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Believe in a healthy community: greater Manchester community needs assessment 2009

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BELIEVE IN A HEALTHY COMMUNITY

Greater Manchester Community Needs Assessment 2009

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A Special Thank You to All Community Reviewers

EXECUTIVE SUMMARY

The New Hampshire Attorney Generals' office is responsible for assuring that all health care organizations that claim to be charitable organizations benefit the public. Charitable organizations are required to conduct a community assessment every five years and to submit a plan and annual updates on how funds are being used to address issues and barriers that related to the health of those served.

This report represents not only a legal obligation, but a dedicated effort on the part of the *Healthy Manchester Leadership Council* partners to assess and reveal the health-related determinants and status of Manchester area residents, to provide a model with strategic imperatives from which to plan, and to hold themselves accountable for responding to and improving the health status of its residents by the year 2015.

The Healthy Manchester Leadership Council, a partnership chaired by Manchester Health Department and composed of several Manchester area health and social services agencies, is committed to "measurably improving the quality of life for all Manchester residents." Part of this mission is accomplished by measuring quality of life. With consultation and funding from other local and state organizations and foundations, the *Healthy Manchester Leadership Council* partners embarked on this 2009 Community Assessment. The focus of this assessment is on the Manchester Health Service Area (HSA) as defined by the New Hampshire Department of Health and Human Services, and includes the towns of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, New Boston, and the City of Manchester.

Economic, social, health, education, public safety, and physical environment information is presented in this report and was collected from a variety of sources. Trends, comparisons among Manchester City, towns in the Greater Manchester HSA, and New Hampshire State data are presented. When possible, Healthy People 2010 Objectives and CDC Health Protection Goals are used as benchmarks. Quantitative information (measurable numerical data) was collected from national, state, and local governmental sources. Qualitative information (opinions, perceptions, thoughts) was derived from conducting structured focus groups with area residents, business leaders, and key providers of health care.

The population of the greater Manchester HSA is growing in size, and living longer; is increasingly multicultural with residents reflecting a variety of nationalities, languages, ethnic traditions, religious beliefs and ideologies; and is composed of many different family structures.[1] The Manchester HSA has the largest population and number of jobs, but also has the lowest average income levels in the state. Increasingly, incomes are failing to meet the costs of living, including the costs of staying healthy and preparing for emergencies. Poverty is highly associated with risky behaviors, educational attainment, health status, employment, and self-reported quality of life. Residents experience discrepancies in health and health care access that are associated with their age, incomes, educational attainment and neighborhood.

This assessment identifies a variety of health-related concerns in Manchester City and the Health Service Area including heart disease, mental health, ambulatory-care sensitive conditions, health risk behaviors, sexual health, substance abuse, emergency department use and premature death.

Inadequate transportation, high cost of health care, and medically underserved areas exist in the region, as does under and overuse of existing health services resulting in a financial burden for the whole community.

Future community health improvement efforts require the "intentional" design of communities oriented around health promotion, disease prevention and population well-being. This needs assessment is an early stage of the Manchester Health Service Area's community health improvement planning process (CHIP). The findings are intended to inform the public, and local governments, providers, hospitals, and other community organizations as they embark on their work of making and planning for a better and healthier Manchester Area.

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I. INTRODUCTION

Believe in a Healthy Community provides a snapshot of the health, well-being, and major issues facing the population of the Manchester Health Service Area (HSA). The Manchester HSA is defined by the New Hampshire Department of Health and Human Services and includes the eight towns Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester and New Boston. This report is written for all area residents and leaders who believe in the potential of the region and who are striving to make it a better place to come to for work, play, raising families, and growing old with friends.

REPORT AIM

This document is part of a collaborative community health improvement process and has been developed to meet two major aims. First, the document provides a standard data resource for the City's non-profit health care organizations for the development of their 2009 Community Benefit Reports. Second, this report will provide important information and data to the City of Manchester Health Department to guide and inform the *2010 Community Health Improvement Process* for the Manchester HSA.

DATA SOURCES

The data collection process was purposefully designed to summarize standardized information from the New Hampshire State and Manchester City government and from local key informants including community members. Qualitative and quantitative data were also summarized and provide important perspectives to the developing portrait of the Manchester area.

Qualitative data were collected from local area residents through 14 separate focus group meetings and 19 key informant interviews, including an interview with a key leader from each of the HSA towns outside of Manchester and one group interview with key local business leaders. These data provide a closer look at the health care needs of the area through the perspective of those who receive - or who are in a position to receive – health care services in the future (i.e., all focus group participants, including participants who represented those who are more apt to have pressing health care needs compared to others), and from those in a position to provide care and services (i.e., key leaders).

Quantitative data were used to summarize aspects of health and well-being for the population. The data were collected from existing local, state, and national sources. The majority of the quantitative data were obtained from the Census Bureau, the American Community Survey, the New Hampshire Behavioral Risk Factor Surveillance System (BRFSS), the New Hampshire Youth Risk Behavior Surveillance System (YRBSS), the Manchester Health Department, and numerous state and local agencies. The New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management provided extensive data and technical assistance to this project.

The final indicators of public health and well-being used in this report were created by developing lists of recommended indicators for each of the Strategic Imperatives. Indicators chosen are science-based and primarily drawn from the following reputable sources: Institute of Medicine's State of the USA Health Indicators report and book;[2] Institute of Medicine Report: Improving Health in the

Community;[3] the Department of Health and Human Service's Community Health Status Indicators;[4] the Centers for Disease Control and Prevention's Chronic Disease Indicators;[5] Healthy People 2010 Leading Health Indicators;[6] and the National Association for County and City Health Officials Tool: Mobilizing for Action through Planning and Partnerships.[7]

Limitations of the Data Sources

It remains challenging in New Hampshire to obtain timely, comprehensive, quantitative public health data that are analyzed at a geographic level smaller than the state or county. However, over the past ten years the New Hampshire Department of Health and Human Services (NHDHHS) has made a concerted effort to provide the City of Manchester Health Department data relevant to the Manchester area population. These data are available, in part, because the city population is large and information describing its population can be summarized, while concurrently protecting the privacy of the individuals from whom these data are collected. By special request, data for the entire Manchester HSA can also be obtained. Town level data can be obtained from NHDHHS but often must be rolled up over multiple years as annual data counts are often too small to be made publicly available. Thus, for purposes of this report we have used town level data when it is available but often had to rely on aggregated HSA data and Manchester City data to tell the story of the local area. It should be noted that when HSA data are used the City of Manchester statistics are included in these data. Thus, because the city population is so large, we assume that what is happening in the city population drives the direction of these data.

Although we made a concerted effort to obtain qualitative data from persons who live outside of the City of Manchester (but who receive services through Manchester health care organizations) our focus groups were dominated by city residents. Thus, in an effort to better describe the needs of those who live within the HSA but outside of Manchester City, we interviewed at least one key leader in each of the seven HSA towns surrounding Manchester. Future assessments of the Manchester HSA might include additional funding for hosting community town hall style meetings for those who live within the HSA, but outside of the city proper.

