.7%
Percentage of Population Living in Linguistically Isolated Households, 2000	4.5%	1.2%
Percentage of Households Without Telephone Service, 2005	5.9%	3.1%
Percentage of Households Without Access to a Car, Truck, or Van for Private Use, 2005	7.7%	4.6%
Percentage of Households With Female Householder, No Husband Present and Own Children Under 18 Years, 2000	7.5%	5.7%
Percentage of Renter-Occupied Housing Units, 2005	47.7%	27.0%
Percentage of Housing Units Built Prior to 1979, 2005	75.9%	61.7%
Percentage of Population Aged 5 Years or Older With a Disability, 2005	17.4%	13.9%
Part One Crime Rate Per 100,000 Population, 2005	3472.2	2051.8

Sources: U.S. Census, American Community Survey, U.S. Department of Justice [5, 17, 18]

MUCH PRIMARY CARE IS DELIVERED IN THE MOST EXPENSIVE VENUE

Ambulatory Care Sensitive Conditions (ACS) are defined as medical conditions that are less likely to require inpatient hospitalization if timely and appropriate primary care is received. Hospital discharges for ACS are costly to the Manchester community. Adjusted rates of ACS discharges for Manchester residents were consistently significantly higher compared to the rest of the state for every year from 2000 to 2004. Adjusted rates of ACS per 100,000 hospital discharges in Manchester increased from 800 per 100,000 population (2000) to 860 per 100,000 (2004). In all other towns of New Hampshire, adjusted rates of ACS increased from 634 per 100,000 population (2000) to 638 per 100,000 population (2004).[19]

On average, Manchester accounts for 11% of the state's discharges and 11% of the state's charges for ACS conditions. The average cost to Manchester per ACS discharge was $11,543 (2004).[19] Assuming that it was possible for Manchester to decrease its rates of ACS discharges (860 per 100,000 discharges in 2004) to the same lower rate of all other New Hampshire towns (634 per 100,000 discharges in 2004), the cost savings to Manchester would be an estimated seven million dollars that could be invested to expand its primary care capacity.



Source: NHDHHS [19]

INEFFICIENT DELIVERY OF PRIMARY CARE SERVICES

Preliminary data from a recent survey administered by the City of Manchester Department of Health to twenty-eight primary care practices, as well as current data from the two hospitals in the community, suggest that the City's primary care system may be reaching its capacity.

Twenty-five out of the twenty-eight primary care practices surveyed in the Manchester area reported that they had open primary care panels and were taking new patients.[20] However, the average wait time reported for a physician appointment was three weeks. In addition, although all twenty-eight practices reported that they provided twenty-four hour coverage (on-call physician/nurse) seven days a week, only six practices reported having office hours and patient appointments on at least one evening during the work week, and only five practices reported that they are open and schedule appointments during the weekend.[20]

Recently analyzed data from the two community hospital emergency departments (ED) illustrate that many community residents are using the EDs to obtain primary care services.[20] In fiscal year 2005, over 30% of patients who used an ED for primary care reported that they did not have a primary care physician. In addition, nearly 18% of ED visits were for patients who reported that they had no health insurance at all. Additionally, although residents are going to the EDs at all times of the day and night, most of the visits occur within the hours of 9:00 a.m. and 9:00 p.m. and are proportionate during each day of the week (i.e., the patient load in the community EDs is similar for every day of the week—including Saturday and Sunday—as a proportion of total patient visits).[20]

The cost of an average ED visit is about five times that of a primary care visit. Thus, based on the overall number of ED visits for care that could have been provided at a primary care site, we estimate that the additional cost to the community in 2007 for this care is nearly $20,000,000.00.

THE ECONOMIC VIABILITY OF PRIMARY CARE PROVIDERS

Primary care providers are being financially challenged to handle an increasing volume of patients who cannot pay for care or whose care is reimbursed at low public rates (i.e., less than 50% of the cost of care with no relation to charges). Low Medicare reimbursements will present important economic barriers to primary care access as baby boomers reach retirement age. Currently, low Medicaid reimbursements result in increasing loss of revenues for providers who see these patients, unless they are reimbursed at the higher state rate allowed through the Federally Qualified Health Center Program (FQHC). Thus, as the proportion of Medicaid, Medicare and uninsured residents increase in a practice, more cost-shifting occurs and access becomes more difficult.

There is an unequal distribution of uninsured and Medicaid patients across provider practices.

For example, "doctors who find that they cannot recoup money from insured patients to cover the losses they incur by taking Medicaid and uninsured patients may explicitly limit the number of such patients they will serve, or even turn them away entirely. As long as other doctors or clinics in the community are willing to take these same patients, the patients' needs may still be met. Recently there have been signs that some residents of Manchester and Nashua are now experiencing a problem finding any doctors who will see them if they are uninsured or are insured only by Medicaid."[20]

The chart on the next page illustrates the unequal distribution of uninsured patients, as a proportion of each practice's patient panel population, across twenty-eight Greater Manchester primary care practices.

Source: City of Manchester Public Health Department, 2007 PCP Practice Survey [20]

The uncompensated costs of providing timely, comprehensive care to more economically vulnerable populations is threatening the viability of the local provider organizations. Community providers incur financial losses every time they see a Medicaid patient (due to poor provider reimbursement) or a patient who is uninsured (due to increased uncompensated care losses). For example, for fiscal years 2004–2006, the Manchester Community Health Center (MCHC), Dartmouth-Hitchcock (D-H), Child Health Services (CHS), The Mental Health Center of Greater Manchester (MHCGM), and the two local hospitals together contributed a total of $133,023,926 in uncompensated care to the local community population: $96,009,416 in free care, $36,088,301 in costs above and beyond what they were compensated for by Medicaid, and $926,209 in costs for interpretation services to address language barriers (please see table below for details).

Manchester Uncompensated Care Summary (Selected Organizations)

	Free Care (Uncompensated)	Medicaid (Above reimbursement)	Interpretation (Uncompensated)	Totals
MCHC				
FY04	$784,037	$44,197	$68,935	$897,169
FY05	$724,354	$0	$76,513	$800,867
FY06	$895,417	$0	$110,365	$1,698,036
D-H				
FY04	$960,983	$2,651,959	$61,715	$3,674,657
FY05	$1,234,914	$2,923,624	$64,916	$4,223,454
FY06	$2,195,330	$3,674,913	$129,921	$6,000,164
CHS				
FY04	$166,430	$1,006,570	$24,774	$1,197,774
FY05	$170,762	$932,240	$30,865	$1,133,867
FY06	$151,802	$922,198	$31,815	$1,105,815
MHCGM				
FY04	$423,162	$0	$33,925	$457,087
FY05	$434,734	$0	$18,520	$453,254
FY06	$461,934	$0	$42,577	$504,511
Catholic				
FY04	$14,457,148	$2,488,982	$14,791	$16,960,921
FY05	$16,206,419	$3,738,284	$18,278	$19,962,981
FY06	$22,433,680	$4,169,751	$36,471	$26,639,902
Elliot				
FY04	$9,532,047	$3,755,889	$42,953	$13,330,889
FY05	$12,124,688	$4,421,925	$40,905	$16,587,518
FY06	$12,651,575	$5,357,769	$77,970	$18,087,314
TOTAL	**$96,009,416**	**$36,088,301**	**$926,209**	**$133,023,926**

Source: Community Provider Organizations

BARRIERS TO ORAL HEALTH CARE EXIST

Based on Manchester's demographics and population trends, Manchester expects the prevalence of oral disease to increase over the next several years. Thus, the City's health care organizations have become convinced that solutions to the problem of access to oral health services must be developed through a community-wide effort to develop a sustainable dental program that is linked to the provision of primary care.

"ORAL HEALTH is sound dentition and supporting structures which function to aid in nutrition, speech and appearance. As a portal to the inner body, the mouth shall be free of disease and shall contribute to the overall health and well-being of the individual."

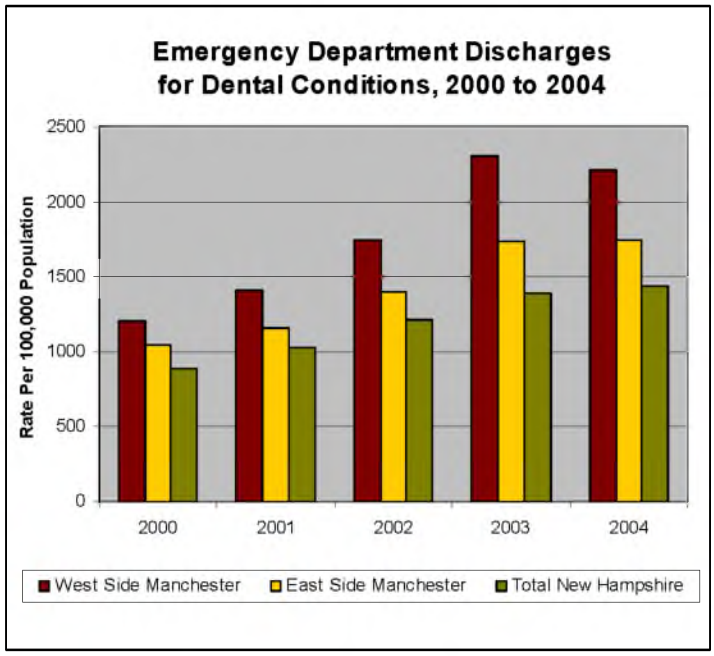
- Irene Coulon, RDH[21]

Access to oral health care is tied to access to medical and dental insurance. National statistics show that for every child without medical insurance, there are 2.6 children without dental insurance, and for every adult without medical insurance, there are three without dental insurance.[22] Many of Manchester's children and families lack medical and dental insurance, that presents significant barriers to access. In 2002, it was reported by the Healthy Manchester Leadership Council that approximately 2,500 children in Manchester lacked access to a medical home. As a result, these children lacked access to preventive care and continuity of care, that can improve health outcomes in general and oral health outcomes in particular. Among the City's kindergarten population in 2001, 21% lacked dental insurance, and 32.2% lacked a dental home.[23]

In New Hampshire, Medicaid dental insurance for children is relatively comprehensive and covers both preventive and restorative treatments including a full range of prophylaxis and restorative treatment. For adults 21 years and older, Medicaid only covers services for the relief of acute pain or elimination of acute infection. However, while Medicaid has a very generous dental insurance program for children, many of Manchester's youth are not enrolled in Medicaid and/or are not eligible. This inability to obtain dental insurance creates financial barriers to access for many families.

In addition to having insurance coverage, the availability of providers and those providers' willingness to accept Medicaid patients are essential to ensuring access to dental services. Beyond providing restorative care, dental health professionals are needed to prescribe and/or provide many evidence-based preventive services, such as the application of dental sealants and topical fluoride applications.

Having limited or no access to a dental home and preventive services forces the population in need to seek emergency oral health services through the community's emergency departments. Over the past several years, the two Manchester hospitals report having a steady increase in emergency department (ED) discharges (visits) for dental care. In 2004, the Catholic Medical Center ED treated 1,493 patients presenting with dental complaints [10] and the Elliot Hospital treated 2,985.[11] ED visits such as these, that might have been prevented through proper access to oral health care, create an increased and ongoing financial burden to the community and to the state (please refer to chart on the next page).



Source: NHDHHS [19]
Note: West Side and East Side rates are based on population estimates and should be interpreted with caution.

THERE IS A NEED TO INTEGRATE BEHAVIORAL HEALTH AND MEDICAL CARE

In 2005, the National Association of State Mental Health Program Directors Medical Directors Council published its eleventh technical paper[24] focused on integrating behavioral health and primary care services. A clear message of this report is that mental health disorders are real health conditions that have a tremendous impact on individuals, families, and communities. These disorders continue to be under-recognized for their impact on population health, prosperity, and overall well-being.

Mental illness is the second leading cause of disability and premature death (death before age 75 years) in the U.S. and accounts for 15% of the overall burden of disease from all diseases (including heart disease, cancer, respiratory conditions, alcohol use, infectious disease, and drug use). "Tragic and devastating, mental health issues such as schizophrenia, depression, bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame."[25] Untreated mental health issues affect our ability to sustain close relationships; achieve and keep jobs; focus on, function in, and graduate from school, etc.

In 1999, Dr. David Satcher issued the first "Surgeon General's Report on Mental Health"[25]. This report makes it clear to the public that evidence-based treatments are indeed available for many mental health disorders. And, the "single explicit recommendation of this report is for individuals to seek help if they have a mental health problem or think they have symptoms of a mental health disorder."[25] However, gaining access to evidence-based behavioral/mental health care is not as simple as just having the will to do so, especially in a health care system where there are multiple portals to access, financial barriers, and continued stigma associated with using these services. Thus, mental illness remains a health care issue with low rates of detection among the general public.

In an effort to address this under-service, the Surgeon General proposed in his report that primary care providers assume a stronger leadership role in providing a portal of entry into the mental health system for both adults and children. Inherent in this leadership role are responsibilities to be able to recognize mental illness and mental health problems, to be able to respond sensitively, to know what

resources exist, and to make proper referrals and/or to address the problems themselves using evidence-based practice.[25]

Thus, one of the guiding principals of the Medical Director's Council Report was that "behavioral health care is a core component of essential services to persons seeking primary health care. Ensuring access to preventive, ongoing, and appropriate behavioral health services is a primary responsibility and mission of general health care providers."[24]

This principle was established based on a robust body of research focused on depression in primary care that reported substantial improvement in depression when behavioral health services were co-located with primary care and when depression care management and stepped care were available to those who needed it.

Suggestive of the credibility of this research, the Health Resources and Services Administration (HRSA) is currently implementing a Primary Care Integration Initiative across the country to make it possible for Federal Community Health Centers to apply for expansion funds to add behavioral health services in their clinics. Additionally, HRSA is requiring that all new Community Health Centers provide mental health and substance abuse services to their primary care patients. MSAP believes that community providers might find it in their best interest financially to follow the lead of the Community Health Centers and incorporate behavioral health services into their local practices. Improved screening and preventive services, and streamlined referral to needed specialty mental health care should result in improved patient outcomes.

SECTION FOUR

MANCHESTER'S CHANGING POPULATION DEMOGRAPHICS

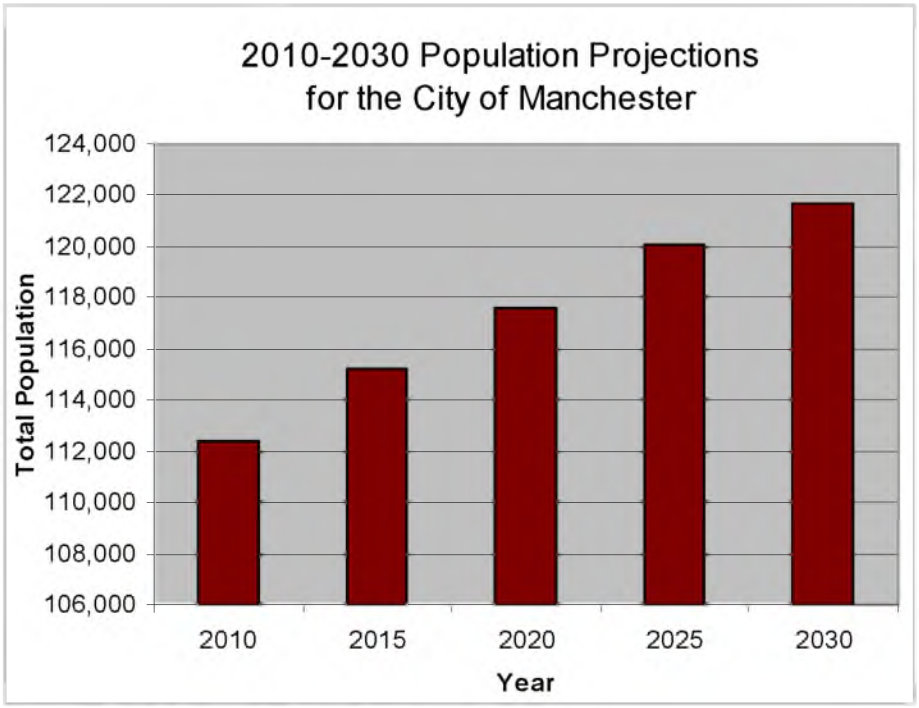
THE DEMOGRAPHICS OF MANCHESTER ARE CHANGING

Manchester's population is growing, aging, and becoming more diverse. Additionally, poverty rates, which have been high for some time, are increasing. These demographic changes are taking place in a city where the cost of living is disproportionately high compared to the rest of the state and in a time when health care costs are skyrocketing. These demographic changes are described in more detail in this section and implications of these changes are summarized in Section Five.

MANCHESTER IS GROWING

Manchester is an economic and demographic hub of the state. The New Hampshire Office of Energy and Planning reports that between 1990 and 2000 Manchester experienced growth in its population (in absolute numbers of people) greater than any other city and town throughout the rest of the state.[26] Thus, the City population is now larger (in absolute numbers of people) than the county populations of six out of the ten counties in New Hampshire.

Over sixty percent of New Hampshire's entire population lives within thirty miles of Manchester and the City is expected to continue to experience a steady increase in population growth over the next several decades (projected growth of an additional 122,000 residents by 2030).[26] This overall growth in population is challenging the local health system and has great implications for future planning of appropriate health care services including programs focused on prevention and management of disease, disability, and injury.