Some community partners requested health data that differentiated among specific groups in the area. Except in a few circumstances, the data provided would not allow for examination of differences among races or ethnicities. Some data from the NHDHHS distinguishes between white or non-white residents, but does not give further racial/ethnic detail. While the size of minority populations has been growing in the HSA, the number of individuals sampled in surveys was too small to provide representative data for race and ethnicity. Additionally, there was lack of available health data regarding smaller age groupings, such as for adults age 75 and over. This is a major limitation of this assessment. The focus group results, however, represent input from a mix of community members that resembles Manchester's actual racial and ethnic distribution.

For further information about race and ethnicity as it relates to community health, please refer to Manchester Health Department's "2004 Snapshots of Social and Economic Well-Being by Race and Ethnicity in our Community" at:
http://www.manchesternh.gov/website/Departments/Health/DataandReports/tabid/700/Default.aspx

HOW TO READ THIS REPORT

The report is organized into chapters that summarize quantitative and qualitative data aligned with the Healthy Manchester Leadership Council Strategic Imperatives. This report does not prescribe action that should be taken in response to the data. It presents data that can be used to help make decisions and shape plans for community health improvement activities.

Chapter I: This *Introduction* provides an introduction to the reader of the report aim, data sources and limitations and provides a short description of each of the chapters to follow.

Chapter II The *Strategic Imperatives for Health Improvement* is described in detail. The framework of these strategic imperatives guided the planning of this needs assessment as well as the organization of the report and its unique chapters.

Chapter III: The *Changing Area Demographics* are presented as an overview of the Manchester Health Service Area (HSA) and Manchester City (Manchester or the City) and attempts to acquaint the reader with basic information that is important for understanding the context of each of the chapters that follow it.

Chapter IV: The first strategic imperative, *Healthy People in Every Stage of Life,* is the basis of chapter four. Since findings are presented and organized by age groups rather than subject areas, the reader needs to seek the data of interest in the sections for the age groups it most affects.

Chapter V: *People Accessing Quality Health Care* summarizes the second strategic imperative and the overall quality of the Manchester HSA health system; focusing on the issues of quality, cost and access. The Data Snapshot at the end of this chapter summarizes input on access from the community perspective.

Chapter VI & Chapter VII: These chapters summarize strategic imperatives three and four, and introduce new ideas about how to think about improving health. Both chapters are organized to introduce board concepts and noteworthy data to the reader. Input from focus group participants and key leaders are included in Chapter Six, Healthy People in Healthy Neighborhoods, but not in Chapter Seven, People Prepared for Emerging Health Threats.

Chapter VIII: In this chapter *The Community Provides Input to This Needs Assessment* we attempted to find themes across input from the focus groups and key leader interviews. The theme of intentional community design and key community health issues as reported by the public are discussed.

Chapters four through eight are organized in the same way starting with a summary of the Key Issues for the age group and followed by an overview and summary of demographics. Then the chapter is organized by the following main themes always presented in the same order: (a) current health - including causes of death and morbidity, (b) access to health care services, (c) risks to future health - including physical and social environmental factors, (d) the community weighs in (summary of focus group and key leader input as appropriate), and (e) Data Snapshot. At the end of the chapter the conclusion section encompasses data from all age groups.

The Data Snapshot: Tables for the age groups described in the *Healthy People in Every Stage of Life* section contains a full list of indicators and baseline data used in each chapter for quick reference. These data are described in detail below so that the reader can use them to their full potential.

The left column of each table is the list of key indicators of health and well being that were selected for each age group for the needs assessment as well as for future tracking within Manchester and/or the health service area (HSA). The columns to the right of the indicators share data about Manchester, the HSA, and the rest of the state of New Hampshire not counting Manchester, so we can compare health measures across those three geographic ranges.

The fifth column on some tables provides some Healthy People 2010 (HP 2010) national targets. HP 2010 "is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats."[6] The Healthy People initiative develops a new set of national targets every ten years. In future needs assessments, HP 2020 objectives will serve as targets.

The data tables provide a quick reference for various aspects of our risks to health and well being in the area. They do not show trends, but do allow limited geographic comparison. When reading the measures associated with a particular indicator, for example, the first one "Percent of births to mothers who are unmarried," compare the columns of data to see if the phenomenon or status is more common in one area or another. For indicators, such as the first one, in which there is an asterisk (*) next to a data point, that amount or percentage is statistically significantly higher then the result for the rest of the state of New Hampshire. A statistically significant result is one in which the difference you see is not likely to have happened by chance. All results presented that do not have an asterisk are not significantly different from the rest of New Hampshire.

Some important aspects of the data tables include:

- Indicators described as "developmental" are ones for which data were not available for this report, but we wish to monitor for future use.
- Found in many cells, "na" means "not available." Results for the HSA towns other than Manchester are not available from the recent (2007) American Community Survey.
- The findings for the Manchester HSA include Manchester with seven other towns. This affects our interpretations when we compare Manchester to the HSA based on the data.
- For a few indicators, Manchester City data are not available because either the resulting number was too small to be used or the sample surveyed was too small for reliable data.
- For many indicators, confidence intervals are available though not listed on the table.

- The list of indicators for each age group was developed first by extensively listing science-based and recommended indicators from reputable sources.

  The primary sources for indictors include:

  - the Institute of Medicine's State of the USA report and the book, Improving Health in the Community;
  - the Department of Health and Human Service's Community Health Status Indicators;
  - the Centers for Disease Control and Prevention's Chronic Disease Indicators;
  - Healthy People 2010 Leading Health Indicators; and
  - the National Association for County and City Health Officials tool, Mobilizing for Action through Planning and Partnerships.

  The indicator lists were then reviewed by people in the health department and in community organizations to ascertain which were most relevant or useful for our community needs assessment. The list was finalized by adding indicators based on community organizations specific interests or data availability.

Chapter IX: The *Conclusion* contains an overview of noteworthy findings.

The Appendices: The *Appendices* contain useful additional materials including the needs assessment methods, more extensive information from community members, and profiles of partner organizations.

II. STRATEGIC IMPERATIVES FOR HEALTH IMPROVEMENT

BACKGROUND

The leading causes of death in the Manchester Health Service Area (HSA) have changed over the past 125 years from death from infectious diseases to deaths from chronic diseases. Currently, children (who represent a small proportion of area deaths) tend to die from accidents or from health conditions with which they were born, compared to the past when they died from conditions related to sanitation and crowding such as diarrhea and enteritis. Likewise communicable diseases (for example, pneumonia, and tuberculosis) that took the lives of adult residents in the 19th century have essentially been replaced by chronic diseases such as heart disease and cancer. Poverty, which has constantly plagued the area, used to contribute to poor population health by forcing people to live in conditions in which diseases spread easily. Now, poverty contributes to population health by limiting people's options for food, activities, work, health care, and living situations in ways that make chronic disease more common.

It is important that the public health community continue to improve sanitary conditions and endeavor to prevent the spread of communicable diseases through efforts to vaccinate area residents. It is equally important, however, for public health to partner with a broad coalition of community organizations, including health care providers, to develop new models to address the environmental, biological, socioeconomic, cultural and behavioral factors associated with the chronic diseases which contribute to the burden of illness, disability, and death in the community today.