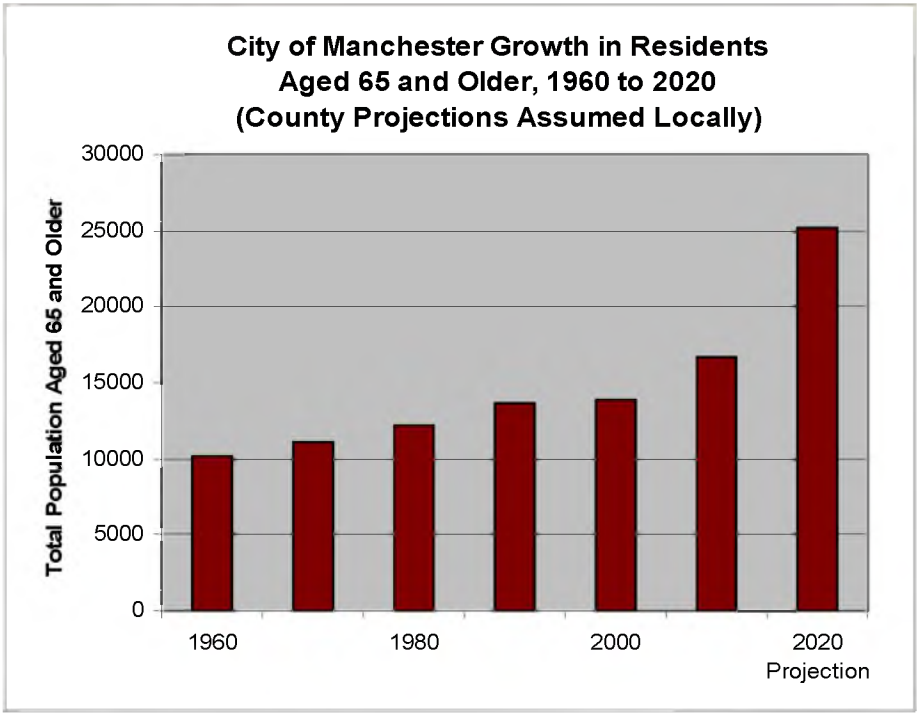
Source: New Hampshire Office of Energy and Planning [26]

THE POPULATION OF MANCHESTER IS AGING

The aging of the population in New Hampshire will have important consequences for the medical care system of the state as well as for its community and state public health systems.

As the older fraction of the population increases, more services will be required for the treatment and management of chronic and acute health conditions. The need for a "full continuum of care for the frail elderly will become fully apparent in the next several decades, greatly expanding the demand for nursing home capacity, congregate care facilities, adult day care programs, and respite as well as other care giver support programs"[27] including enhanced community support systems. Additionally, enhanced services outside of the realm of the typical "medical model" of care will be essential for maintaining the function and well-being of our elders. For example, as persons age, the need for enhanced and accessible transportation, housing, nutrition, and social service supports from the local community and from friends and families increases.

"It is anticipated that the number of Manchester residents age 65 and older will nearly double by the year 2020, and will represent over 20% of the City's total population. As this senior population grows, a new era of need for long term care, senior housing, home visiting programs and retirement communities will emerge."[28]



Source: City of Manchester Public Health Department [7]

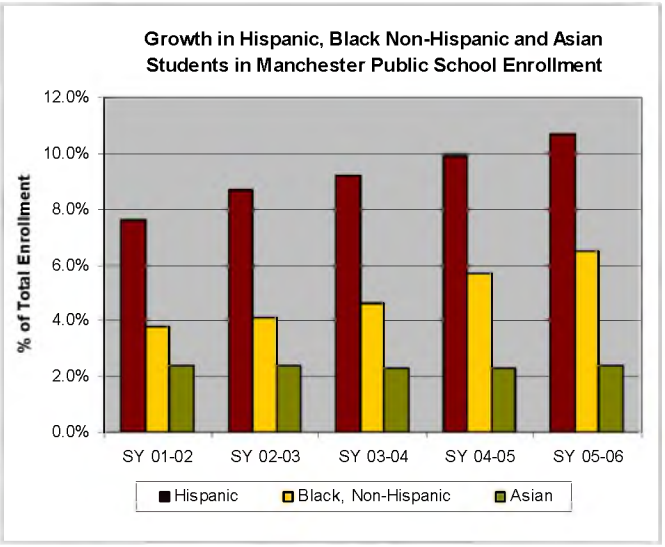
THE CITY IS DIVERSE AND BECOMING MORE DIVERSE

As the Manchester community continues to become more diverse, medical providers and other professionals involved in health care delivery are interacting, often for the first time, with patients and consumers from different cultural and linguistic backgrounds who have unique needs for care and care delivery.

For example, many measures of mortality, disease incidence, and disability differ significantly by race and/or ethnicity. In 2003, the national age-adjusted death rates for Black Americans were 43% higher for stroke, 31% higher for heart disease, 23% higher for cancer, and almost 750% higher for HIV disease compared to non-Blacks.[29] In addition, a higher percent of Black Americans (15.4%) reported having some limitation of activity caused by chronic conditions compared to 10.2% of non-Blacks.[29] The reasons for these differences in health status are due to "complex and poorly understood interactions among socioeconomic, psychosocial, behavioral, and health care related factors"[30] and it is these factors that need to be taken into account when developing public health interventions for diverse populations. Additionally, because culture and language are vital factors in how health care services are delivered and received, providing services in a culturally and linguistically sensitive way has the potential to improve access to care, quality of care and ultimately, health outcomes.[31]

The rate of population change by race and ethnicity has not been the same across all New Hampshire communities. In both the cities of Manchester and Nashua, rates of growth of minority and ethnic populations exceeded those of New Hampshire overall. In Manchester between 1990 and 2000, the African descendent population grew by about 157% compared to 25% growth for the state. The Latino population grew by 126% compared to 72% growth for the state.[32]

School enrollment for African descendents increased from 3.5% of the Manchester total school population to 6.5% and for Latinos from 7.6% of the school population to 10.7% (from school years 2001–02 to 2005–06.) Increases in enrollment in the Limited English Proficient Programs have more than doubled in the past ten years from 1,126 students (1993–1994) to 2,755 students (2003–2004).[33] Between fiscal years 2004 through 2006, Manchester community health care provider organizations reported a total of nearly $1,000,000 in uncompensated care for the provision of interpretation services.



Source: NH Department of Education [6]

In 2004, the New Hampshire Minority Health Coalition published "The Health of African Descendents and Latinos in Hillsborough County". Important information about access to health care was described in the report:[34]

- 38% of African descendents had no medical coverage.
- 62% of Latinos had no medical coverage.
- 6% of African descendents and 29% of Latinos with no coverage received reduced fee/discounted care.
- Of those with health insurance, 22% of African descendents, and 14% of Latinos were covered by Medicare or Medicaid.
- 30% of African descendents and 42% of Latinos had no regular health provider.
- Barriers to access included cost, language, and clinic hours.

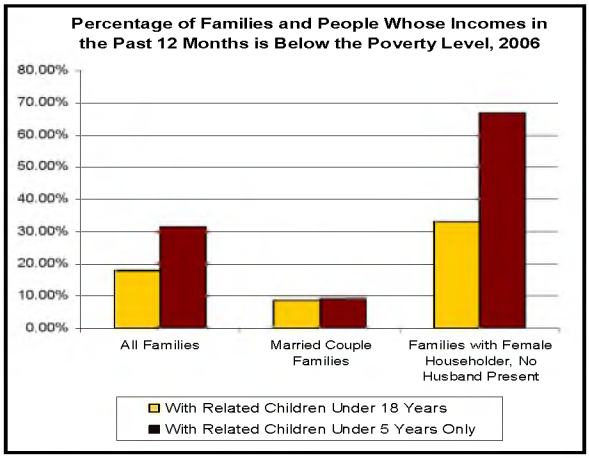
In 2006, Ryan et al. further analyzed this information to explore whether self-reported racial discrimination was associated with mental health status and if variation across race/ethnicity (African descendents and Latinos) or immigration status existed. Using three separate study methods, the authors concluded that perceived discrimination may be an important predictor of poor mental health status among African descendent and Latino immigrants.[35] Furthermore, it was concluded that the association between self-reported discrimination and lower mental health status was stronger for immigrants who had resided in the United States. for longer periods of time. Thus, given the increasing diversity of Manchester and its interest in providing evidence-based primary care services to all residents, it is imperative that Manchester providers now develop and implement integrated models of primary care practice that include behavioral health services.

FAMILY STRUCTURE IN MANCHESTER IS CHANGING

Across the nation, the definition of family is changing and with this restructuring, economic, and social stressors are greatly affecting the health status of adults and children.

Single Mother Families

In Manchester, the percentage of births to unmarried women has increased dramatically in recent decades, from 8.9% in 1973 to 34.2% in 2003. Over 56% of these births, or one in five of total births in the City, are to unmarried mothers enrolled in Medicaid. As of 2006, two thirds of all families with a female householder (with no husband present and related children under the age of five) were living below the poverty level.[36]



Source: U.S. Census Bureau, American Community Survey [36]

In 2006, the National Health Interview Survey reported that children in the United States in single-mother families were:[37]

- more likely to not get medical care or to have delayed getting medical compared with children in two-parent families.
- more likely to have had two or more visits to an emergency department in the past twelve months compared with children in two-parent families (11% vs. 7%).
- more than twice as likely to have been absent from school for eleven or more days in the past year due to illness or injury compared with children in two-parent families (9% vs. 4%).
- more likely to have unmet dental needs compared with those in two parent families (10% and 6%).

In addition, children in single-parent families do not do as well on measures of development, performance, and mental health as children in two-parent families. Children's relationships with their parents, social support, nurturance, and sense of self-efficacy have been shown to be related to their mental and physical health and even to their future economic productivity.[38]

Births to Mothers Aged 19 and Younger, 2000–2003

	2000	2001	2002	2003
Total Births to Manchester Mothers	1485	1471	1571	1559
Total Births to Manchester Mothers Aged 19 and Younger	132	134	145	110
% of Total NH Births to Mothers Aged 19 and Younger Who Are Manchester Residents	13.2%	14.6%	16.4%	13.3%

Source: NHDHHS [19]

On average, the City has consistently experienced approximately 135 babies born each year to adolescent and teen mothers; this figure is analogous to the size of a small elementary school in most cities and towns throughout the state. Children born to adolescent moms are far more likely to be physically abused, abandoned, or neglected and may experience greater difficulty in school. Problems continue for these children as they grow up; they are more likely to drop out of school, lead an unproductive life, and have poorer health throughout their lifetime. In Manchester, young mothers aged 19 and younger are twice as likely to be unmarried (86%), use Medicaid to pay for their delivery (50%), use tobacco during pregnancy (30%), have late or no prenatal care (5%), and experience low birth weight births (12%) as compared to mothers aged 20 and older.[19]

Family Structure is Changing for the Elderly

In Manchester, one in four senior householders do not own a vehicle. Over 34% of residents aged 65 and older live alone compared to 28% throughout New Hampshire. In the center city core, nearly 57% of this population is at risk for social isolation.[17] In addition, most of the survivors at the highest ages are women, and in particular, widowed women. This imbalance of the sexes has been associated with reduced income, greater poverty, poorer health including depression, and greater risk of institutionalization of older women.[18] In 2000, there were 3,627 female householders and 1,112 male householders aged 65 and older living alone throughout the City[28] (please refer to the table on next page).

Manchester and All Other New Hampshire Residents Age 75 and Older with Selected Risk Factors, 2000

	Manchester City	All Other New Hampshire
Total Population Age 75 and Older	7,269	55,124
Total Occupied Housing Units With a Householder 75 Years and Older Living Alone	3,021	24,485
% of Total Occupied Housing Units With a Householder 75 Years and Older Living Alone	6.8%	5.0%
% of Total Residents Age 75 and Older Living Below Poverty Threshold	13.9%	8.6%

Source: 2000 U.S. Census [5]

POVERTY RATES ARE HIGH AND ARE INCREASING

"Poverty should be defined by an individual's inability to affect change in their lives ..."

Kathleen McHugh
"Save the Children"[39]

Manchester is a city with large areas of poverty and need. While sections of Manchester have become prosperous neighborhoods, the City has a large proportion of people who still live with limited resources. Currently, Manchester residents comprise 8.3% of the state's total population; however, 14% of the people living below poverty in New Hampshire are Manchester residents.[40]

Correlated with an increase in poverty is an increase in persons who must turn to public programs for assistance. Thus, it is not surprising that Manchester is also now home to a disproportionate share of the state's Medicaid recipients. While about 8% of the state's population lives in Manchester,[5] it is now home to about 15% of the state's Medicaid Enrollees.[41] Additionally, 15% of the uninsured residents of the state reside in the Greater Manchester Health Service Area.[38]

Manchester residents who are living in poverty often receive inefficient and costly services in emergency departments, either long after the benefits of preventive health care are realized, or in lieu of receiving care in a less costly primary care setting. And, as is well known, poverty is often associated with poorer health outcomes. In many cases, underserved populations do not ever access primary care due to: (a) a haphazard and difficult system to navigate, including limited clinic hours in relation to work schedules, (b) socio-cultural barriers (i.e., language barriers), (c) economic barriers such as the lack of health insurance, dental insurance, prescription drug coverage, childcare and/or telephone service, and/or (d) geographic barriers, including a lack of adequate transportation.

Poverty is becoming a leading issue of concern in Manchester, especially in regard to its children. Of note, in the table on the following page is the substantial increase from 1990 to 2006 in poverty rates among Manchester children under age 18 years of age. In 1990, 12.6% of Manchester's children below the age of 18 years lived below 100% of the federal poverty threshold.[42] By 2000, this figure had increased to 15% [5] and by 2006 to 26.0%.[3] Additionally, the 2000 U.S. Census reported that 27,715 (25.9% of the City's population) were living below 200% of the poverty threshold and 11,343 people (10.6% of the City's population) were living below 100% of poverty. [5] Results of the 2006 American Community Survey estimates that this percentage had increased and that 13.3% of Manchester residents were now living below 100% of the poverty threshold.[36] This increase in poverty is also occurring among all other residents throughout the rest of New Hampshire but at a

significantly lower percentage (7.5% of the population outside of the City live below the poverty threshold).

Percent of Manchester Families and Residents Living Below 100% of the Poverty Threshold, 1990, 2000, 2005, and 2006

	U.S. Census (1990)	U.S. Census (2000)	American Community Survey (2005)	American Community Survey (2006)
All Families	6.3%	7.7%	9.5%	9.8%
With Related Children Under 18 Years	9.9%	12.3%	18.4%	17.8%
With Related Children Under 5 Years Only	14.3%	17.2%	22.2%	31.5%
All People	9.0%	10.6%	12.9%	13.3%
Under 18 Years	12.6%	15.0%	22.4%	26.0%
18 Years and Over	7.9%	9.3%	10.2%	9.5%
18 to 64 Years	7.0%	8.8%	10.4%	9.3%
65 Years and Over	12.2%	11.7%	9.5%	10.8%

Source: U.S. Census, American Community Survey [3, 5, 36, 42]

How is Poverty Defined?

For purposes of this report, people and families are classified as living in poverty if their income is less than the U.S. Census poverty threshold. For example, if a family's income is less than half the poverty threshold, this is described as living below 50% of poverty; likewise, if the family's income is less than the threshold itself, this is described as living below 100% of poverty. The greater the ratio of income to poverty, the more people fall under the category, because higher ratios include more people with higher incomes. For example, in 2006, the total annual income used to determine whether or not a family of four lived below 100% of the poverty threshold was $20,614 or less. For this same family to fall below 200% of the poverty threshold, their income would be less than $41,228.[43]

Poverty Thresholds for 2006 by Size of Family and Number of Related Children Under 18 Years (Dollars)

Size of family unit	Weighted average thresholds	Related children under 18 years								
		None	One	Two	Three	Four	Five	Six	Seven	Eight or more
One person (unrelated individual).....	10,294									
Under 65 years.....	10,488	10,488								
65 years and over.....	9,669	9,669								
Two people.....	13,167									
Householder under 65 years.....	13,569	13,500	13,896							
Householder 65 years and over.....	12,201	12,186	13,843							
Three people.....	15,079	15,769	16,227	16,242						
Four people.....	20,614	20,794	21,134	20,444	20,516					
Five people.....	24,382	25,076	25,441	24,662	24,059	23,691				
Six people.....	27,560	28,842	28,957	28,360	27,768	26,938	26,434			
Seven people.....	31,205	33,187	33,394	32,680	32,182	31,254	30,172	28,985		
Eight people.....	34,774	37,117	37,444	36,770	36,180	35,342	34,278	33,171	32,890	
Nine people or more.....	41,499	44,649	44,865	44,269	43,768	42,945	41,813	40,790	40,536	38,975

Source: U.S. Census Bureau [44]

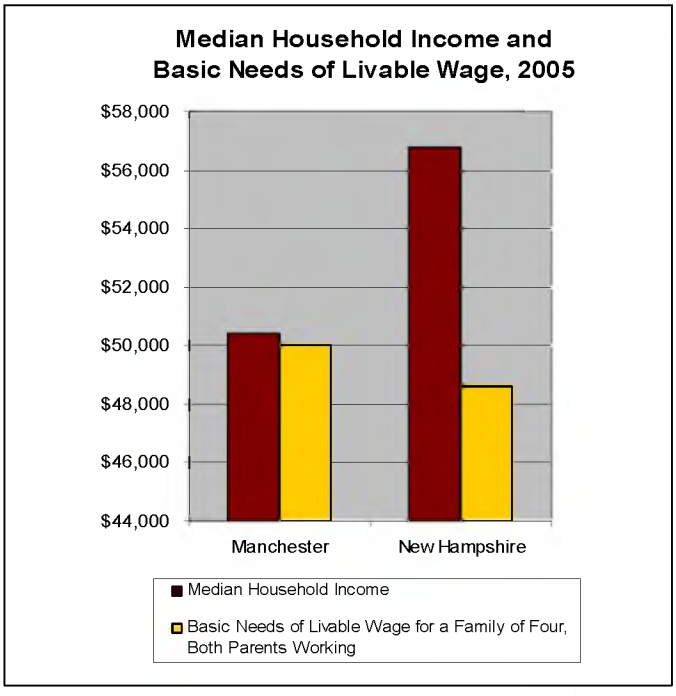
THE COST OF LIVING IS HIGH IN MANCHESTER

By definition, a "livable wage" is a wage sufficient to pay for basic needs for families such as food, rent, utilities, basic telephone service, clothing, household expenses, transportation by automobile, child care, health care, and allowance for personal expenses.[17] In New Hampshire, this varies by family size and by community.