In the late 1990s a partnership of eleven health and social service organizations serving the Manchester HSA, originally known as the Manchester Compass Steering Committee, came together to conduct the Greater Manchester Area Community Needs Assessment. The Steering Committee, now named the Healthy Manchester Leadership Council (HMLC), is chaired by the City of Manchester Health Department's Public Health Director and Deputy Public Health Director. Since 1997, the Council has grown in membership and has worked to address critical health issues identified by local needs assessments.

Healthy Manchester Leadership Council's 2015 Strategic Imperatives

The Healthy People 2010 Overarching Goals and the Center for Disease Control and Prevention's Health Protection Goals have shaped the development of our own Healthy Manchester 2015 Strategic Imperatives. The Healthy Manchester 2015 Strategic Imperatives are organized around four overarching goals:

Goal 1: **Eliminate preventable disease, disability, injury and premature death.** This goal is a relatively measurable standard by which to judge success of the community health improvement process. In this report our analysis and recommendations are directed toward the four outcomes of preventable disease, disability, injury and premature death.

Goal 2: **Achieve health equity and eliminate health disparities.** A community that has eliminated health disparities does not have differences in health status that occur by gender, race or ethnicity, education or income, disability, geographic location or sexual orientation. A community that has achieved health equity is a community in which the policies, systems, and institutions treat everyone similarly and fairly. Both concepts are based on the premise that all people have a right to health. A community with health equity and without health disparities is one in which all people have equal opportunity to reach their full health potential.

Goal 3: **Create social and physical environments that promote good health for all.** This goal recognizes that determinants of health are broad, and that most aspects of our daily lives ultimately have an effect on community health. As is recognized in this report, improving the social setting and environment in which we live will take a coordinated effort beyond what the health department, hospitals, and social service providers can accomplish alone.

Goal 4: **Promote healthy development and healthy behaviors at every stage of life.** This goal further shaped the organization of the assessment process and this report, directing us to focus on age groups rather than specific behaviors or health problems. This goal implies the importance of coordinating the efforts of disparate organizations and entities that affect certain age groups.

These four overarching goals shaped the development of the HMLC 2010 Strategic Imperatives that are summarized below.

STRATEGIC IMPERATIVE #1: Healthy People in Every Stage of Life. This directs us to consider life as a succession of stages, each of which has specific risks, needs, advantages and challenges.

STRATEGIC IMPERATIVE #2: People Accessing Quality Health Care. This strategic imperative touches on various components of health care in the Manchester area, including quality, cost, usage, access and outcomes.

STRATEGIC IMPERATIVE #3: Healthy People in Healthy Places. This strategic imperative recognizes the need to consider the physical context that supports or hinders community health.

STRATEGIC IMPERATIVE #4: People Prepared for Emerging Health Threats. This strategic imperative directs us to take steps to help the community be as prepared as possible to identify emerging threats and to reduce community vulnerabilities.

These strategic imperatives (as framed by the Healthy People 2010 Goals) provided the platform for the development of the Healthy Manchester 2015 Framework (see figure on the following page). This framework will provide area leadership with components of a powerful roadmap for improving the health and well being of the population of the Greater Manchester Area and guided the planning of this needs assessment process, as well as the organization of this report.


HEALTHY MANCHESTER 2015
COMMUNITY HEALTH IMPROVEMENT PLAN
"HEALTHY PEOPLE IN HEALTHY NEIGHBORHOODS"
Goal 1: Eliminate preventable disease, disability, injury, and premature death.
Goal 2: Achieve health equity and eliminate health disparities.
Goal 3: Create social and physical environments that promote good health for all.
Goal 4: Promote healthy development and healthy behaviors at every stage of life.
PREVENT
STRATEGIC IMPERATIVE #1:
Healthy People in Every Stage of Life
IMPROVE
STRATEGIC IMPERATIVE #2:
People Accessing Quality Health Care
PROMOTE
STRATEGIC IMPERATIVE #3:
Healthy People in Healthy Places
PROTECT
STRATEGIC IMPERATIVE #4:
People Prepared for Emerging Health Threats
WORKING IN PARTNERSHIP WITH RESIDENTS AND COMMUNITY COLLABORATIONS
HEALTHY MANCHESTER LEADERSHIP COUNCIL
CITY OF MANCHESTER HEALTH DEPARTMENT

III. CHANGING AREA DEMOGRAPHICS

AREA POPULATIONS ARE GROWING

Manchester and the surrounding towns of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett and New Boston make up what is known as the Manchester Health Service Area (HSA). The HSA has a population of 179,894 persons (2007), represents approximately 14% of the New Hampshire state population (1,315,829) and makes up most of the major service area of the two Manchester hospitals.[8] In 2006 the HSA experienced 11.3% of the state's total births and 10% of the state's total deaths.[9]

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

	1990	2000	2007	2010 (estimate)	2020	2030
Auburn	4,085	4,682	5,157	5,360	5,790	6,170
Bedford	12,563	18,274	21,146	21,810	23,940	25,400
Candia	3,557	3,911	4,181	4,250	4,570	4,840
Deerfield	3,124	3,678	4,181	4,420	4,780	5,100
Goffstown	14,621	16,929	17638	18,600	20,260	21,800
Hooksett	8,767	11,721	13,675	14,330	16,360	18,100
New Boston	3,214	4,138	5,042	5,190	5,690	6,160
Manchester	99,567	107,006	108,874	112,400	117,620	121,700
Total Manchester Health Service Area	**149,498**	**170,339**	**179,894**	**186,360**	**199,010**	**209,270**

Source: New Hampshire Office of Energy and Planning and US Census

The City of Manchester (referred to as Manchester or the City throughout this report) is the largest community in northern New England. With a total population of 108,874 residents, Manchester represents 60.5% of the HSA and 8.3% of the state's total population. The table below displays how the population of Manchester is distributed by age and gender.

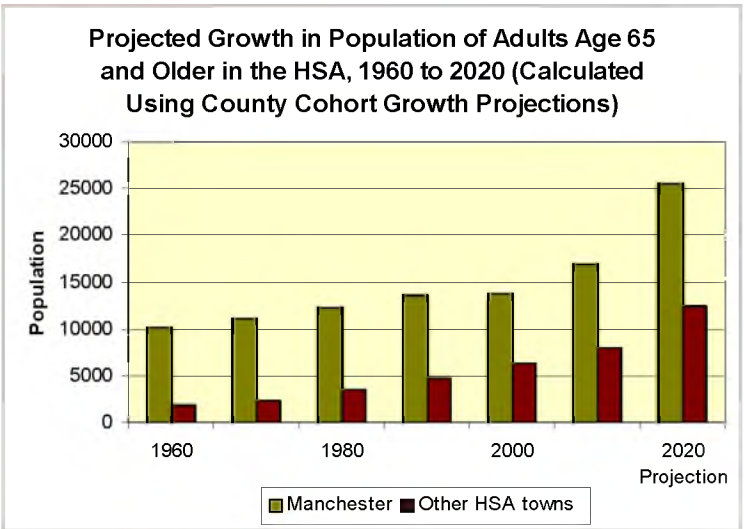
Age in Manchester	Approximate Population 2007	Percent of Total 2007
Under 5	8,944	8.3%
5 to 17	15,668	14.5%
18 to 29	18,912	17.5%
30 to 49	31,946	29.5%
50 to 64	19,152	17.7%
65 and up	13,732	12.7%
All Males	54,344	50.2%
All Females	54,010	49.8%

Source: American Community Survey

A LONGEVITY REVOLUTION

More people are living longer and individuals in the large "baby boomer" age group are now reaching the retirement age of 65. In the next forty years the number of people in the nation age 65 and older is expected to more than double.[1] The population of the Manchester HSA is expected to experience the same type of growth.