The costs of basic needs are increasing in New Hampshire:[17]

- Child care costs have increased by 88% over the last five years.
- Health insurance costs have increased 103% over the last seven years.
- Costs of rent and utilities have increased by 35% over the last six years.
- The average costs of child care and health insurance in New Hampshire have been increasing faster than New Hampshire's median family income.
- The average costs of child care, health insurance, rent, and utilities and telephone in New Hampshire have been increasing at a greater rate than the national consumer price index.

It is more expensive to live in Manchester compared to the rest of the state.



Source: New Hampshire Small Business Development Center [17]

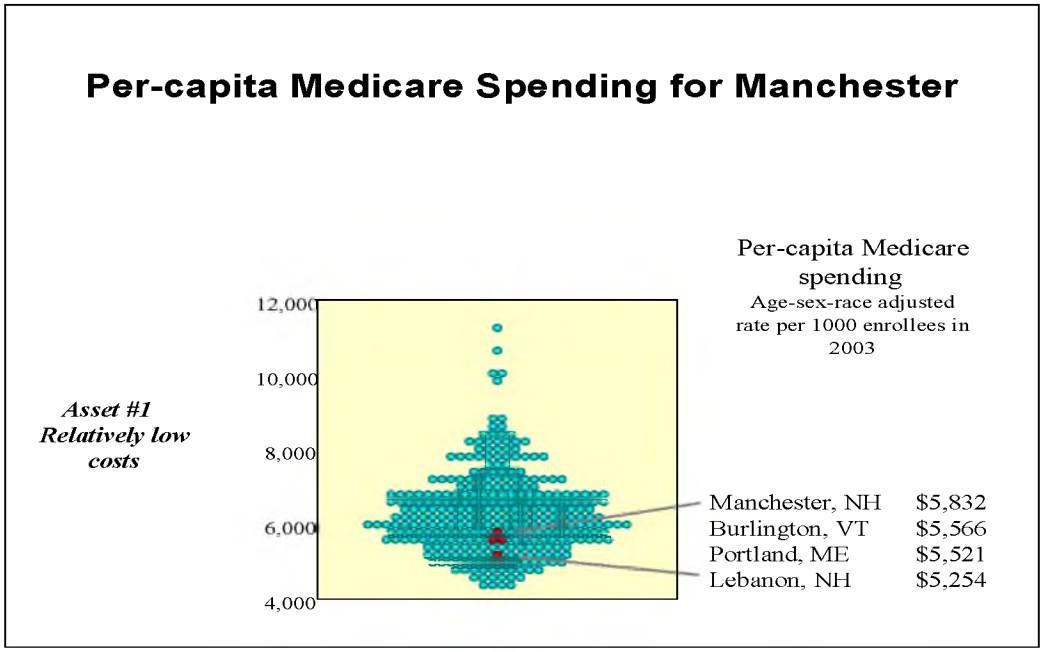
In Manchester, the livable wage (earnings that support the basic needs of the family) for a family of four with both parents working was $50,000 in 2005.[17] This was significantly higher than the livable wage for the state ($48,625). In contrast, for the same year, the City's median household income of $50,404 was nearly $6,000 less than the state median income of $56,768. These data suggest that Manchester residents, on average, live with fewer resources in a city with a higher cost of living compared to their neighbors throughout New Hampshire.

THE COST OF HEALTH CARE IS SKYROCKETING

Health care costs and subsequent costs of health care insurance premiums continue to rise at a rapid rate, both nationally and in New Hampshire. Rising costs make it increasingly unaffordable to families and to the government, which pays a substantial share of these costs through programs like Medicare and Medicaid.

Across the nation, more employers are shifting the costs of insurance premiums to their employees or dropping health coverage altogether. Thus, because of the costs of these premiums, more employees are unable to purchase health insurance even when it is offered. As a consequence, more persons in New Hampshire and across the nation are joining the ranks of the uninsured or underinsured. Or, if they are eligible, they obtain health coverage through public programs such as Medicaid.

In 2005, health care expenditures in New Hampshire accounted for 16% of the gross domestic product (GDP) of the state.[45] This rate of expenditure continues to increase by about 10–12% annually.[45] While this is troublesome for the state, it is also true that New Hampshire currently has low total per capita spending rates for its Medicare population (this is reflective of health care spending rates for the total population). Thus, curtailing spending at current rates would be a step in the right direction and would help to ensure the viability of the state's health system for the future. At the community level, state monitoring of Medicare spending across Health Service Areas (HSAs) could provide benchmarks for assessing and improving the efficiencies of local health care systems.



Source: Fisher, Elliot., Presentation to the NH Citizens Health Initiative [46]

SECTION FIVE

IMPLICATIONS OF A CHANGING LANDSCAPE
– VULNERABLE POPULATIONS OF MANCHESTER –

For purposes of this report, we have defined vulnerable populations as those residents of Manchester who are uninsured or underinsured. Included in this definition are residents who are homeless, Medicaid Enrollees, refugees and immigrants, expectant mothers, infants and children, residents of public housing, frail elderly, and residents with chronic illness and disability. Below we briefly describe the vulnerable populations of Manchester.

THE UNINSURED

"Uninsured people suffer worse health and die sooner than those with insurance."[47]

Uninsured adults are:[48]

- more likely to go without medical care than insured adults;
- less likely to have a doctor or personal health care provider;
- more likely to report being in "fair" or "poor" health compared to insured adults; and
- less likely to receive preventive services including mammograms, Pap smears, PSA tests, blood stool tests, sigmoidoscopies, or colonoscopies.

Although there is very little City level data available on the uninsured, we assume that in Manchester the profile of the uninsured is similar to that of the state. In addition, because of the higher rate of poverty in the City, we also assume that the rates of uninsured and underinsured populations are substantially higher compared to the rest of the state. Below we present a summary of state-level data on the uninsured.

- Nearly one out of every four persons in New Hampshire under the age of 65 went without health insurance for all or part of the two-year period from 2002-2003 (23%, n=259,000).
- Most uninsured New Hampshire residents are members of working families (87.8%, n=227,000).
- Poor families are much more likely to be uninsured.
- "Families with even one member who is uninsured lose peace of mind and can become burdened with enormous medical bills."[49]

Likelihood of Manchester Residents Under Age 65 Being Uninsured by Income – Assuming State Estimates Locally (2002–2003)			
Income as Percent of Poverty Threshold	Population	Number Uninsured	Percent Uninsured
Income at or below 200% of Poverty	22,362	16,973	75.9%
Income at or above 201% of Poverty	68,967	8,138	11.8%

Source: City of Manchester Public Health Department [7]

THE NUMBER OF UNINSURED RESIDENTS IS GROWING

The most pressing impact of changing demographics (i.e., rising poverty rates and skyrocketing health care costs) on primary care access in Manchester is one of economics. As poverty rates increase, more residents join the ranks of the uninsured or underinsured. Or, if they are lucky enough to meet certain requirements, they may become eligible for the state Medicaid program.

The Greater Manchester area provides health care services to about 15% of the state's uninsured population.[50] And, in a recent survey, 11.5% of Manchester adults compared to 9.7% of New Hampshire adults reported that during the past 12 months they were unable to get needed medical care because of the cost of care.[51]

"The presence of a sizable or growing population of uninsured persons may impose destabilizing financial stresses on the health care providers that serve all community members and on the public and private sources that finance local health care."[49]

The bottom line is that everyone pays for the costs of health care for the uninsured. [8]

- Forty-four percent (44%) of the cost of care for the uninsured is paid by people with health insurance through higher premiums.
- Thirty-five percent (35%) is paid for through out-of-pocket costs by the uninsured themselves.
- Twenty-one percent (21%) is funded by government programs.

In the table below we illustrate how much premiums have increased for individuals and for families due to the increases in numbers of the uninsured and the associated costs of their care that is not covered by any type of insurance, government, or city program.

Increases in Total Annual Premium Costs Due to the Unpaid Cost of Care for the Uninsured In New Hampshire		
Year	Individual	Family
2005	$252	$805
2010 (projected)	$375	$1,356

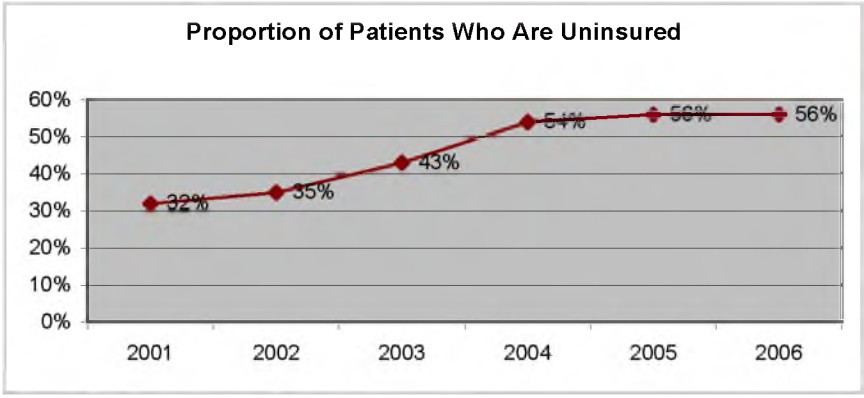
Source: Families USA [8]

- In New Hampshire in 2005, the added cost of a health care premium for an individual was $252 higher, and for a family $805 higher, due to the unpaid cost of health care for the uninsured.
- For the year 2010, these additional costs are projected to be $375 for an individual and $1,356 for a family.

Over the past several years, more uninsured Manchester residents are being seen by local providers and health care organizations as a proportion of their total patient population.

For example, in 2001, 32% of the patients cared for by the Manchester Community Health Center (MCHC) were uninsured compared to 56% in 2006.[12] MCHC, by virtue of its status as a Federally Qualified Health Center, has a mandated mission to provide care to the uninsured. MCHC receives federal grant dollars of approximately $720,000 per year (2008), as well as an enhanced Medicaid reimbursement rate to support this work. However, these dollars, even when supplemented with generous community funds, are not adequate for sustaining such growth.

Manchester Community Health Center – Growth in Number of Patients with No Insurance



Source: Manchester Community Health Center [12]

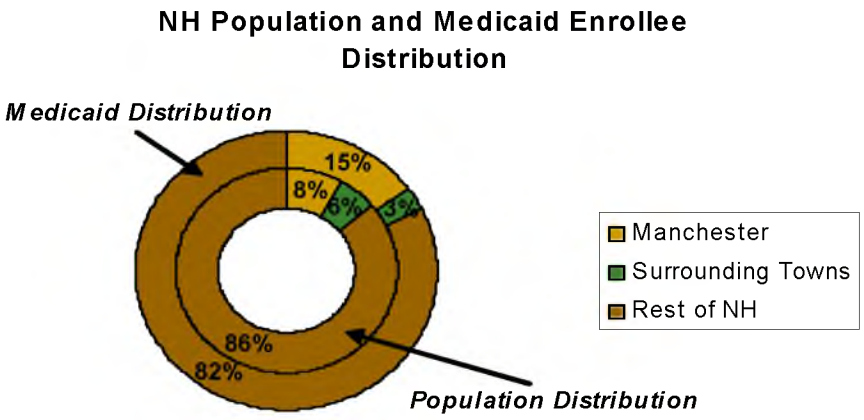
All other provider organizations in Manchester provide care to the uninsured (albeit not at such high proportions of total patient population as the MCHC) and to high numbers of patients who are "self-pay" or charity patients. During the three year period of 2004–2006, the major community primary care providers (Manchester Community Health Center, Dartmouth-Hitchcock, and Child Health Services) cared for 14,326 unduplicated patients who either had no insurance or were "self-pay" or charity care patients.

MEDICAID ENROLLEES

Medicaid is a program that funds defined health care services for low income families and individuals including low income children and adults, children with disabilities, adults with physical or mental disabilities, and the elderly poor. Medicaid is funded jointly by the state and the federal government. However, the rates of reimbursement do not cover the full cost of care by most providers. The Medicaid program in New Hampshire (Dec. 2005) provides essential health services to 103,563 Medicaid Enrollees.[41]

As illustrated in the figure below, while Manchester makes up 8.3% of the state's population, it accounts for about fifteen percent (n=16,405) of New Hampshire's Medicaid Enrollees. Additionally, almost three percent of the state's Medicaid Enrollees (n=3,281) reside in the "Towns Surrounding" Manchester (Auburn, Bedford, Candia, Chester, Deerfield, Goffstown, Hooksett, and New Boston). Thus, a total of 19,686 Medicaid Enrollees reside in the Manchester Health Service Area (HSA).

Medicaid Summary



Source: NHDHHS Medicaid Office [41]

As described in the table below, Manchester's distribution of Medicaid Enrollees by eligibility group is similar to all other New Hampshire towns. However, Manchester does have a higher percent of low income adults (17% vs. 13%) and a slightly lower proportion of low income children (60% vs. 62%).[41]

The towns surrounding Manchester are the most different in types of Medicaid Enrollee residents. Compared to Manchester and all other New Hampshire towns, the towns surrounding Manchester have lower percents of low income children, low income adults, and mentally disabled enrollees. In addition, the towns surrounding Manchester have a slightly higher proportion of severely disabled children and a much higher proportion of elderly Medicaid Enrollees (21% compared to 8% Manchester and 8% all other New Hampshire towns).[41]

	Manchester Health Service Area				All Other NH	
Medicaid Eligibility Group	Manchester		Towns Surrounding Manchester		NH without Manchester Health Service Area	
Low Income Child (<=18)	9248	60%	1596	55%	53188	62%
Low Income Adult (>18)	2578	17%	228	8%	10945	13%
Severely Disabled Child	85	1%	79	3%	1016	1%
Disabled Physical	1049	7%	205	7%	5996	7%
Disabled Mental	1311	8%	172	6%	6870	8%
Elderly	1257	8%	613	21%	7125	8%
Total	15528	100%	2893	100%	85140	100%

Source: NHDHHS Medicaid Office (data year 2006) [41]

A Large Proportion of Medicaid Dollars are Spent in Manchester

Manchester accounts for 18% of the state's net Medicaid payments, 15% of the state's Medicaid inpatient hospital payments, and 14% of the state's allowed emergency department ambulatory care payment.[41]

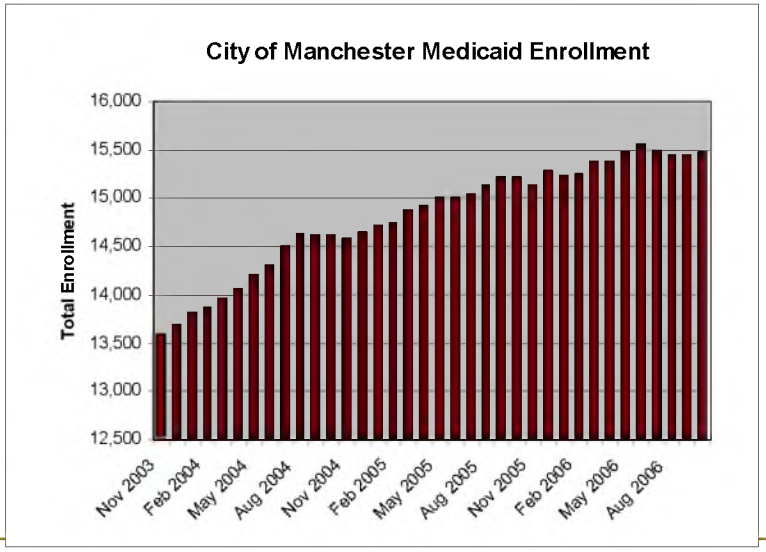
	Proportion of NH's Population Residing in Manchester	Proportion of NH's Population Residing in Manchester Health Service Area
Population	8%	14%
Medicaid Enrollees	15%	18%
Net Medicaid Payments	18%	21%
Net Medicaid Inpatient Hospital Payments	15%	18%
Allowed ED Ambulatory Care Payments	14%	15%

Source: NHDHHS Medicaid Office (data year 2006) [41]

The Numbers of Medicaid Enrollees are Growing

In Manchester, the number of Medicaid Enrollees has increased by nearly 14% from November, 2003 to August, 2006 in contrast to an increase of 8.5% throughout the rest of New Hampshire.[41]

More Residents are Uninsured or Enrolling in Public Assistance



Source: NHDHHS [41]

Medicaid data were provided by the New Hampshire Department of Health and Human Services Medicaid Office and provide a snapshot of the population for December 2005

THE HOMELESS

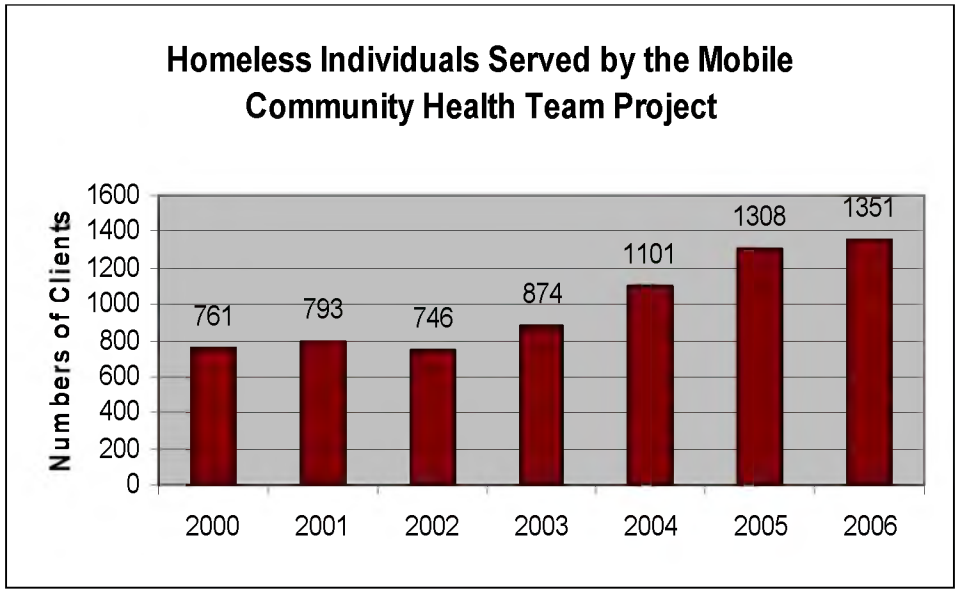
"People experiencing homelessness are three to four times more likely to die prematurely than their housed counterparts."

- National Health Care for the Homeless Council, 2005 [52]

Under federal law, a person is considered homeless if he/she "lacks a fixed, regular, and adequate nighttime residence and has a primary nighttime residency that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings". The term "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law.[7]

City leadership is particularly worried about being able to provide adequate health care services to the homeless populations of Manchester because their numbers have continued to rise over the past five years. The City first received federal funding to support health care services for its homeless population in 1987. This funding is utilized to provide primary medical care, substance abuse services, and case management for homeless individuals. Today, all services are provided by Catholic Medical Center's Community Health Services Mobile Community Health Team (MCHT), that functions under contract to the Manchester Health Department.

The number of persons receiving health care services through MCHT was 761 persons in 2000 compared to 1,351 persons in 2006. In 2005, eighteen percent of the clients of this project were between the ages of 0 and 19 years (n=233).[9]



Source: Manchester Mobile Community Health Team Project [9]

Nearly 75% of these youth had access to health insurance through CHIP Medicaid or through private insurance. In contrast, of the 1,077 clients cared for between the ages of twenty years or older, only 26% had access to health insurance through Medicaid or Medicare or through private insurance. Overall, sixty-five percent of the clients seen through the MCHT program during 2005 had no health insurance.[9]

Homeless Manchester Youth Age 24 and Younger by Age and Gender Cohort Served by the MCHT Project in 2005

Developmental Age Cohort	Age	Manchester		
		M	F	Total
Infants and Toddlers	0-3	11	15	26
Preschool	4-5	2	3	5
School-age	6-11	12	12	24
Early Adolescents	12-14	50	7	57
Older Adolescents	15-18	82	14	96
Early Adult	19	12	13	25
Total Homeless Children	**0-19**	**169**	**64**	**233**
Young Adult	20-24	84	83	167
Total Homeless Population Age 24 And Younger Served	**All**	**253**	**147**	**400**

Source: Mobile Community Health Team Project [9]

MCHT provides a wide range of primary care services to the City's homeless and underinsured populations. Full health care services are provided at New Horizons homeless shelter five days per week and at Families in Transition sites two days per week. Each of these sites has one fully equipped exam room, one room for private intake and interviewing, one room for patient counseling, and an ample waiting area. Both sites provide classrooms where health education, parenting classes, wellness programs, behavioral education groups, and recovery counseling sessions are provided to their clients.

In addition, MCHT provides nursing outreach services at the YWCA Battered Women's Shelter, the City's Emergency Housing Family Shelter, The Way Home Transitional Housing, and the Child and Family Services Homeless Runaway Teen Resource Center. MCHT nurses screen all patients during intake to determine their eligibility for local and state social service and entitlement programs and assist them in applying and enrolling for available services. MCHT also works closely with substance abuse treatment programs, "detox" shelters, halfway houses, and the facility for the dual diagnosed at The Mental Health Center of Greater Manchester.

NEW AMERICANS

Over the past 28 years, more than 5,000 refugees from all over the world have been resettled throughout the Manchester community. Historically, refugees of similar ethnicity, for example, at one time the Vietnamese and later the Bosnians, were resettled in large groups in one area over a decade or so. This ethnic concentration gave both the ethnic communities themselves and the service providers the ability to address common language and cross-cultural needs fairly efficiently. However, the current federal trend to resettle refugees from multiple and diverse countries simultaneously makes resettlement more challenging than it has been in the past. Currently, between the immigrant and refugee populations, over seventy languages are now spoken in the City.[7]

Resettlement efforts are also more challenging because the recent refugee populations, such as the Liberian and Somali Bantu populations, are from developing nations with vastly different cultural values. Additionally, these refugees have experienced extreme, prolonged periods of deprivation in which basic education, health care, and adequate nutrition were nonexistent.

Thus, even though the absolute numbers of refugees resettled in New Hampshire appears small, the ensuing cultural, linguistic, and health needs that these groups bring to the state and to their new communities are initially challenging to the mainstream service provider community.

As illustrated in the table below, 1,882 refugees have been resettled in New Hampshire over the past six years (2002–2007). Of great importance to the primary care, social service, and education systems of Manchester is that 67% of these refugees were resettled in Manchester. In addition, because Manchester is a hub for primary refugee resettlement it is also a hub for secondary resettlement (when a refugee moves from his primary resettlement city to another location).

Refugee Resettlement by Municipality: Federal Fiscal Year 2002–2007							
	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	TOTAL
Manchester	182	195	471	165	146	99	1,258
Concord	11	38	75	126	54	94	398
Laconia	33	5	8	15	55	13	129
Franklin	13	6	0	2	0	0	21
Nashua	0	0	0	2	5	51	58
Haverhill	5	0	0	0	0	0	5
Milford	4	0	0	0	0	0	4
Hooksett	3	0	0	0	0	0	3
Warner	0	0	0	2	0	0	2
Hanover	2	0	0	0	0	0	2
Peterborough	0	0	1	0	0	0	1
Boscawen	0	0	1	0	0	0	1
TOTAL	251	244	556	312	260	257	1,882

Source: NH Office of Refugee Resettlement [53]

Note: NH Resettlement started in Manchester in 1980.

RESIDENTS OF PUBLIC HOUSING

Similar to other special populations, residents of public housing tend to be in poor health relative to other populations, yet often do not have access to needed preventive and primary care.

Although individuals and families living in public housing suffer from many medical conditions common to low-income populations (i.e., hypertension, asthma, diabetes, ear infections, and mental illness), they also have special health care needs.[54] The USDHHS Health Resources and Services Administration (HRSA) uses the length of waiting time for public housing and Section 8 certificates as criteria for measuring barriers to care when evaluating new access point proposals designed to increase access to primary health care services.

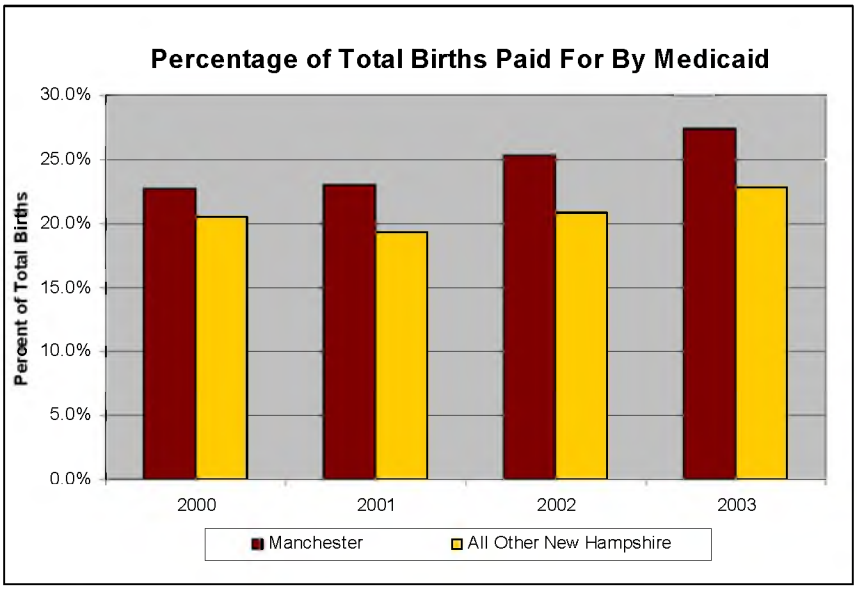
In the City, the Manchester Housing and Redevelopment Authority (MHRA) is the largest public housing agency—and largest landlord—in Northern New England. The MHRA owns and manages 1,271 public housing apartments throughout the community for low income families, elderly, and adults with disabilities. In addition, the agency provides housing subsidies for over 1,800 households through the administration of the Section 8 Housing Choice Voucher Program, which offers rental assistance and home ownership options to extremely low, very low, and low income households. This program also provides assistance to senior citizens and disabled persons on fixed incomes, displaced families, and homeless individuals with disabilities.[55]

Currently, the wait time for Section 8 Housing certificates in Manchester extends beyond four years. For public housing, wait times start at one and a half to two years for a one bedroom unit and two to

two and a half years for a two bedroom unit. Any household larger than that has been deemed an "indefinite" time of entry. In total, the MHRA reports that there are over 15,000 unduplicated names on their wait lists for either public housing or housing subsidy.[55]

EXPECTANT MOTHERS

The health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the U.S. population and as a predictor of the health of the next generation.[56] Maternal and child health (MCH) is "the professional and academic field that focuses on the determinants, mechanisms and systems that promote and maintain the health, safety, well-being and appropriate development of children and their families in communities and societies in order to enhance the future health and welfare of society and subsequent generations."[57] While improving the health of women, infants, and children has been touted by the Centers for Disease Control and Prevention as one of the top ten greatest public health achievements in the 20th century, disparities in access to adequate prenatal care still remain.



Source: NHDHHS [19]

Demographic and socioeconomic factors are associated with a woman's health and health behaviors during pregnancy and often translate to poor birth outcomes. Among the important maternal demographic and socioeconomic factors are age, income, marital status, and education.[58] In Manchester, expectant mothers proportionately use Medicaid more to pay for their deliveries than do other mothers throughout the rest of New Hampshire. Statistically significant differences also exist among unmarried mothers, mothers with less than a high school education, and low birth weight births. In addition, infant mortality is an important measure of a community's health and a worldwide indicator of health status and social well-being.[56] Between 2001 and 2003, nearly 40 infants died before their first birthday in Manchester, for an overall rate of 5.2 deaths per 1,000 live births.[19]

Maternal and Infant Health Indicators, 2001–2003

	Manchester	Manchester Health Service Area	All Other NH Without Manchester
Socioeconomic Variables			
Mother Unmarried at Time of Birth	35.1% *	27.1%	23.2%
Mother's Education <12 Years	17.5% *	12.7%	8.6%
Birth Paid for By Medicaid	25.3% *	19.1%	21.1%
Risk Behavior and Health Care Utilization			
Tobacco Use During Pregnancy	15.6%	12.0%	14.8%
Early and Adequate Prenatal Care	70.7% *	72.8%	67.6%
Late or No Prenatal Care	2.3%	1.8%	3.1%
Infant Health Outcomes			
Infant Mortality Rate Per 1000 Live Births	6.0	5.1	5.0
Low Birth Weight	7.3% *	6.8%	6.3%

Source: New Hampshire Department of Health and Human Services [19]
*denotes statistically significant differences between Manchester and all other NH residents

INFANTS AND CHILDREN

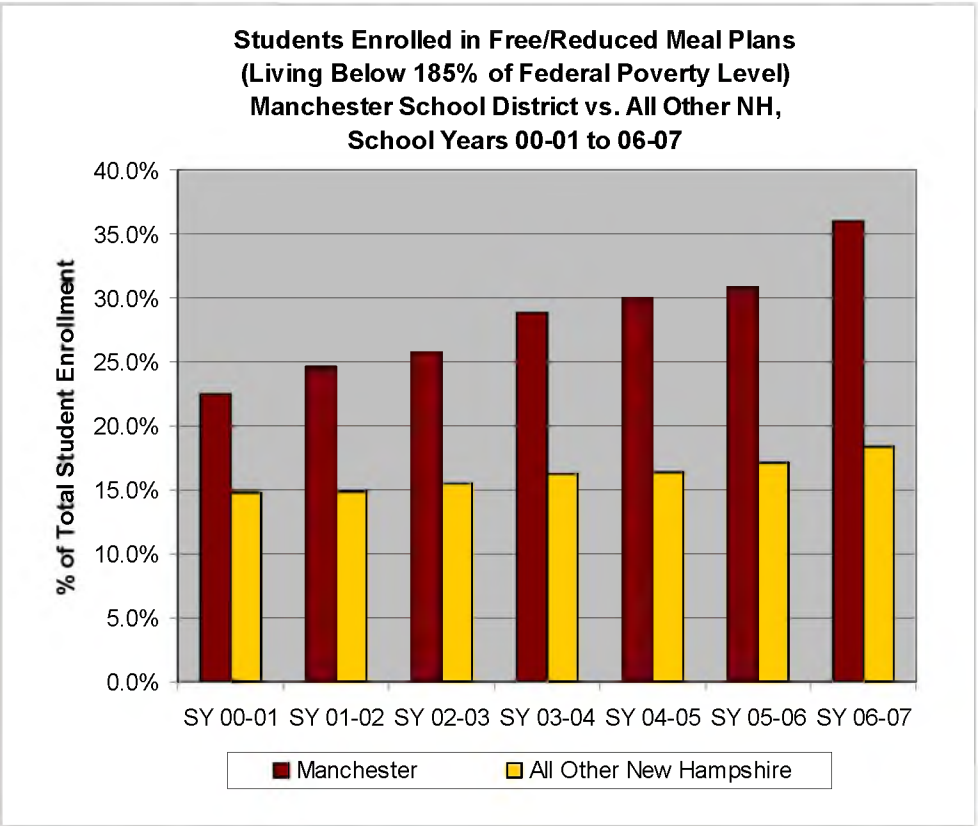
Manchester has reason to worry about the health of its children. Relative prosperity and education levels are both highly correlated with health. Over the past several years, Manchester has witnessed both an increase in poverty levels among its children and variations to access to care by neighborhoods. These socio-demographic indicators suggest that Manchester's children are now at risk for poorer health outcomes and that this may have implications for their health later in adulthood.

Manchester School District Early Onset of Barriers to Care

	Low-Income Public School Population	All Other Public School Population	Total Public School Population
First Graders With No Health Insurance, SY 02–03	16.6%	6.2%	12.3%
First Graders With No Primary Care Provider, SY 02–03	13.4%	4.2%	9.6%
Two Year Olds Who Are Under immunized, SY 06–07	20.0%	9.0%	16.0%
Second and Third Graders With Untreated Dental Decay, SY 03–04	34.0%	18.0%	29.0%
First Graders Who Are Obese Based on 95% BMI, SY 05–06	17.1%	10.5%	14.4%

Source: City of Manchester Public Health Department [7]

The measure of "free/reduced meals" received by children in school is highly correlated with poverty and with barriers to access to medical care.[59] The proportion of students on free and reduced meals in Manchester increased from about 23% in 2000 to about 36% in 2006.[6]



Source: NH Department of Education [c]

RESIDENTS WITH CHRONIC ILLNESS AND DISABILITIES

Some of leading causes of disability and death in the United States, such as heart disease, cancer, and diabetes, are chronic in nature and claim the lives of more than 1.7 million Americans every year.