For example, the number of Manchester adults ages 65 and older grew by 13% from 1980 to 2000. It is projected that this population will grow by another 85% from 2000 to 2020. The population of older adults in the other HSA towns grew by 82% from 1980 to 2000 and is projected to more than double from 2000 to 2020.



Source: NH Office of Energy and Planning, US Census, Manchester Health Department

This high growth rate of the elderly group in the Manchester HSA suggests that leadership should anticipate and plan for an increase demand for services that adequately address the needs of older adults.

GROWING MULTICULTURALISM

Over the last decade, in addition to growing in size, Manchester HSA's population has become more diverse in its cultures, languages, religious beliefs and other ideologies. This is especially true for Manchester which is a refugee resettlement site.

TOTAL NEW HAMPSHIRE REFUGEE RESETTLEMENT BY MUNICIPALITY: FEDERAL FISCAL YEAR 2002–2008

	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY08	TOTAL
Manchester	182	195	471	165	146	99	246	1,504
Concord	11	38	75	126	54	94	192	590
Laconia	33	5	8	15	55	13	59	188
Franklin	13	6	0	2	0	0	0	21
Nashua	0	0	0	2	5	51	12	70
Haverhill	5	0	0	0	0	0	0	5
Milford	4	0	0	0	0	0	0	4
Hooksett	3	0	0	0	0	0	0	3
Warner	0	0	0	2	0	0	0	2
Hanover	2	0	0	0	0	0	0	2
Peterborough	0	0	1	0	0	0	0	1
Charlestown	0	0	0	0	0	0	3	3
Boscawen	0	0	1	0	0	0	9	10
TOTAL	**251**	**244**	**556**	**312**	**260**	**257**	**521**	**2,403**

Source: New Hampshire Department of Education; New Hampshire Office of Refugee Resettlement

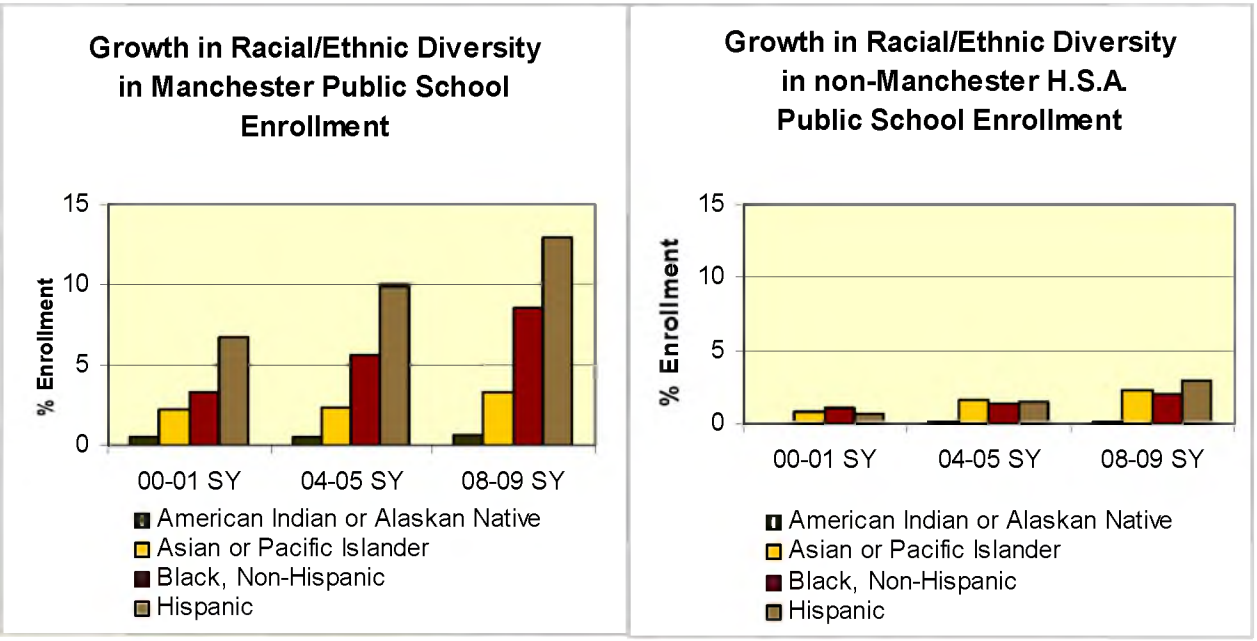
As of 2007, nearly 10% of Manchester's residents were born outside of the United States, which is twice the percent of people in all of New Hampshire who are foreign born. Over 17% of Manchester's residents speak a language other than English at home. Around 5% of households are linguistically isolated, meaning that all members of the household ages 14 and older have at least some difficulty with English.[8] The HSA towns of Hooksett, Goffstown, and Bedford also report having enrolled students with Limited English Proficiency although their numbers have dropped over the years.

Students with Limited English Proficiency in Public Schools

	SY 00-01	SY 01-02	SY 02-03	SY 03-04	SY 04-05	SY 05-06	SY 06-07	SY 07-08
Auburn	0	0	0	0	0	0	1	0
Bedford	13	14	53	7	4	2	5	5
Candia	0	1	2	0	2	0	0	0
Deerfield	0	0	0	0	0	0	1	0
Goffstown	1	11	15	30	21	29	34	22
Hooksett	24	24	27	38	40	50	15	13
New Boston	0	3	3	4	3	1	0	0
Manchester	1,326	1,456	1,342	1,296	1,181	1,202	936	942
TOTAL	**1,364**	**1,509**	**1,442**	**1,375**	**1,251**	**1,284**	**992**	**982**

Source: New Hampshire Department of Education, Limited English Proficiency Enrollment

In the Manchester school system (which draws students from the HSA towns of Hooksett, Auburn and Candia for high school), the proportions of enrolled students who are non-white has increased over the past decade with about a two-fold increase in those who are Hispanic and Black.



Source: New Hampshire Department of Education

The Carsey Institute reported that between 2000 and 2007 the minority population in Manchester grew by 32% (5,200 people) while the non-Hispanic white population declined by 2%.[10]

FAMILY STRUCTURE IS CHANGING

Across the United States family households take a variety of forms. Households may be headed by married or unmarried partners as well as by individuals. They may or may not have school-age children present. They may be headed by grandparents. They may contain foster children. Over the past seven years the percent of households in Manchester composed of two married parents with their own school-age children has decreased from 19.2% to 14.8%.

Household Composition in Manchester, the HSA and New Hampshire, 2000 and 2007

Households	2000 HSA (excluding Manchester)	2000 Manchester	2000 New Hampshire	2007 Manchester*	2007 New Hampshire*
Percent of all households that are composed of a married couple family with own children under 18	33.78%	19.20%	25.36%	14.80%	22.80%
Percent of households with an adult householder living alone	16.43%	31.70%	24.44%	32.80%	24.10%
Percent of households that have a male adult householder, no wife present, and children present under 18 years	1.99%	2.80%	2.49%	2.90%	2.40%
Percent of households that have a female adult householder, no husband present, and children present under 18 years	4.26%	8.10%	6.27%	10.30%	6.50%

** 2007 Data are not available for the Manchester HSA*
Source: 2000 Census , 2007 American Community Survey

JOBS AND WAGES

Within the HSA, Bedford has the highest median household income and Manchester City has the lowest. Similarly, Manchester has the highest percentage of families living in poverty, while Deerfield has the lowest. Yet jobs in Manchester, many of which are held by people who live outside the City, pay relatively well (second only to Bedford). Also, Manchester has the most jobs of any town in the HSA, with an average annual employment of 67,349 in 2007.

LABOR FORCE, INCOME, AND WAGES IN THE HSA

	AUBURN	BEDFORD	CANDIA	DEERFIELD	GOFFSTOWN	HOOKSETT	MANCHESTER	NEW BOSTON
Size of Labor Force, 2007	3,167	11,374	2,629	2,302	10,337	7,968	62,106	3,006
Median Household income, 1999	$70, 774	$84,392	$61,389	$61,367	$55,833	$61,491	$40,774	$66,020
Per capita income, 1999	$28,405	$37,730	$25,267	$24,160	$21,907	$24,629	$21,244	$26,488
Families below poverty level, 1999	1.6%	1.6%	2.3%	1.3%	2.6%	3.2%	7.7%	3.1%
Average employment in goods producing, 2007	665	1321	317	69	457	1,842	9,245	122
Average weekly wage in goods producing, 2007	$891	$1271	$962	$926	$855	$1,179	$999	$714
Average employment in service providing, 2007	619	12,038	404	195	1,957	5,584	50,769	385
Average weekly wage in service providing, 2007	$795	$933	$696	$483	$486	$737	$875	$648
Average employment in government, 2007	156	902	114	173	1129	607	7,335	173
Average weekly wage in government, 2007	$654	$799	$690	$633	$687	$679	$1,046	$732
Total average employment, 2007	1439	14,262	835	437	3,544	8,033	67,349	681
Average weekly wage, 2007	$824	$955	$796	$612	$598	$834	$910	$681
Total Tax rate per $1000, 2007	$13.71	$18.99	$18.59	$17.53	$24.70	$22.68	$16.57	$14.02

■ = highest ranked HSA towns for this economic measure ■ = lowest ranked HSA town for this economic measure

Source: Economic & Labor Market Information Bureau, New Hampshire Employment Security, 2008[11]

In 2005 in Manchester, a family of four with both parents working needed to make $50,031 annually ($12.03 per hour) to meet basic needs.[12] That same year the median household income in Manchester ($50,199) was a bit above the basic needs level ($50,404).[8] However, in 2007, only 55% of the households in Manchester reached the livable wage level[13] which had increased to $53,192 (equivalent wage of $12.79 per hour).

According to the American Community Survey, the most common type of employment in Manchester is in educational services, health care, and social assistance (20.3%). Manchester makes up 8.2% of the state's labor force.

IV. HEALTHY PEOPLE IN EVERY STAGE OF LIFE
(Strategic Imperative One)

HEALTHY START: BIRTH TO SIX

KEY ISSUES

- Death and disability from preventable injuries remain a concern for the area's children.
- Manchester and Manchester HSA mothers are more likely to be unmarried at the time of birth, have less than a high school education, and have smoked while pregnant compared to the rest of New Hampshire.
- A higher proportion of births in Manchester result in low-birth weight infants.
- Hospitalization for acute Ambulatory Care Sensitive Conditions for children from birth to age 4 in Manchester and the HSA is significantly greater than in the rest of the state.
- Many children in Manchester HSA are born into circumstances that adversely affect their health and development. For example, aging housing stock in the City is associated with high levels of lead exposure, and poverty is associated with higher levels of childhood anemia.

Overview

Promoting the health of young children before five years of age could save society up to $65 billion in future health care costs according to an examination of childhood health conducted by Johns Hopkins Bloomberg School of Public Health.[14] From this study it was determined that unintentional injury, tobacco exposure, obesity, and mental health contribute substantial burdens to the health of pre-school children and are precursors to a variety of health problems throughout the lifespan.

Demographics

Population of 0-5 year olds in HSA, 2000		
HSA Town	Number	Percent of town's population
Manchester	7,162	6.7%
Auburn	327	7.0%
Bedford	1,329	7.3%
Candia	265	6.8%
Deerfield	268	7.3%
Goffstown	895	6.5%
Hooksett	764	6.5%
New Boston	316	7.6%
Source: United States Census Bureau, 2000		

Population of 0-5 year olds in Manchester, 2007			
Age Groups	Number in 2007	Percent of Manchester population, 2007	Across NH, Percent of population, 2007
Under 3 years	4,830	4.4%	3.3%
3 and 4 years	3,994	3.7%	2.4%
5 years	1,189	1.1%	1.1%
All children 0-5	10,013	9.2%	6.8%
Source: American Community Survey 2007			

Current Health

Causes of Death

The leading causes of death for children 0-4 years of age in Manchester, the HSA, and New Hampshire from 2001 to 2006, are summarized below.[15]

- Perinatal conditions
- Congenital malformations, deformities and chromosomal abnormalities
- Unintentional injury (accidents)
- Cerebrovascular diseases
- Malignant neoplasms

The rate for each cause of death is not significantly different when comparing Manchester to the HSA or to the rest of New Hampshire from 2001 to 2006.

Low Birth Weight and Very Low Birth Weight

Infants born with a low birth weight (LBW) are at a higher risk of infant mortality and of long-term health issues than babies born at a normal weight.[16]

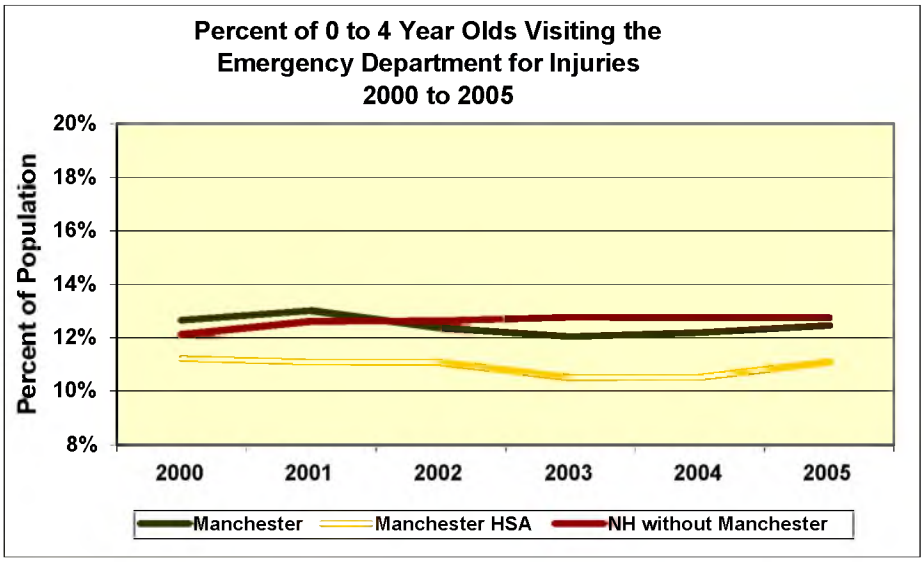
In the past decade some maternal and child health outcomes in Manchester have improved; however, there remains reason for concern regarding indicators associated with higher infant mortality such as low birth rate (LBW is <2500 grams or 5.5lbs) and very low birth weight (VLBW is <1500 grams or 3.3 lbs).[15] The Healthy People 2010 national target for LBW is no more than 5.0% of all births and for VLBW no more than 0.9% of all births.[17] Both the HSA and City of Manchester exceed these targets.