Chronic diseases are illnesses that are prolonged, do not resolve spontaneously, and are rarely cured completely. Some of the leading causes of disability and death in the United States, such as heart disease, cancer, and diabetes, are chronic in nature and claim the lives of more than 1.7 million Americans every year. These diseases are responsible for 7 out of every 10 deaths in the United States and cause major limitations in daily living for more than 25 million people.[60] These diseases are expensive to manage and account for more than 70% of the $1 trillion spent on health care each year throughout the country.[60]

As of 2004, the average 75-year-old had three chronic conditions to manage and used five prescription drugs.[28] Given current trends, one in three of today's first graders will develop diabetes over their lifetimes.[61] This may be the first generation that will be less healthy and have a shorter life expectancy than their parents.[61]

Types of Disabilities Reported by Manchester's Civilian Non-Institutionalized Residents, 2000

	Age 5 to 15 Years	Age 16 to 64 Years	Age 65 and Over	Total
Sensory Disability (sight or hearing)	195	1,579	1,876	3,650
Physical Disability	228	5,361	3,786	9,375
Mental Disability	1,307	3,623	1,238	6,168
Self-care Disability	151	1,384	1,065	2,600
Go-outside-home Disability		4,188	2,890	7,078
Employment Disability		9,003		9,003

Source: U.S. Census [5]

Also important to the future health of the Manchester community is the prevention and treatment of disabilities. In 2006, seven percent of Manchester's children age 5 to 15 years had a disability (defined as a limitation in one or more functional areas).[36] A total of 2,600 residents of all ages reported a self-care disability, that is defined as a physical, mental, or emotional condition causing difficulty in dressing, bathing, or getting around inside the home.[5] Over 7,000 residents of all ages reported having a condition that made it difficult to go outside the home to shop or visit a doctor.[5]

FRAIL ELDERLY

In 2011, the first wave of America's 76 million baby boomers will turn 65. This will trigger dramatic shifts in all aspects of American life.[28] For Manchester, this "community within a community" represented nearly 13% of the total population in 2000.[28] In fact, the City ranks 58th among the nation's 239 cities with 100,000 residents or more for populations 65 years and older.[28]

The most rapidly growing segment of the general population is the group aged 85 and older.[27] By 2040, Americans aged 80 and over are projected to outnumber all American children under the age of five years.[27] Relatedly, the impact of the caregiver role will become increasingly recognized as more and more children are thrust into having to care for their aging parents.[28] For the frail elderly without family ties, this longevity revolution will challenge community resources beyond their current capacity to reach those with much needed supports.

According to a recent presentation made by the City of Manchester Department of Health summarizing 2000 U.S. Census data,[27] approximately 24% of the Manchester city population age 65 years and older currently live below the poverty threshold and 28% live below 200% of the poverty threshold. 17% of women and 9.5% of men who live below the poverty threshold also have at least one disability.[5]

Among the non-institutionalized elderly in Manchester, 5% of those 65 to 74 years old and 11% of those 75 years and older needed assistance with daily activities such as bathing, preparing meals, and doing chores around the house.[5] In addition, 15.8% of the City's non-institutionalized population age 65 to 74 years old and 28.4% of the non-institutionalized residents age 75 years old and older reported difficulty going outside of their homes alone to shop or to visit a doctor's office.[5] Finally, it is estimated that more than half of the non-institutionalized population age 85 years old and older throughout the country is in need of some form of daily assistance.[5]

SECTION SIX

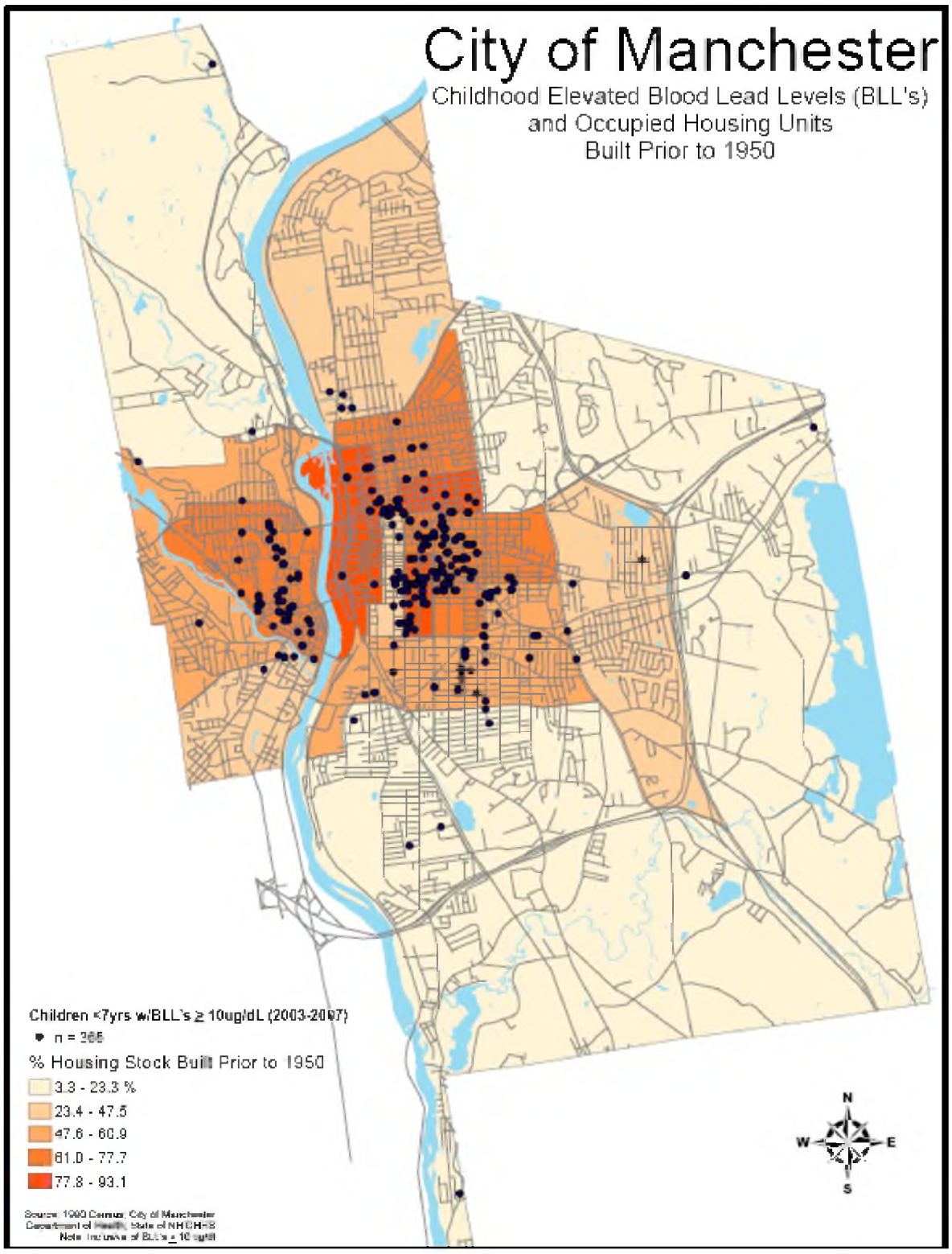
NEIGHBORHOODS OF NEED
– THE CHALLENGES OF PLACE –

WHERE YOU LIVE CAN IMPACT YOUR HEALTH

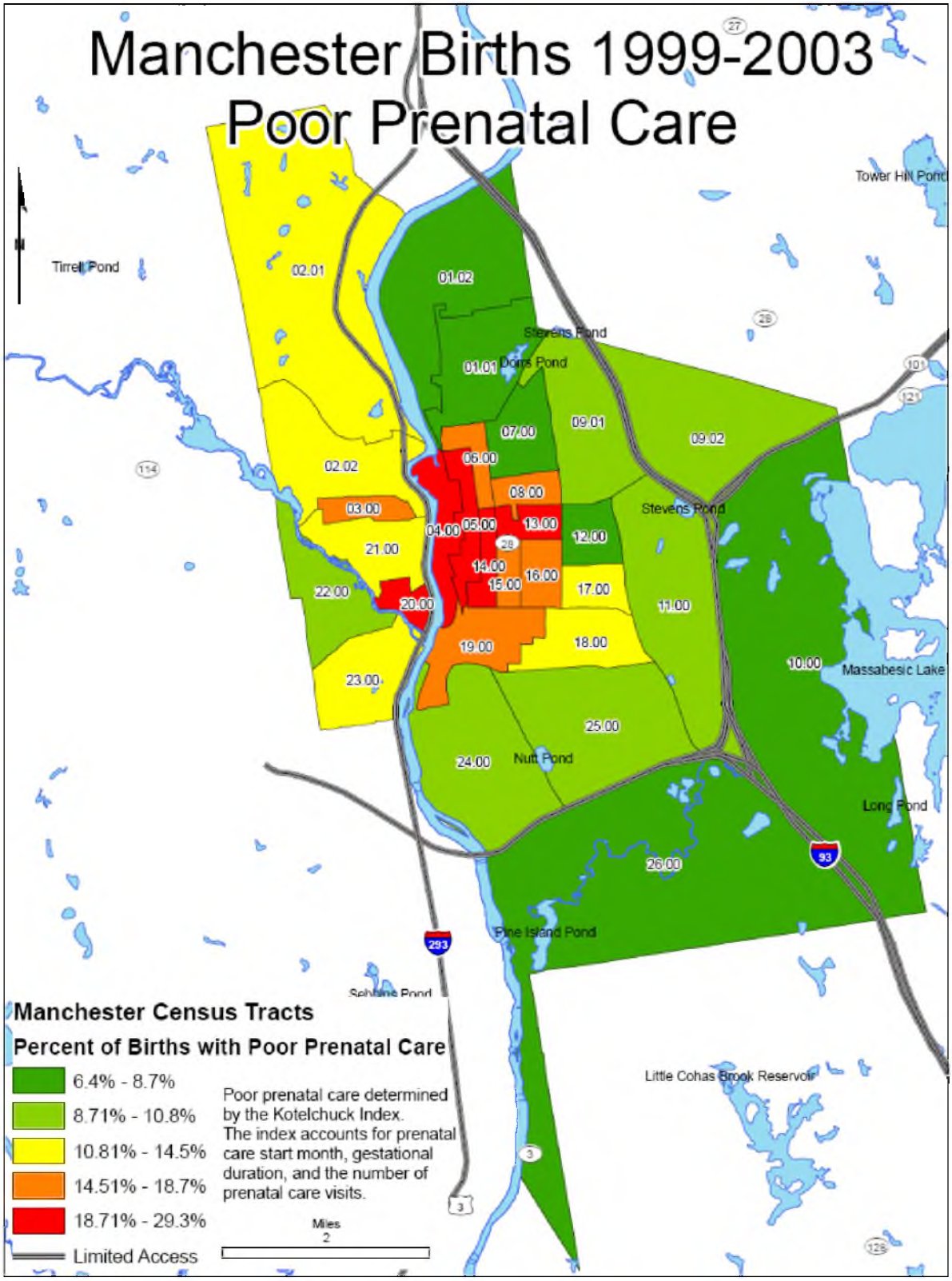
For both individuals and populations, health depends not only on health care, but also on other factors including individual behavior, genetic makeup, exposure to health threats, and social and economic conditions.[27] Manchester's health care delivery system is compounded by patients who are exposed to these complex determinants of health. This leaves little room for the provision of preventive care and causes a more heavily focused acute care system.

Residence in a neighborhood of socioeconomic priority need has been linked to higher rates of mortality, functional decline, poorer health status, and higher incidence and prevalence of chronic conditions such as diabetes, cardiovascular disease, and cancer.[62] People living within neighborhoods of elevated need are likely to experience multiple dimensions of poor environmental and social quality, including higher-priced yet lower-quality foods, high crime rates, poor-quality housing, limited transportation, toxic environments, and lower social cohesion and social support, all of which may contribute to poorer health.[63]

In addition, multilevel studies have been published that link various indices of neighborhood variation and poverty to individual risks of cigarette smoking, higher body mass index, depressive symptoms, lower quality diet, poor self-rated health, as well as intimate partner violence.[62] In almost all urban areas, serious health problems are highly concentrated in a fairly small number of distressed neighborhoods. As an example, the map on the next page, "Childhood Elevated Blood Lead Levels in Occupied Housing Units Built Prior to 1950", illustrates that a high proportion of Manchester's children with elevated lead levels live in neighborhoods predominately of older housing stock. In addition, the map on page 48, "Manchester Births 1999-2003, Poor Prenatal Care", illustrates that expectant mothers with inadequate prenatal care are more likely to live in some of the poorest neighborhoods of the City. Thus, understanding where population needs are greatest, and justifying these epidemiological nuances geographically, are essential elements of health planning that must be considered for improving future access to health care.



Source: City of Manchester Department of Health



Source: NHDHHS [64]

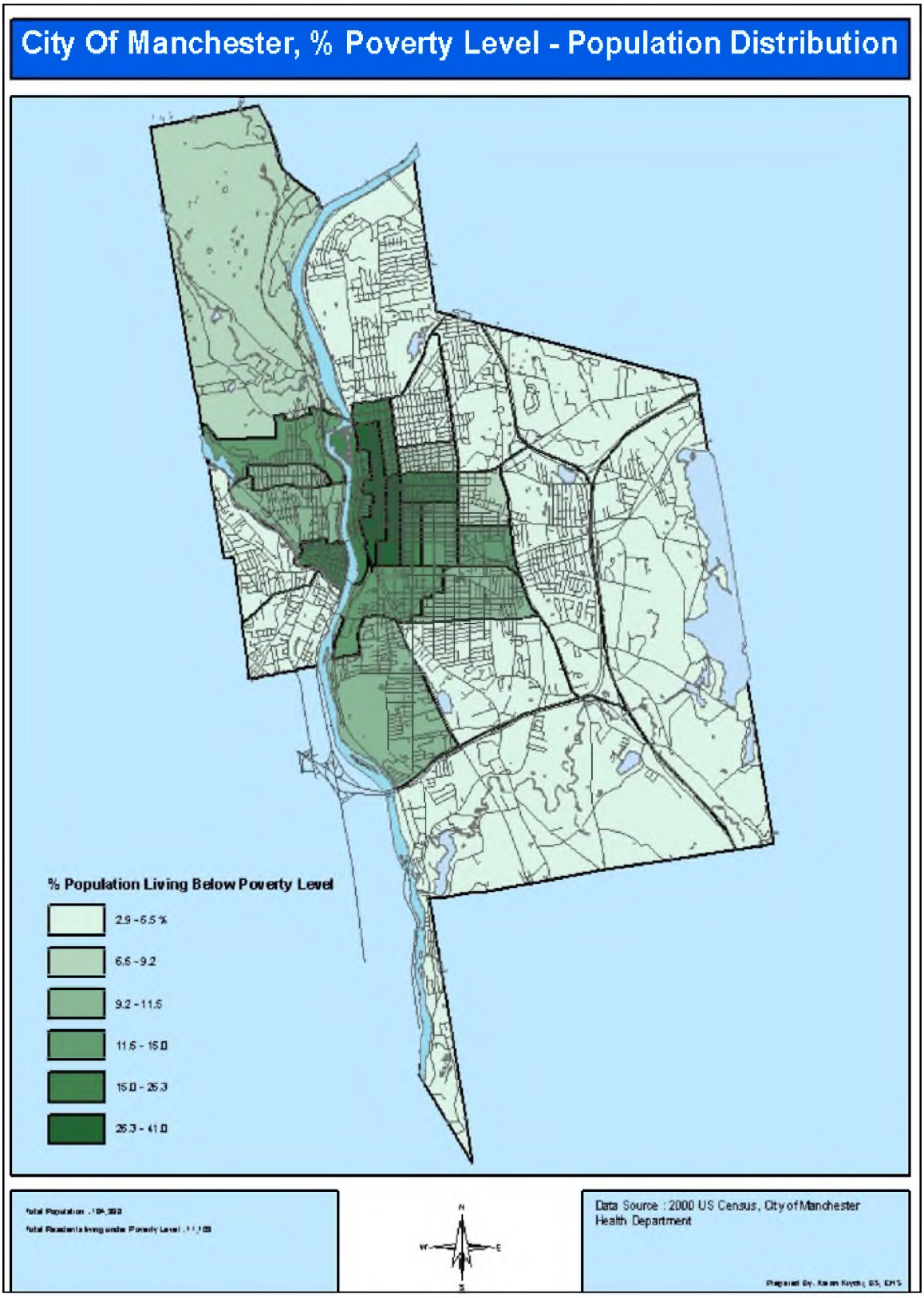
In Manchester, neighborhoods of need exist on the east side and the west side of the City. Over half of the residents living in at least three of the City's 29 census tracts (Census Tract 20 on the west side and Census Tracts 5 and 14 on the east side) are living below 200% of the poverty threshold. Additionally, as illustrated by the table below, on all indicators of socioeconomic status, residents of both the west and east side of the City do not fare as well as other New Hampshire residents.