In the HSA in 2006, 305 births resulted in LBW or VLBW babies who were immediately at increased risk for poor health outcomes (see table on next page).

Low Birth Weight and Very Low Birth Weight Rates				
	Manchester 2006	Manchester HSA 2006	NH without Manchester 2006	Healthy People 2010 Target
Infant Mortality (rate/1,000)	1.9 (0.4-5.4)	1.3 (0.3-3.7)	1.7 (1.1-2.6)	4.5
Low Birth Weight	6.8%	5.8%	5.5%	5.0
Very Low Birth Weight	1.6%	1.6%	1%	0.9
Source: NH DHHS, Healthy People 2010				

Unintentional Injury - Accidents

Nationally, injuries and accidents cause the most disabilities and deaths among pediatric populations, affecting 20% to 25% of this age group annually. Infants have the second highest injury rate of all groups of children. Many injuries are preventable and are associated with the surrounding environment. Toddlers and preschoolers experience a large number of falls and poisonings as they are active and inquisitive and have not fully developed logic abilities.[18] The graph below depicts the percent of children from birth to four years from Manchester and Manchester HSA who went to the emergency department to be treated for injuries from 2000 to 2005.



Source: New Hampshire DHHS

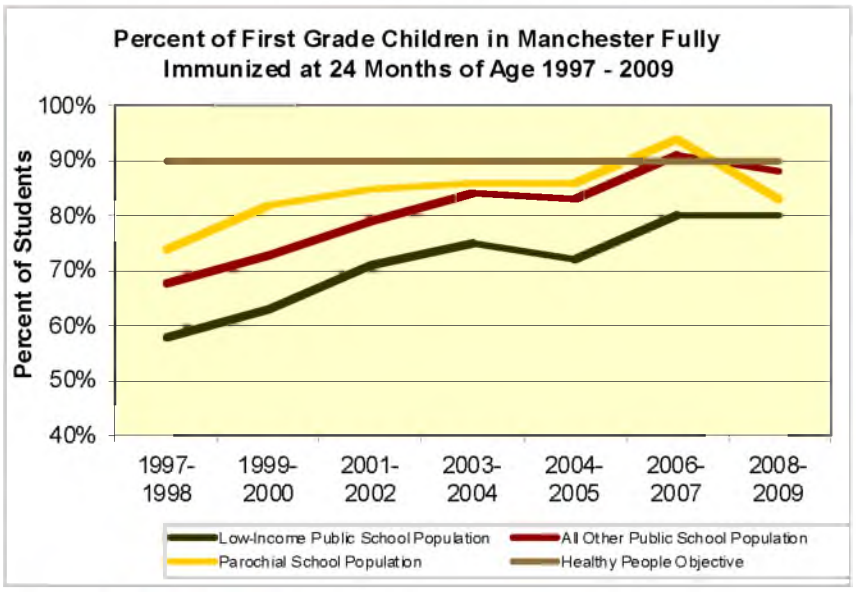
Trends in Emergency Department (ED) use for injury trends for this age group in the City of Manchester are similar to the rest of New Hampshire, but significantly higher than those of the HSA.[15]

Visits to an Emergency Department for Injuries among Children age 0 to 4 in 2005			
	# of ED Visits	% of children 0-4	95% C.I.
Manchester	846	12.5%	(11.7-13.2%)
Manchester HSA	1,207	11.0%	(10.4-11.6%)
Rest of NH	8,505	12.7%	(12.5-13.0%)
Source: Manchester Health Indicators, Hospitalization Data from Office of Health Statistics and Data Management, NH DHHS			

Access To Health Care Services

Access to Care

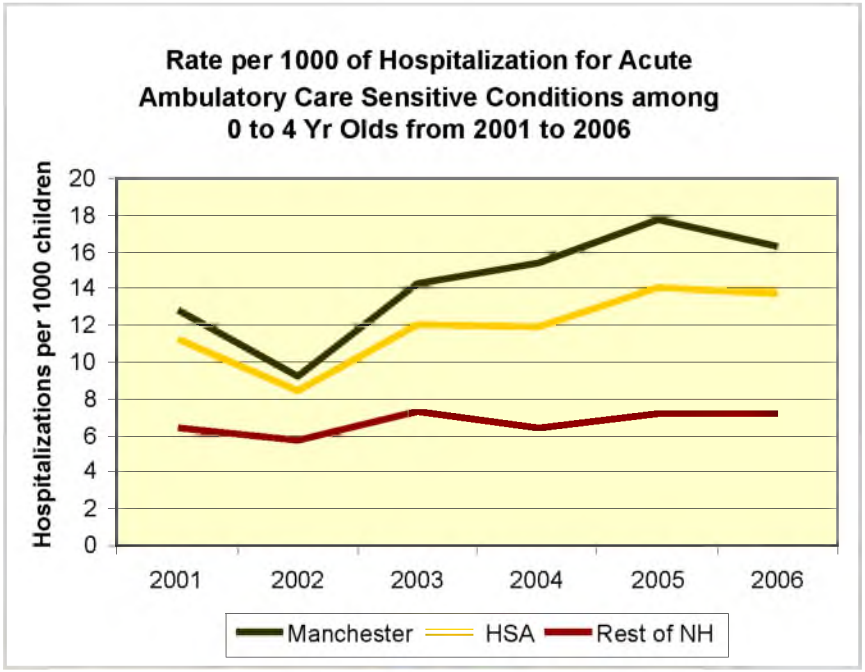
In order for children to achieve optimal health, they should have regular access to high-quality medical and oral health care including access to preventive health services such as immunizations and screening tests, as well as counseling designed to support change in the personal health behaviors of patients or families before clinical disease develops.[19]



Source: Manchester Health Department

Immunization is among public health's greatest achievements within the past century and remains the foremost weapon in the battle against vaccine-preventable diseases. The graph illustrates the percent of first grade children in Manchester who were fully immunized with the 4:3:1 series at 24 months of age from 1997-2009 (% immunized = DPT/DTaP 4, Polio 3, MMR 1). Concentration of need persists in some neighborhoods within the community. For example, the low-income public school population (Title I schools) in Manchester continue to have immunization rates below the Healthy People 2010 target of 90% coverage by age two.[20]

Ambulatory care sensitive conditions, such as diabetes and asthma, are conditions where appropriate outpatient care can prevent or reduce the need for admission to a hospital. A disproportionately high rate of such conditions has been associated with barriers to access to primary care.[21] Hospitalization of children from birth to age four in Manchester and the HSA for acute Ambulatory Care Sensitive Conditions is significantly greater than in the rest of the state.



Source: Office of Health Statistics and Data Management, NH DHHS

Risks To Future Health

Risk factors that can impede healthy childhood development include environmental and economic factors. Communication, collaboration and partnerships among multiple community systems are warranted to address the environmental health needs of children and families.[22]

Pregnancy Environment

Parents and care givers can help assure the health of their children by: (a) getting timely and appropriate prenatal care, (b) not smoking during pregnancy or around their children in their homes, and (c) creating a safe home environment.

Maternal and Infant Health Indicators, 2006

	Manchester	Manchester HSA	State of NH Without Manchester
Tobacco Use During Pregnancy	19.7%*	16.1%	17.5%
Late or No Prenatal Care	2.6%*	2.2%*	1.3%
First Trimester Prenatal Care received among all pregnant women	73%*	75%*	68%
White pregnant women	74%*	77%*	68%
Non-White pregnant women	67%	69%	66%

** Difference between Manchester and NH is statistically significant by z score*
Source: NH DHHS

The proportion of women who smoke during pregnancy in Manchester in 2006 (19.7%) was significantly higher than in the HSA (16.1%) or the rest of the state (17.5%). Women who smoke during birth are more likely to give birth prematurely, have complications in birth, and give birth to a low-birth weight baby.[23]

Compared to the rest of the state (2006), a significantly higher proportion of pregnant women in Manchester and its HSA received prenatal care within their first trimester of pregnancy (73% Manchester, 75% Manchester HSA, vs. 68% state without Manchester). It is important, however, to note that in both Manchester and the HSA a higher percentage of white women received first trimester care compared to non-white women.

During the same year a significantly higher proportion of Manchester and Manchester HSA pregnant women received prenatal care late in their pregnancies or not at all (Manchester 2.6%, n=42 ; Manchester HSA 2.2%, n=52) compared to the state (1.3%, n=170). Thus, of all the pregnant women in the state who received late or no prenatal care, 25% were from Manchester HSA.

Physical Environment and Safety

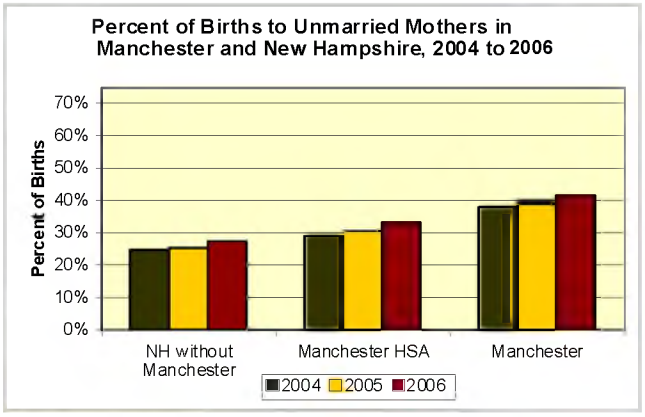
The City of Manchester was declared a high-risk community for lead poisoning due to the abundance of older housing stock with lead paint. Approximately 43.8% (2007) of Manchester's housing was built prior to 1950.[24] Based on the City's high-lead risk designation, a universal screening approach is recommended (i.e., all one and two year old children are screened for high lead levels). Since 2000, a total of 19,602 children under age six have been screened for blood lead and 583 children have been identified as having an elevated blood lead level $\geq$ 10 ug/dl.

Blood Lead Screening and Elevated Blood Lead among Children Under 6 in Manchester and New Hampshire, 2008			
	Number of Children Screened for Blood Lead	Number of Children with New Confirmed Elevated Blood Lead (>=10 ug/dL)	Confirmed Elevations/Total Children Screened
Manchester	2,524	49	1.9%
New Hampshire	15,545	140	0.9%
Source: New Hampshire Childhood Lead Poisoning and Prevention Program.			

Lead poisoning can have broad affects on children including intellectual and behavioral deficits.[25] The table below outlines blood lead screening data from 2006 to 2008 within the City of Manchester.

2006-2008 Blood Lead Screening: Blood Lead Levels and Elevated Blood Lead among Children Screened					
Town	Pre-1950 Housing %	Age Group (months)	2006	2007	2008
Manchester	43.8%	12-23 screening	77.5%	75.1%	73.6%
		24-35 screening	38.6%	52.1%	45.9%
		12-35 elevations	**2.7%**	**2.0%**	**1.9%**
Source: NH Childhood Lead Poisoning Prevention Program, 2008					

Family and Social Environment

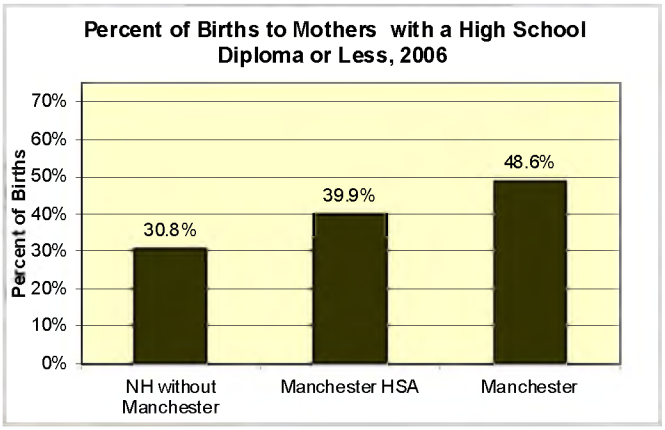


Source: NH DHHS

Family structure may influence early child well-being. For example, children in households with single parents are at higher risk of disadvantages, such as living in a household with food insecurity.[26] Single-parent households may have lower incomes, and in turn may experience challenges accessing medical and oral health care, including routine preventive care. Since 2001, increasing numbers of children in the HSA and City have been born to unmarried mothers.

Education

The first years of life are considered the most important for cultivating the foundation for success throughout the life span. Children are learning from the time of birth and they thrive on stable and nurturing relationships, which encourage their curiosity and learning potential. Children flourish when their care providers are learners themselves.[27] A measure of maternal education may be a predictor of a parents' ability to encourage children to grow and learn. The percent of births to mothers with a high school diploma or less has been consistently higher in Manchester than the HSA and the rest of the state since 2000.[15]



Source: NH DHHS

Poverty

Children who live in poverty may achieve lower levels of education, be less likely to be gainfully employed, and will have an increased chance of living in or near poverty.[28] The percent of Manchester families with children living below 100% of poverty has risen significantly over the past two decades. Among Manchester children for whom poverty information can be calculated, approximately 30% of children 0-6 years of age are living at 100% of poverty. Approximately 42% of children 0-6 years of age are living at or below 185% of poverty.[8] The tables below provide important data about family poverty for the years 1990, 2000, and 2007 for Manchester, Manchester HSA towns, and New Hampshire.