Top Three Neighborhoods of Socioeconomic Priority in the City of Manchester

	West Side	East Side			
	Census Tract 20	MUA Census Tract 5	Census Tract 14	City of Manchester	New Hampshire
Total Population, 2000	2434	1847	2456	107,006	1,235,786
Percentage of Population Living Below Poverty, 2000	23.2%	32.0%	40.9%	10.6%	6.5%
Percentage of Population Living Below 200 Percent of the Poverty Threshold, 2000	51.3%	53.7%	65.4%	25.9%	19.0%
Unemployment Rate of Civilian Labor Force, 2000	7.3%	6.0%	21.2%	5.8%	3.8%
Percentage of Persons Aged 25 and Older With Less Than a High School Education, 2000	32.9%	36.9%	41.1%	19.3%	12.6%
Percentage of Households With Income Less Than $30,000, 2000	54.5%	64.9%	68.2%	35.0%	27.3%
Percentage of Households With Public Assistance Income, 2000	15.7%	10.1%	22.0%	5.4%	3.0%
Percentage of Households With Rent Costs Exceeding 50% of Income, 2000	17.1%	15.1%	21.6%	14.9%	15.0%
Percentage of Households Without Telephone Service, 2000	1.0%	13.7%	3.6%	1.5%%	1.1%
Percentage of Households Without Access to a Car, Truck, or Van for Private Use, 2000	23.7%	41.8%	44.8%	11.0%	5.8%
Percentage of Families With Female-Headed Household With Dependent Children, 2000	22.3%	18.1%	29.8%	11.5%	8.4%
Median Value of Owner Occupied Unit, 2000	$90,700	$112,500	$68,000	$114,300	$133,300

Source: U.S. Census, MODE-PTD Neighborhood Deprivation Index [63]

Poverty Concentration by Census Tract Neighborhood, 2000



Source: City of Manchester Health Department, 2000 U.S. Census [5]

THE EAST SIDE STORY

As of 1994, Census Tract 5 has been designated as a Medically Underserved Area (MUA), which is a federal designation of a geographic area that meets the criteria (travel time, availability of resources, and presence of unusually high need such as elevated infant mortality and poverty) of needing additional primary care services. This MUA designation is a requirement for the existence of the Federally Qualified Health Center (FQHC); the Manchester Community Health Center, which is eligible for enhanced state and federal grant dollars in support of primary care services to the local area. Over 70% of Manchester's residents and selected health events, are distributed on the east side of the City as illustrated below.

Selected Demographic and Health Indicators

	Total East Side	Total West Side	Total Manchester	% East Side	% West Side
Total Population, All Ages, 2000	80,966	26,040	107,006	75.7%	24.3%
Total Population Age 65 Years and Older, 2000	10,412	3,513	13,925	74.8%	25.2%
Total Population Living Below 200% Poverty Threshold, 2000	20,040	6,964	27,004	74.2%	25.8%
Total Medicaid Enrollees All Ages, 2006	11,389	4,172	15,561	73.2%	26.8%
Total Births to Mothers with Less than a High School Education, 2000–2004	1,391	423	1,814	76.7%	23.3%
Total Births to Mothers Who Used Tobacco During Pregnancy, 2000–2004	791	324	1,115	70.9%	29.1%
Total Low Birth Weight Births, 2000–2004	379	128	507	74.8%	25.2%
Total Ambulatory Care Sensitive Inpatient Discharges, 2000–2004	6,426	2,443	8,869	72.5%	27.5%
Total Inpatient Discharges for Asthma, 2000–2004	580	199	779	74.5%	25.5%
Total Emergency Department Discharges for Dental Conditions, 2000–2004	7,922	2,913	10,835	73.1%	26.9%
Total Emergency Department Discharges for Drug Abuse, 2000–2004	4,020	1,002	5,022	80.0%	20.0%
Total New Cases of Breast Cancer, 2000–2003	210	70	280	75.0%	25.0%
Total New Cases of Colorectal Cancer, 2000–2003	145	54	199	72.9%	27.1%
Total New Cases of Prostate Cancer, 2000–2003	252	101	353	71.4%	28.6%
Total Deaths Before the Age of 65 Years, 2000–2004	854	246	1100	77.6%	22.4%
Total Deaths Due to Heart Disease, 2000–2004	1,183	397	1,580	74.9%	25.1%

Source: NHDHHS [19]

The West Side Story – New Area of Concern

There is a growing concern that an increasing number of west side residents have no access to appropriate primary care. Since the west side of the City is potentially eligible for MUA designation, it is being studied as a reasonable site for locating an additional community-based FQHC.

Additionally, the absolute numbers of persons living in poverty is expected to continue to grow on the west side of the City as the population of the area grows. By 2010, it is projected that 30,000 persons will be living on the west side. Assuming no increase in the rate of poverty, this will equate to a population of close to 8,100 area residents who will be living below 200% of poverty and in need of more comprehensive, intense, and proactive primary care services.

One out of Every Six Persons Living on the West Side is a Medicaid Enrollee

As of July 2006, there were 15,561 Medicaid Enrollees residing in Manchester (excluding the qualified Medicare Beneficiaries). Of these, 4,172 lived on the west side of the City, 11,144 on the east side and 245 held Manchester P.O. Box addresses (located within two separate locations on the east side of the City).[41] Thus, the west side of Manchester is home to nearly 27% of the City's total Medicaid population.

Based on the 2000 Census population data for Manchester (city population of 107,006),[5] it is estimated that 24.3% of Manchester city residents live on the west side (n=26,040). Thus, the 4,172 Medicaid Enrollees who reside on the west side account for about 16% of the local area population (i.e., one out of every six persons living on the west side of the City is a Medicaid Enrollee).

Twenty-seven percent of west side residents live below 200% of poverty. In at least one census tract, this is as high as 51% and the third highest out of the twenty-eight census tracts of Manchester.[5] In addition, poverty at its worst has increased overtime on this side of the river (8.1% of the local population living below 100% of Federal Poverty Level in 1990[42] compared to 10.6% in 2000).[5]

Primary Care is Often "Inappropriately Sought" and Provided in Local Hospital Emergency Departments

The delivery of primary care through local hospital emergency departments is uncoordinated, ineffective, and expensive. Catholic Medical Center (CMC), which is located on the west side of Manchester, has recently extensively reviewed their utilization data. From this review, it has become clear that patients are often using the CMC emergency department inappropriately, and also that much of the uncompensated care provided by CMC is initiated at the emergency department. Most surprisingly to CMC, much of the emergency department care generated at their hospital is from local neighborhood residents. The following describes CMC findings:

- 73.6% of CMC's uncompensated care is generated by patients who live in their own primary and secondary service areas. More than half are Manchester residents.
- 66% of the overall uncompensated care for CMC is initiated in the Emergency Department (ED).
- 73.8% of Manchester city patients who generate uncompensated care reside in the local area of CMC, in the west side and south end city zip codes.

- 53% of the uncompensated care provided by CMC in Manchester is to patients who are below the age of 40:

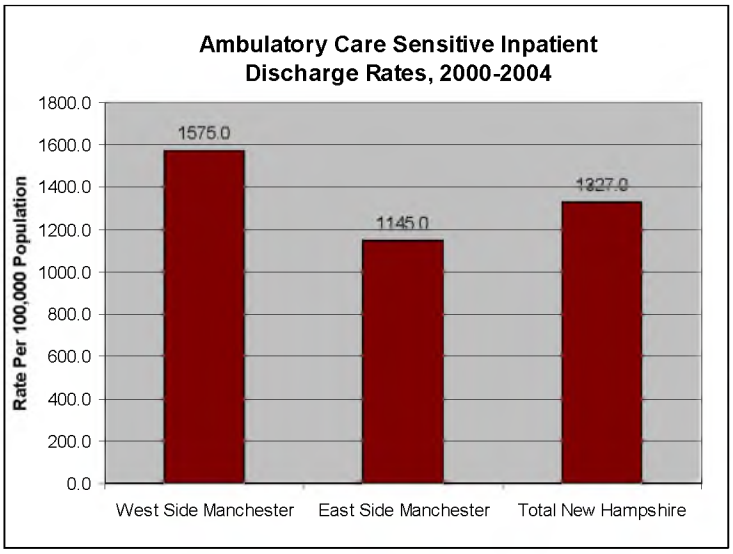
0–20 years	7%
21–29 years	26%
30–39 years	20%
40–49 years	19%
50–59 years	20%
60+ years	8%

- In 2005, 14% of ED visits that might have been avoided by access to primary care were for patients insured by Medicare, patients insured by Medicaid (18.5%), and patients who were uninsured (27.9%). These trends have increased over the past few years.

CMC is committed to providing area residents the care that is most appropriate, efficient, and of highest quality. Based on their own internal review of patient utilization, they have determined that the residents of the local community, particularly those who are uninsured or underinsured, would receive better health care and have better health outcomes if they had access to primary care in their own local area. This decision is in tune with a recent report from the National Association of Community Health Centers that reported that "uninsured people living within close proximity to a health center are less likely to have an unmet medical need, less likely to visit the emergency department or have a hospital stay, and more likely to have had a general medical visit compared to other uninsured."[65]

The New Hampshire Department of Health and Human Services Bureau of Health Statistics data confirms that there is a need for enhanced medical, behavioral, and oral health services throughout the City and that the need is significant for the west side population based on their calculations of ambulatory care sensitive (ACS) discharges for the resident population.

Ambulatory sensitive conditions (ACS) discharges are defined as medical conditions that are less likely to require inpatient hospitalization if timely and appropriate primary care is received. An indication of the need for enhancements to the primary care system are the significantly higher rates of ACS for the west side population compared to the east side and state populations [1,575 ACS discharges per 100,000 population west side, vs. 1,145 per 100,000 east side, vs. 1,327 per 100,000 state population (2000–2004)].[19] Estimated charges for the west side ACS discharges alone were $5,771,500 during 2004.



Source: NHDHHS [19]
Note: West and East Side rates are based on population estimate and should be interpreted with caution.

In addition, the rate of emergency department discharges for drug abuse for the west side population have been higher than the state rate for every year from 2000–2004. In 2004, the west side rates were significantly higher compared to the state (777.0 per 100,000 population west side, vs. 545.3 per 100,000 population state).[19]

Similarly, the rates of emergency department discharges for dental conditions for the west side population were significantly higher in 2001 through 2004 compared to the east side rates and the state rates.[19]

Emergency Department Discharge Rates Per 100,000 Population for Dental Conditions

Year	West Side Manchester	East Side Manchester	Total New Hampshire
2001	1,404.3	1,160.8	1,023.3
2002	1,746.1	1,395.1	1,212.1
2003	2,301.1	1,733.8	1,386.9
2004	2,207.3	1,739.9	1,436.8

Source: NHDHHS [19]

Note: West side and east side rates are based on population estimate and should be interpreted with caution.

SECTION SEVEN

A CALL TO ACTION . . .

– SHARING THE RESPONSIBILITY OF DECREASING – ECONOMIC BARRIERS TO PRIMARY CARE ACCESS

The Community Steps up to the Plate

The price that Manchester will pay for ignoring the economic barriers to primary care access of today will be devastating to the community provider systems and to community health in the future. A recent report issued by Families USA[66] suggests that even more New Hampshire families will join the ranks of the uninsured and underinsured unless there is meaningful action taken at national and local levels to make health care affordable and accessible to all. While Manchester leadership cannot readily change national policy, it can influence the future, improved development of the City's primary care delivery system, especially one focused on improving the system for the City's most vulnerable. This is exactly the intent of the Manchester Sustainable Access Project (MSAP), a project supported by the Healthy Manchester Leadership Council (HMLC).

The HMLC is the community collaborative that guides and monitors the community health improvement process (CHIP)[27] for the Greater Manchester area. HMLC has been active in the City since 1995 and has successfully employed interventions that have reduced adolescent pregnancy, improved oral health outcomes, and increased access to substance abuse treatment services for adolescents. The four strategic imperatives being considered by HMLC currently are: (a) healthy neighborhoods, (b) maternal and child health improvement, (c) chronic disease prevention, (d) healthy youth, (e) healthy aging, (f) public health preparedness, and (g) access to primary care including medical, oral, and behavioral health services. MSAP is the vehicle by which HMLC will meet its goals and objectives for its strategic objective focused on enhancing access to primary care services.

"Primary care, as the entry point for the health care system, is the foundation of an integrated network. Comprehensive primary care networks play an important role in coordinating care for people with both acute and chronic health conditions, and offer mental and oral health services. Through such networks best practices in health promotion and prevention, including services such as health education, nutrition counseling, and wellness checks for community members are provided. In essence, community networks can provide the tools needed to help everyone in the community be good stewards of their health and their health care."[27]

The Manchester Sustainable Access Project (MSAP)

The aim of MSAP is to develop an integrated health care network in Manchester that will increase access to proactive, comprehensive, coordinated, and evidence-based primary care (including mental and oral health services). Although this network will first target the City's most vulnerable populations (i.e., uninsured, underinsured, Medicaid Enrollees, refugees, immigrants, and homeless), it is meant in the long-term to serve all city residents in their own local neighborhoods. It is the hope of the HMLC that the community providers and leaders will actively support this initiative and participate in its realization.

There is a Need for Providers to Work Together in a "Network"

The following description of why the community needs such a network and what it might look like has been adapted from recommendations summarized in the report "Health Care That Works for All Americans".[67] This report was developed by the Citizens' Health Care Working Group and is based on input from community forums that were held across the United States.

"Currently, local providers negotiate a host of diverse funding programs targeted at different subpopulations from a variety of state and local government agencies as well as national, regional, and local philanthropic organizations, foundations and other private organizations. Community systems also receive reimbursement for services from public and private insurers and direct payments from patients. The result is a mixture of revenue streams, with each source beginning or ending at different times. From this ever-changing pool of funding, local systems must design a set of short-term programs that provide

services some of the time to some of the people. Inconsistencies in services provided and populations served contribute to confusion, frustration and missed opportunities." [67]

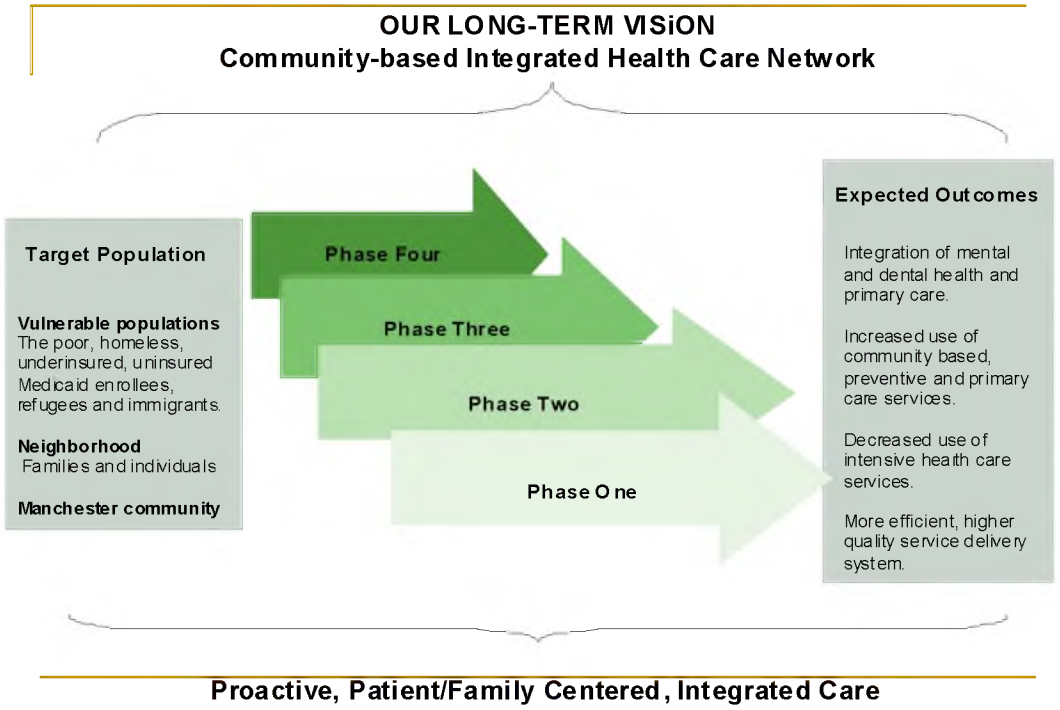
In order to meet their full potential to serve those most in need, these systems and individual providers must be freed up to devote more of their energies and talents to the provision and management of care. It is the hope of Manchester's leading health care organizations that joining together in a network—an innovative, integrated community network for primary care—will provide them the opportunity to enhance the care system of the community, while creating economic efficiencies of care delivery.

STRENGTHENING THE PRIMARY CARE SAFETY NET

MSAP is actively pursuing a major health system enhancement initiative that will provide the framework for development of Manchester's Integrated Health Care Network. During the past three years (2006–2008), MSAP has generated nearly one million dollars of seed money from foundations and community health care organizations to fund this work. Key initiatives of MSAP are the development of a health system strategic planning board and the expansion and integration of primary care - including medical, dental, and behavioral health services.

These two major initiatives of MSAP are being implemented through four work phases, each having its own distinct goals and objectives: (a) develop a health system strategic planning board, (b) expand access to, and integration of, primary care services, (c) improve and stabilize care coordination, and (d) use data to drive community health system improvement.

While each phase of the MSAP initiative could be interpreted as a separate project, the goal of MSAP is that these efforts be integrated and coordinated through the leadership of the Strategic Planning Board. Through this mechanism, the City will be able to maximize and enhance the availability of federal, state, and local health care resources and lay the groundwork for the development of a coordinated and financially sustainable service delivery system for the City's most vulnerable residents. Each of these work phases is described below.



PHASE ONE: DEVELOP A HEALTH SYSTEM STRATEGIC PLANNING BOARD

It is imperative that the community join together to develop a long-term strategy for improving and maintaining the health of its local population, including its most vulnerable residents. The current incentives for community planning for safety-net services perpetuate competition and decrease the possibility of full collaboration across local providers. Thus, MSAP sees it as a priority to develop a formal planning infrastructure that can negotiate conceptually different incentives and stronger partnerships based on mutual trust and mutual gain across all provider organizations in the City.

To this end, MSAP has developed a formal community strategic planning entity – The Manchester Health System Strategic Planning Board (the Board). Membership to the Board includes key decision makers/leaders of the City's major health care provider organizations, as well as the Manchester Health Department, Easter Seals, and city government. Commitments to the mission, vision, and guiding principles of the Board as described below were formalized through the signing of a "Declaration of Commitment" on June 02, 2008 (please see page 69 for a copy of the signed Declaration of Commitment).

MSAP STRATEGIC PLANNING BOARD MISSION

The mission of the Manchester Sustainable Access Project is to strategically plan and recommend a system to measurably improve the health of uninsured and underinsured residents of the Greater Manchester area.

MSAP STRATEGIC PLANNING BOARD VISION

By 2013, we will develop (for and with the community, including the City's vulnerable populations) a community-based, coordinated, cost-effective, and high quality primary care delivery system that integrates medical, behavioral, and oral health services.

MSAP STRATEGIC PLANNING BOARD GUIDING PRINCIPLES

1. MSAP believes the Greater Manchester area health care providers have a desire to provide the City's vulnerable populations an appropriate medical and dental home.
2. MSAP believes its Strategic Planning Board should be a community resource for proactive, collaborative planning of a primary care delivery system that improves access and enhances the health and well-being of un/underinsured residents of the Greater Manchester area.
3. MSAP believes that organizations involved in prevention and primary care delivery to the un/underinsured should be invited to join the MSAP Strategic Planning Board (SPB).
4. MSAP believes all its initiatives should be designed to be sustainable, effective, and efficient.
5. MSAP believes in involving the community, including the City's vulnerable populations, in setting short-term and long-term goals, developing the strategic plan, and monitoring its effectiveness over time.
6. MSAP believes all strategic planning decisions should be based on reliable, agreed upon data and information, and on evidence-based practices.
7. MSAP believes it should seek opportunities to lead health system reform efforts in the region and state as appropriate.

PHASE TWO: EXPAND ACCESS TO, AND INTEGRATION OF, PRIMARY CARE SERVICES

Phase two of MSAP calls for the immediate expansion, and whenever possible, integration of primary care services within the City. Under this phase of the work, MSAP will support the planned move and expansion of the Manchester Community Health Center (MCHC), the development of at least one additional community-based primary care site, the expansion of oral health services (first for children), and the development and implementation of care delivery models in which medical, oral, and behavioral health services are integrated in a seamless system of care delivery.

The FQHC community health center model may provide added economic stability to Manchester's primary care system.

MCHC is a Federally Qualified Health Center (FQHC) that receives federal grant dollars and enhanced Medicaid reimbursements to support its mission to address the complex primary care needs of the vulnerable populations of the City.

An FQHC is a federal designation assigned by the U.S. Department of Health and Human Services (DHHS) to community health centers in an effort to expand access to quality, comprehensive primary care services. FQHC status provides an array of benefits to health care organizations that operate in underserved, high need areas and/or serve underserved high need populations. Organizations having FQHC status receive federal grants, enhanced reimbursement from Medicare and Medicaid, as well as benefits in regard to malpractice insurance and drug pricing.

FQHCs provide health services to underserved populations, including those who have difficulty paying for services, experience language, or cultural barriers to access, or disparities in health status. In addition, FQHCs are established in communities where there is limited health professional capacity and resources. Health centers may focus their work on providing services to specific special populations such as homeless people, migratory and seasonal farm workers, residents of public housing, or at-risk school children. However, most FQHCs serve a cross-section of the population in their communities.

MCHC is the FQHC in Manchester designated to provide services to the general population. Currently, however, using absolute numbers of unduplicated patients, MCHC provides care only to a small proportion of the Medicaid and uninsured residents of the City. The following table describes the distribution of care in Manchester for unique patients (we could not control for duplication of patients across providers) among the City's major primary care provider organizations (i.e., MCHC, Dartmouth-Hitchcock Manchester (D-H), and Child Health Services (CHS)). As illustrated, the bulk of the primary care for the uninsured and Medicaid Enrollees is provided by D-H, which provides care to four times as many Medicaid patients and almost three times as many uninsured patients compared to MCHC.

Patients by Payer Mix	Primary Care		
	MCHC	D-H	CHS**
Number of Unique Patients (unduplicated 2004-2006)	7,408	84,413	2,602
PAYER DISTRIBUTION			
Percent Medicaid*	36%	13%	61%
Number of Medicaid Patients	2,648	11,213	1,587
Percent Medicare	5%	5%	0%
Number of Medicare Patients	361	4,104	0
Percent Commercial	14%	70%	3%
Number of Commercial Patients	1,012	59,094	78
Percent Self-Pay and No Insurance	46%	12%	36%
Number of Self-Pay and No Insurance	3,387	10,002	937

Source: Community Providers

** Child Health Services Data includes the Main Program and Teen Health Clinic

In an effort to improve the economic stability of the primary care infrastructure in Manchester, the community is supporting the expansion of MCHC. MCHC must relocate to a new building by June of 2008. However, inherent in this move is a plan by the MCHC to expand its capacity to serve a larger number of Manchester residents. Such an expansion, if coordinated through the federal Community Health Center Program, could be an important opportunity for the MCHC to enhance its capacity of federal grant dollars to support the growth of safety-net services in the community.

Additional expansion of primary care capacity is needed.
Since the MCHC is not able to assume the risk of growing its organization beyond its fiscal limits, and since its proposed expansion for 2008 is not robust enough to meet the future health care needs of the City's growing population, the community has offered to share this risk with the MCHC by opening an additional clinical site on the west side of the City (the West Side Neighborhood Health Center). The expectation for this new health center is that it will become an additional cornerstone organization for enhancing access to federal, Medicaid, city and foundation dollars targeted to the provision of medical, behavioral, and dental primary care services to vulnerable populations. However, should the numbers of uninsured residents continue to rise faster than the Medicaid population, funding stability, even with access to additional federal resources, will become even more challenging.

Through the development of the West Side Neighborhood Health Center, the community plans to immediately consolidate isolated community efforts that have been started in an effort to enhance access to primary care services. Such an approach will enhance administrative efficiencies and direct the design of more streamlined, comprehensive, and coordinated care for local residents. The model of care proposed for this primary care site will integrate behavioral health and dental services with medical care. Integration will be accomplished at the structural, clinical, and financial levels of operation and management.

It is MSAP's hope that the Strategic Planning Board will develop short-term and long-term goals and objectives that lay out a community plan for future additional development and governance of primary care capacity for the City.

PROMOTE THE CONCEPT OF A MEDICAL HOME FOR ALL RESIDENTS

A medical home is a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health promotion and wellness, as well as acute and chronic condition management. A medical home is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effect."[68]

While City residents are able to access emergency care when needed, many City residents report (through local ED data) that they do not have a regular source of care or a "medical home". MSAP believes that assuring all vulnerable residents a primary care medical home that integrates medical, behavioral, and oral health care is the first step toward improving the health and well-being of the City's population.

DEFINING A MEDICAL HOME [69, 70]

A Medical Home Should Provide:

- Provision of care according to a chronic care model;
- Assurance of ambulatory and in-patient care for acute illnesses, 24 hours a day, 7 days a week (during the working day, after hours, on weekends, 52 weeks of the year);
- Provision of care over an extended period of time to enhance continuity;
- Identification of the need for subspecialty consultation and referrals and knowing for whom and where these can be obtained;
- Interaction with school and community agencies;
- Maintenance of a central record and data base containing all pertinent medical information, including hospitalizations;
- The use of evidence-based medicine and clinical decision support tools to guide decision making;
- Organization of the delivery of care according to a chronic care model'
- Measurement of quality indicators to demonstrate continuous improvement through the use of health information technology;
- Utilization of programs that provide feedback and guidance on the performance of practices and their physicians;
- A personal physician; and
- Care that is based upon full integration including the characteristics of quality and safety as well as an "added value" payment framework for the patient.

CREATE A COMMUNITY-BASED ORAL HEALTH SYSTEM

In an effort to address the barriers faced by much of the City's population to accessing comprehensive oral health services, the Manchester community has worked to prevent tooth decay in its entire population and to provide needed prevention services, first to its most needy children. In 2000, the City passed and implemented a referendum to elevate the fluoride levels in the public water supply to provide the population added protection against tooth decay. In addition, through the efforts of the Manchester Public Health Department, the City has established a limited screening and sealant program in its Title 1 schools (schools serving a predominately poor population of children), and the Catholic Medical Center has opened a two chair dental facility that is open to all residents regardless of ability to pay for services.

While these ad hoc programs provide important dental care services to the City residents, they are unable to meet the growing needs of the population. MSAP has become convinced that solutions to the problem of access to oral health services must be developed through a community effort to develop a sustainable city-wide oral health program with a goal to provide all city residents access to a dental home.

DEFINING A DENTAL HOME [71]

A Dental Home Should Provide:

- Comprehensive oral health care including acute and preventive services
- Comprehensive assessment of oral diseases and conditions
- Individualized preventive dental health program based on caries and periodontal disease risk assessment
- Anticipatory guidance about growth and development issues
- Plan for acute dental trauma
- Information about the proper care of teeth and gingivae
- Dietary counseling

Referrals to dental specialists, when necessary and appropriate

This goal will be difficult to reach, particularly since funding (even through insurance) for oral health services is inadequate. However, the MSAP project leadership believes that co-location of oral and medical care capacity, cross-training of providers, and sound business modeling might result in leveraged capacity for oral health services. Thus, as MSAP works to develop primary medical care capacity in the City, it will make it a goal to also integrate oral health services as possible.

INTEGRATE BEHAVIORAL HEALTH SERVICES AND PRIMARY CARE

Through the work of MSAP we will review several models of integrated care, including inpatient and outpatient care, which have been described by Wulsin et al.[72] These researchers make the case that "better linked, coordinated, and integrated care models that redefine the interaction between primary care providers and mental health specialists are needed to improve quality of care and health outcomes." [72]

The key functional infrastructure of the model of integrated care envisioned by MSAP is the co-location of behavioral health services in the primary care setting. Integration of care in this clinical environment will be accomplished through structural, clinical, and financial elements that will be clarified through a joint business model of collaboration.[73]

This model will be framed on six critical components for outcome improvement:[74]

- readily available psychiatric assessment in the primary care setting,
- active screening in the primary care setting to identify high-risk patients who have psychiatric illnesses/disorders,
- ability to apply pharmacotherapeutic, psychotherapeutic, and psychosocial interventions that have been proven effective through well-designed studies,
- coordination and integration of medical and psychiatric care among clinicians,
- case management for patients with chronic or complex illness, as well as
- support of medical care providers and/or terms to (a) identify more effectively, patients who have medical-psychiatric co-morbidity, (b) communicate better with these patients and to provide basic psychosocial care and (c) improve communication within the network of medical care provision.

This integrated model of care will be appropriate for persons with mild-to-moderate behavioral health disorders.[72] Thus, general mental health care—triage, medication management, medication prescribing, and some care management will occur on-site, while specialty mental health care and long-term care/community support will be referred to The Mental Health Center of Greater Manchester.

MORE THAN JUST WORDS ...

Behavioral healthcare is a continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof), which are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death.

Mental illness is the term that refers collectively to all diagnosable mental disorders.

Source: USDHHS

Phase Three: Improve Care and Stabilize Care Coordination

Phase three of the MSAP initiative will focus on improving and stabilizing care across major community providers of services. The MSAP envisions developing a community care coordination program directed by a nurse care manager. This program will serve the entire community and all health provider organizations and will build on the successes of both the Manchester, Laconia, and Derry care coordination programs.

The goal of the care coordination program will be to work in concert with all provider organizations to develop the infrastructure of an educational/referral/triage system to promote efficiency and quality in the health care delivery system (i.e., develop a system of coordination that insures that patients receive the right care at the right time in the right place). The program will assume the following initial goals and responsibilities:

- Working with both hospitals, set realistic benchmark goals for ED use for primary care by patients.
- Ensure culturally sensitive educational programs to create better awareness and understanding among new refugees and immigrants about how and when to use the community ED.
- Develop a strategy with the community to provide all residents a medical home and if possible, a dental home.
- With the Manchester Public Health Department, administer an in-depth assessment of patient distribution across providers.
- Work with the Strategic Planning Board to develop a plan of action to implement and expand the patient care management/referral program based on the lessons learned through the Lakes Region Hospital Health Link Program.
- Explore opportunities for the development of a patient record that can be shared across provider organizations and used to help enhance quality and efficiency of care delivery.

Phase Four: Use Data to Drive Community Health System Improvement and Explore Options for 100% Access to Medical and Dental Homes

Phase four of MSAP emphasizes the need for the development and use of data to inform community health system improvement; including the exploration of options to increase access to primary care through insurance for 100% of all Manchester residents.

It is our vision that a community and patient information infrastructure will be developed to guide the decision-making process of the Strategic Planning Board and the community. These data will be housed and maintained by the Manchester City Public Health Department. This data infrastructure will be developed so that it connects in some way to the data being developed by the New Hampshire Citizen's Health Initiative (dashboard of quality indicators) and with the work that the Manchester Public Health Department has already accomplished in the development of the Manchester Public Health Report Cards.

A data base and system, such as the one envisioned, will serve as the infrastructure for ongoing long-term planning for future health system development. Population health outcome measures will be monitored overtime and used to assess the quality and efficiency of the integrated health system as it develops.

SECTION EIGHT

CONCLUSION

Time is of the Essence

An inexperienced team of climbers learns to work in concert, efficiently and effectively, by "doing" the climb. These climbers begin their ascent with muscles cold and with slim confidence in each other. Thus, their climb upward is especially demanding; not only as a result of the steep terrain, but also by the extra work of defining the path, leaving excess baggage behind, and fostering reciprocal trust among the team members. Once these climbers have reached the mountain's first plateau, their legs are warm, and they are unburdened by the weight of unnecessary items. They have also learned an enormous amount about working together. Now, as a cohesive unit, the climbers hit their stride with the vision of the final peak in clear sight. Although the ascent from here on will continue to be arduous, the challenge of the climb now singularly stems from natural elements—the grade of the terrain or the inclemency of the weather—as the team is no longer burdened with the tasks of building trust and defining the roles of its members.

And, so it is with the Manchester Sustainable Access Project. We have reached the first plateau of our climb, accomplishing initial goals and objectives while building a strong sense of team. We are now gearing up for the rest of our journey knowing that successful collaboration among MSAP partners is key to realizing our vision.

Collaboration or Bust

No one organization can do this alone

- Proactive planning
- Share data
- Maximize resources
- Seek system-wide solutions
- Shared responsibility
- Everyone must invest something

MSAP Goals Accomplished (as of June 2008)

- **Developed a Formal Strategic Planning Board**
  Building on existing collaborative relationships we have developed the Manchester Sustainable Access Health Systems Strategic Planning Board as a formal hub for primary care strategic planning in the City. Agreement is being reached on the Mission, Vision, and Guiding Principles of this Board and on hiring appropriate personnel to insure its function and sustainability for the long term.

- **Supported the expansion and move of the Manchester Community Health Center**
  MSAP partnered with leadership of the Manchester Community Health Center (MCHC) to determine the best location of its new clinical site. Additionally, MSAP worked on behalf of the MCHC to apply for and obtain substantial grant funding to support its move to this new location. About 23% of the grant funding awarded to MSAP ($800,000) between 2005–2007 was allocated to the MCHC ($180,700).

- **Developing the West Side Neighborhood Health Center**
  In an effort to maximize and expand federal, state, and foundation dollars for primary care MSAP agreed to open a neighborhood primary care center on the west side of the City. Once this center is operational, MSAP shall submit an application to the federal government to obtain FQHC status for this center. The Strategic Planning Board shall then determine if there is a need for additional primary care capacity in the City and if this funding mechanism should be replicated.

- **Developing a Community Oral Health Plan**
  MSAP, with community support, is developing pilot tests of oral health initiatives that if successful, will lead to the expansion of oral health services for children. MSAP is concurrently developing a strategic plan, including long-term goals and objectives, that define an approach for expanding oral health services to adults.

- **Developing Data to Inform Strategic Planning**
  Through a close partnership with the Manchester Public Health Department, and in collaboration with the MSAP organizations, we have developed this report. The MSAP data committee will develop this report further in an effort to meet the needs of the Healthy Manchester Leadership Council (the community initiative of which MSAP is a project), the community, and the MSAP Strategic Planning Board to inform their decision making process.

MSAP Long-Term Vision (Draft as of June 2008)

The Strategic Planning Board of MSAP has developed long-term goals and objectives for improving the health of the local population. The Board will, over the course of the next year, bring this strategic plan to community leaders and local residents (including those most likely to face barriers to access). Once the Board has community input, it will work with the local health care organizations toward realizing the vision outlined by this strategic plan. Below is a first draft of the Board's long-term goals:

All Manchester residents will:

- have access to a medical and dental home that provides quality, appropriate, and value added health care,
- achieve specific measures of health status,
- reside in a neighborhood that supports their total well-being and healthy living in which social capital is maximized,
- are "health literate" and able to make healthy choices,
- work together with public health, the health service delivery system, and community government to attain a healthier population, and
- work to maximize social capital to sustain the community's health.

A CALL TO ACTION

As the MSAP moves forward in its work to decrease the economic barriers to primary care access, the project leaders and community have agreed to work collaboratively to enhance the quality and cost effectiveness of the health care delivery system for all vulnerable residents in Manchester.

Manchester is a city in need. It is also a city at the tipping point of great change. The question today for Manchester leaders is not whether the plan described in this document is the perfect solution for addressing the economic barriers that are burdening their community. The question is whether Manchester leaders have the political will to change the paradigm of how we work together. The question is whether we have the will to collaborate and maximize the cumulative resources of local providers to create a delivery system that works for ***all*** area residents and providers - a delivery system that is fiscally sustainable and prevents further loss to the community's health security.

DECLARATION OF COMMITMENT

BY THE MANCHESTER SUSTAINABLE ACCESS PROJECT STRATEGIC PLANNING BOARD

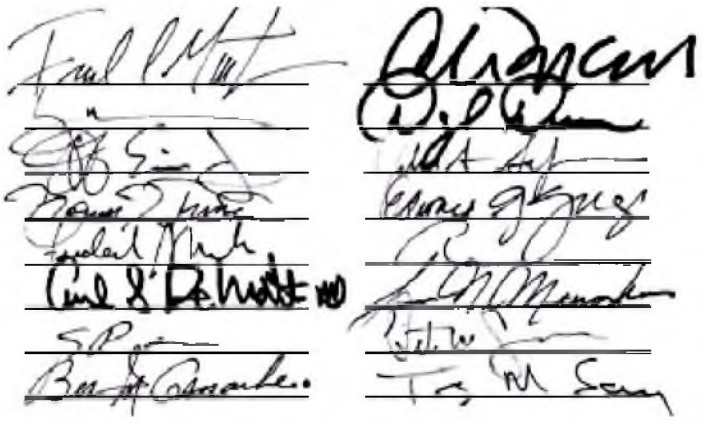
WHEREAS, *the undersigned health care providers and community representatives from the Greater Manchester area seek to strategically plan and implement a system to measurably improve the health of uninsured and underinsured residents of the greater Manchester area, and*

WHEREAS, *we have come to believe that a local solution designed by all our institutions working together is the most effective way to improve the quality of medical care for these residents, and to provide the maximum community benefit, and*

WHEREAS, *we understand that none of our institutions working alone can accomplish these goals,*

NOW THEREFORE, *we are committed to and agree to be bound in our work together by the following Guiding Principles:*

- MSAP believes the Greater Manchester area health care providers have a desire to provide the city's vulnerable populations an appropriate medical and dental home.
- MSAP believes its Strategic Planning Board (SPB) should be a community resource for proactive, collaborative planning of a primary care delivery system that improves access and enhances the health and well-being of uninsured and underinsured residents of the Greater Manchester area.
- MSAP believes that organizations involved in prevention and primary care delivery to the uninsured or underinsured should be invited to join the MSAP Strategic Planning Board.
- MSAP believes all its initiatives should be designed to be sustainable, effective and efficient.
- MSAP believes in involving the community, including the city's vulnerable populations, in setting short and long term goals, developing the strategic plan and monitoring its effectiveness over time.
- MSAP believes all strategic planning decisions should be based on reliable, agreed upon data and information and on evidence-based practices.
- MSAP believes it should seek opportunities to lead health system reform efforts for vulnerable populations and as appropriate.



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APPENDIX

MANCHESTER SUSTAINABLE ACCESS PROJECT
MEMBER PROFILES

100 McGregor Street
Manchester, NH 03102
(603) 668-3545
www.catholicmedicalcenter.org

MISSION

The heart of Catholic Medical Center is to provide health, healing and hope to all. We offer innovative, quality health care in a compassionate environment, built on trust and respect.

HISTORY

In 1892, the Sisters of Mercy opened Sacred Heart Hospital. Two years later, the Sisters of Charity of St. Hyacinthe opened Notre Dame Hospital, accommodating 30 beds. By 1956, Sacred Heart grew to accommodate 150 beds, and its services expanded to include Our Lady of Perpetual Help Maternity Hospital. At the same time, Notre Dame had grown to 114 beds and, in 1974, Notre Dame and Sacred Heart merged to form Catholic Medical Center.

DESCRIPTION

Today, Catholic Medical Center is a 330-bed full-service healthcare facility dedicated to providing health, healing and hope to all. Catholic Medical Center offers full medical-surgical care with more than 25 subspecialties, comprehensive orthopedic care, inpatient and outpatient rehabilitation services, a 24-hour emergency department, inpatient and outpatient psychiatric services, and diagnostic imaging. It is also the home of the Poisson Dental Facility that opened on the campus of Catholic Medical Center in 1983.

Catholic Medical Center is also home to the nationally recognized New England Heart Institute, which provides a full-range of cardiac services, and is a pioneer in offering innovative surgical procedures. The Institute is also a national center for advanced clinical trials and cardiovascular rehabilitation and wellness education to help patients recover in a multi-step program of exercise, education, risk factor management and the development of healthy lifestyles.

SERVICE AREA

Catholic Medical Center's primary service area includes Allenstown, Auburn, Bedford, Candia, Deerfield, Dunbarton, Goffstown, Hooksett, Manchester and New Boston.

TOTAL DISCHARGES

Total Discharges 2005 = 40,119 discharges
Ambulatory Surgery = 5.2%
Emergency Room = 75.5%
Observation = 9.9%
Other = 9.4%

Child Health Services
1245 Elm Street
Manchester, NH 03101
(603) 668-6629

Teen Health Clinic
(603) 629-9707

www.childhealthservices.org

MISSION

Child Health Services is dedicated to improving the health and well being of children from low income families in the Greater Manchester area. A fully integrated system of bio-psychosocial health care, social services and nutrition services, CHS is a medical home delivering specialized care that is adapted to the physical and psychosocial needs of children. The interventions prescribed and promoted by CHS are designed to help children and their families function to their full capacity.

The mission of our Teen Health Clinic is to serve the unique needs of adolescents. Using the same comprehensive model as Child Health Services, the Teen Health Clinic enables hundreds of children in Manchester to access services and the larger health care system.

Child Health Services is also home to four contracted programs focused on meeting the special health care needs of children and youth. Supported by Special Medical Services, New Hampshire's Title V Program, 1,100 children and adolescents receive services at our Child Development and Neuromotor Clinics, and statewide Nutrition and Community Based Care Coordination programs.

HISTORY

Founded in 1980, Child Health Services is dedicated to providing comprehensive medical care, social support services and nutrition consultation to more than 2,000 infants, children and adolescents from low-income families in the Greater Manchester area.

DESCRIPTION

The primary goal of Child Health Services is that all children served will be functioning to their full capacity-physically and psychosocially-and that their families will be able to find and use support services effectively. Using a trans-disciplinary approach, our model relies on quality medical care that is delivered within a social support system to promote parent strengths. With a staff of pediatricians, nurse practitioners, nurses, social workers and nutritionists, Child Health Services provides a "medical home" to a population of children that may not otherwise have access to our health care system.

SERVICE AREA

Child Health Service's primary service area includes Auburn, Bedford, Candia, Goffstown, Hooksett, Manchester and New Boston.

TOTAL UNIQUE PATIENTS

Unduplicated 2004-2006 = 2,602 patients (includes both Child Health Services and Teen Health Clinic)

City of Manchester Department of Health
1528 Elm Street
Manchester, New Hampshire 03101
Phone (603) 624-6466
Fax (603) 628-6004
www.manchesternh.gov

MISSION

To be a healthy community where the public can enjoy a high quality of health in a clean environment, enjoy protection from public health threats, and can access high quality health care.

HISTORY

Since the Department's formation in 1885, the City of Manchester Department of Health (MHD) has diligently worked to adhere to its mission and has met the changing public health needs of its population with great vigor. The MHD is served by a five member Board of Health that is composed of a physician, a dentist, a nurse, and representatives of labor and the public at large.

DESCRIPTION

Governmental public health departments are responsible for creating and maintaining conditions that keep people healthy. Accordingly, a local public health department exists for the common good and is responsible for demonstrating leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; preventing illness, disease, injury, and premature death; and eliminating health disparities. The MHD is a "Functional Health Department" as defined by the National Association of County and City Health Officials (NACCHO) and carries out the core functions of public health that include assessment, policy development and assurance through its four main Divisions: Chronic Disease Prevention & Neighborhood Health, Community Health, Environmental Health & Emergency Response, and School Health.

SERVICE AREA

The City of Manchester Department of Health directly serves the residents of Manchester and partners with the surrounding towns of Auburn, Bedford, Candia, Chester, Deerfield, Goffstown, Hooksett and New Boston (the Health Service Area) in planning for public health preparedness and emergency response.

TOTAL RESIDENTS

City of Manchester 2005 = 109,691
Health Service Area 2005 = 184,307

Dartmouth-Hitchcock Manchester
100 Hitchcock Way
Manchester, NH 03104
(603) 695-2500
www.dartmouth-hitchcock.org/manchester

Dartmouth-Hitchcock Bedford
25 South River Road
Bedford, NH 03110
(603) 695-2572

MISSION

To provide high quality health care and comfort to the ill, to prevent illness among the well, and to advance health care through education, research, community service, and the improvement of clinical practice. We are committed to patient satisfaction, honest and respectful communication, and working collaboratively.

HISTORY

Dartmouth-Hitchcock Manchester was founded in 1984, when six respected local physicians joined forces to create Manchester's first multi-specialty group practice. Their goal was to serve the health and medical needs of the citizens of Manchester and surrounding communities.

In 1998, to meet the increasing demands of the community, a new state-of-the-art, 120,000 square-foot ambulatory care facility was completed to house the Manchester group practice.

DESCRIPTION

Dartmouth-Hitchcock Manchester is a multi-specialty, community group practice with more than 100 physicians and associate providers. Our primary and specialty care departments offer a full range of healthcare services. Specialists from the Dartmouth-Hitchcock Medical Center in Lebanon see patients at the Children's Hospital at Dartmouth (CHaD) and the Norris Cotton Cancer Center, both located at our Manchester facility.

Our affiliation with Dartmouth-Hitchcock Medical Center, the state's leading teaching and specialty-care hospital, gives patients access to a nationally-renowned academic medical center. Our physicians also serve on the medical staff of Elliot Hospital and Catholic Medical Center.

SERVICE AREA

Towns covered in Dartmouth-Hitchcock Manchester's service area include Auburn, Bedford, Candia, Chester, Deerfield, Goffstown, Hooksett, Manchester, and New Boston, New Hampshire.

TOTAL UNIQUE PATIENTS

Unduplicated 2004-2006 = 84,413 patients

555 Auburn Street
Manchester, NH 03103
(603) 623-8863
(800) 870-8728
www.nh.easterseals.com

MISSION

To provide exceptional services to ensure that all people with disabilities or special needs and their families have equal opportunities to live, learn, work and play in their communities.

HISTORY

Easter Seals was founded in New Hampshire in 1936, when Dr. Ezra Jones, the state's first orthopedic surgeon, opened a facility for children in Nashua. In the 40s, we expanded our services to include the adult and geriatric populations. Easter Seals currently leads several collaborative efforts including the Autism Network, Seniors Count and the Easter Seals Transportation Resource Access and Coordination project. Whether helping someone improve their physical mobility, return to work or simply gain greater independence for everyday living, Easter Seals offers a variety of services to help people with disabilities address life's challenges and achieve their personal goals.

DESCRIPTION

Easter Seals has been helping individuals with disabilities and special needs, and their families live better lives for nearly 75 years. Our programs fall into the following service areas: childcare and early intervention services, special education, camping and recreation services, medical rehabilitation, vocational services, veterans services, senior services, and transportation. At the core of the Easter Seals organization is a common passion for caring shared by its 1,377 staff members in New Hampshire.

Easter Seals prides itself on its ability to make its services available to all, not just those who can afford them. In 2007, we provided more than $3.1 million in free and reduced-price services to New Hampshire families who needed, but could not afford the services.

SERVICE AREA

Easter Seals provides services throughout the State of New Hampshire.

TOTAL UNIQUE PATIENTS

2007 individuals and families served: 25,225

One Elliot Way
Manchester, NH 03103
(603) 669-5300
www.elliothospital.org

MISSION

The mission of Elliot Hospital is dedicated to providing its community with excellent services offered with dignity, caring and respect.

HISTORY

Established in 1890, Elliot Hospital is the oldest community hospital in New Hampshire and the first general hospital in the state.

DESCRIPTION

Elliot Health System (EHS) is the largest provider of comprehensive healthcare services in Southern New Hampshire. The cornerstone of EHS is Elliot Hospital, 296-bed acute care facility located in Manchester (New Hampshire's largest city).

Elliot Hospital is a premier healthcare provider in many disciplines, and is the designated trauma center for the Greater Manchester area. It is also home to the Elliot Regional Cancer Center, The Max K. Willscher Urology Center, and has one of only three Level 3 Neonatal Intensive Care Units (NICU) in the state of New Hampshire. In June 2002, the Elliot Senior Health Center was opened to provide comprehensive and coordinated senior healthcare in one location. It is one of only a handful of its kind located throughout the country.

Elliot Physician Network offers primary care services throughout 17 physician practices in the Greater Manchester area.

SERVICE AREA

Elliot Hospital's primary service area includes Allenstown, Auburn, Bedford, Candia, Deerfield, Dunbarton, Goffstown, Hooksett, Manchester and New Boston.

TOTAL DISCHARGES

Total Discharges 2005 = 50,822 discharges
Ambulatory Surgery = 5.2%
Emergency Room = 75.2%
Observation = 13.7%
Other = 5.9%

MANCHESTER
community
HEALTH CENTER

1415 Elm Street Second Floor
Manchester, NH 03101
Phone (603) 626-9500
www.mchc-nh.org

MISSION

The mission of the Manchester Community Health Center is to foster, through both direct services and collaboration, high-quality, comprehensive family-oriented primary healthcare services that meet the needs of a diverse community regardless of age, ethnicity or income. Our focus is to provide access to those who cannot **access** primary healthcare services.

HISTORY

MCHC was established in 1993 to principally provide family oriented primary health care services to the people of Manchester and surrounding areas believed to be uninsured, underinsured or lacking access to sources of affordable, quality healthcare. It is a Federally Qualified Health Center (FQHC) and is funded by the Bureau of Primary Health Care under Federal 330 of the Federal Department of Health and Human Services, Health Resources and Services Administration.

DESCRIPTION

Services are provided on a discounted fee scale based upon the patient's income and family size and address the patient's medical and social needs. Basic services offered include: family medicine; perinatal care; nutrition counseling; translation services; health education; preventive screening; Medicaid outreach; medical case management; social service coordination; mental health counseling; adolescent preventive health services and referral assistance.

SERVICE AREA

Manchester Community Health Center 's service area covers Greater Manchester including, but not limited to, the communities of Goffstown, Hooksett, Auburn , Candia, Londonderry, Derry and Bedford. Its target population consists of the uninsured, the underinsured and includes pregnant women, infants and children, teenagers, adult men and women, senior citizens, Manchester 's refugees and patients who qualify as low income or indigent. Currently about 1 in every 3 patients who visit the Health Center requires an interpreter.

TOTAL UNIQUE PATIENTS

Unduplicated 2004-2006 = 7,408 patients

401 Cypress Street
Manchester, NH 03103
(603) 668-4111
www.mhcgm.org

MISSION

To provide an accessible, comprehensive, evidence-based system of mental health services that empowers individuals to achieve recovery and serves to promote personal and community wellness.

HISTORY

Founded in 1960, The Mental Health Center of Greater Manchester is the largest organization of its kind in the region. The Center has grown over the last 45 years into one of the nation's most respected mental health centers, providing service to approximately 9,000 adults, children and seniors annually. The Center is affiliated with Dartmouth Medical School and is an off-campus training site for residents in psychiatry.

DESCRIPTION

Designated by the NHDHHS Bureau of Behavioral Health as a regional community mental health program for Region 7 (Greater Manchester). As such, it provides a broad range of services to 3,000 people who have a serious and/or persistent mental illness and provides 24/7 emergency psychiatric response to the community. It also manages all the behavioral health services for Catholic Medical Center, a local 330 bed general hospital.

Of note, MHCGM has developed an international reputation as a center of excellence providing consultation to providers from at least 33 other states and 10 foreign countries interested in learning about the "Manchester Model". MHCGM has a research department and is actively involved in a number of research projects.

One of The Center's programs, Bedford Counseling Associates, is an outpatient counseling and psychiatric medication service for about 5,000 area citizens who require psychiatric care for a range of conditions. These patients do not meet the state's eligibility standards for severe and/or persistent mental illness, thus are not eligible for state funding for their care but they do require mental health services.

Our recovery-oriented approach means we are able to provide the right care, at the right time, in the right setting. Offering over 30 programs and delivering services through eight locations, we provide high quality, accessible and comprehensive behavioral health services for the Greater Manchester area, enabling our clients to restore the quality of their lives as soon as possible.

SERVICE AREA

The Mental Health Center of Greater Manchester's primary service area includes Auburn, Bedford, Candia, Goffstown, Hooksett, Londonderry, Manchester and New Boston.

TOTAL UNIQUE PATIENTS

Unduplicated 2004-2006 = 15,989 patients