Manchester Families Living Below 100% of Poverty			
	1990 U.S. Census	2000 U.S. Census	2007 American Community Survey
Families with Related Children Under 18 Years	9.9%	12.3%	20.2%
Families with Related Children Under 5 Years	14.3%	17.2%	25.5%
All People under 18 Years	12.6%	15.0%	24.9%
Source: American Community Survey 2007, Census 2000, Census 1990			

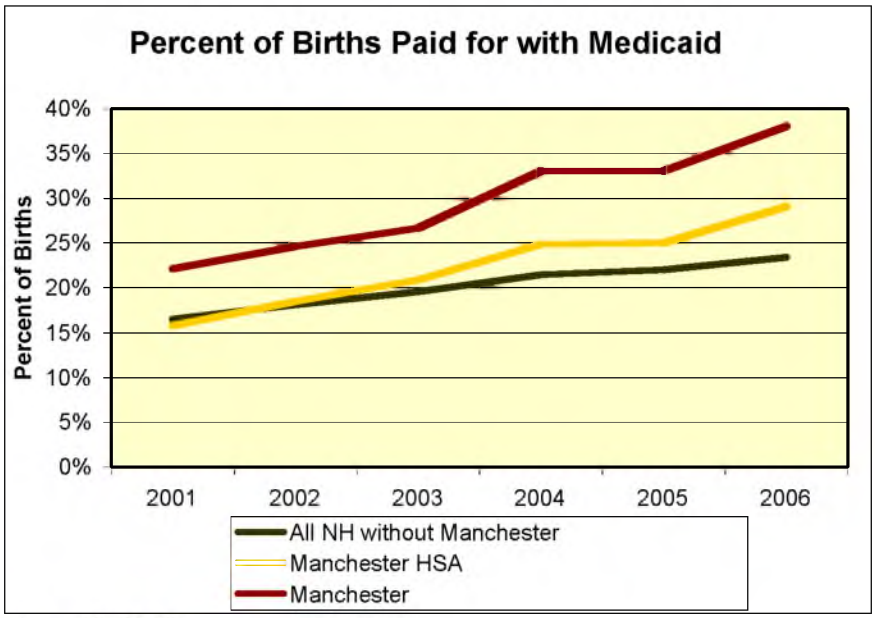
New Hampshire Families Living Below 100% of Poverty			
	1990 U.S. Census	2000 U.S. Census	2007 American Community Survey
Families with Related Children Under 18 Years	3.2%	6.5%	7.5%
Families with Related Children Under 5 Years	1.8%	8.9%	7.9%
All People under 18 Years	1.8%	7.3%	8.8%
Source: American Community Survey 2007, Census 2000, Census 1990			

Families Living Below 100% of Poverty in the Health Service Area, 1999								
	Bedford	Goffstown	Manchester	New Boston	Hooksett	Auburn	Candia	Deerfield
Families with Related Children Under 18 Years	1.8%	3.7%	12.3%	4.3%	4.6%	0.7%	1.6%	1.0%
Families with Related Children Under 5 Years	0.0%	4.9%	17.2%	2.7%	4.5%	1.5%	1.9%	0.0%
All People under 18 Years	1.9%	3.3%	15.0%	5.7%	6.0%	70.0%	2.3%	1.0%
Source: Census 2000								

Public Assistance Program in Support of Children and Families

Federally-funded health and social service programs have been established to address the health, educational and nutritional needs of low income young children. For pregnant women and children Medicaid is a needs-based health insurance program. Head Start is a successful, national school readiness program which has operated since 1965. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals and nutrition education.

Women who are eligible for Medicaid insurance during their pregnancy and delivery must have incomes below 185% of Federal Poverty guidelines. Thus, the number of Medicaid funded births provides a partial estimate of the number of children born into poverty. The graph indicates that the percentage of births paid for by Medicaid in Manchester has exceeded those in the HSA and the rest of New Hampshire since 2001. As of 2006, close to 40% of the births in Manchester City, 29% in the HSA, and 23% in the state were paid for by Medicaid.[15]



Source: NH DHHS

Head Start is a successful, national school readiness program which has operated since 1965. The Head Start Program in the City of Manchester has three centers in the area, with approximately 156 children enrolled at any one time during the year. As of April 2009, approximately 63 children were on the waiting list.[29]

From 2006 to 2008, there were 5,415 Manchester children (unduplicated count) ages six months to four years enrolled in WIC. Across the state, anemia has been reported as a major issue for children enrolled in the WIC program. Almost 23 % of all Manchester WIC enrolled children age six months to four years were anemic compared to about 11% of WIC enrolled children statewide. Thirty-one percent of black WIC enrollees and 16% of Hispanic enrollees in New Hampshire were anemic. The state WIC program attributes these numbers to slow introduction of solid foods, low protein and longer reliance on milk.[30] Children who participate in the WIC Program have better linkages to the health care system and are more likely to receive both preventative and curative care than children who were not enrolled in WIC.[31]

Focus Group Participants Weigh In: Healthy Start—Birth To Six

Several of the focus groups conducted included participants who were caregivers of young children, newborns or pregnant mothers. Many of these participants described barriers to obtaining health care for themselves and their children. Issues discussed included the high cost of health insurance; long waits for some health care providers; inability to access appointments to health care providers on weekends, evenings or early mornings; and inability to access to oral health care.

"When I was pregnant with my second child, Planned Parenthood gave me a list of providers to call. Out of seven doctors, only two had space for Medicaid patients. I did not get my doctor until I was close to three months pregnant. Things that happened in the first months of pregnancy really make a difference in the pregnancy. I had morning sickness and felt tired and wished I had the comfort of a doctor. I feel I would have had an easier time getting a doctor if I had private insurance."

KEY ISSUES REPORTED BY PARTICIPANTS:

- Although they were able to schedule medical appointments easily, the appointments were months away.
- The high turnover rates among primary care practices created barriers to building a relationship with a provider.
- The quality of the prenatal care received was excellent, but for those without insurance it was more difficult to access the care needed.
- Coordinating care and financial services and billing issues between providers and insurance companies is very difficult.
- It has been difficult to secure appropriate equipment necessary to care for a child who is diagnosed with a severe chronic disease.

Data Snapshot: Healthy Start—Birth To Six

HEALTHY START (0-6 YEARS) INDICATORS				
	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Family and Social				
Percent of births to mothers who are unmarried, 2006, NH DHHS Birth Data	41.7% * (n=673)	33.5%* (n=775)	27.7% (n=3,510)	na
Percent of births to mothers who used tobacco during pregnancy, 2006, NH DHHS Birth Data	19.7% (n=317)	16.1% (n=373)	17.5% (n=2,218)	1.0%
Number of child care slots, 2009, Easter Seals, NH Bureau of Child Care Licensing	4,562	na	44,120	na
Percent of children ages 0-5 years from whom parents report difficulty finding adequate child care	developmental			
Ratio of founded cases of child maltreatment to total assessed cases, 2008, Division of Children, Youth, and Families, NH DHHS	61:932	na	missing	na
Domestic violence before or during pregnancy	developmental			
Percent of children ages 0-5 whose parents say it is very or somewhat easy to find someone to talk to when they need advice about raising their child	developmental			
Economic Circumstances				
Percent children under 5 years who in the past 12 months live below the poverty level, 2007, American Community Survey	25.1%*	na	10.4%	na
Percent of mothers who use Medicaid to pay for birth, 2006, NH DHHS Birth Data	38%* (n=613)	29%* (n=677)	23% (n=2,968)	na
Head Start enrollment, 2007-2008, Southern NH Services, Head Start-State Collaboration Office	156	na	1,961 all NH	na
Average number of WIC participants per month in 2008, NH DHHS	4,014	na	17,906 all NH	na
Education				
Percent of births to mothers with a high school diploma or less, 2006, NHDHHS Birth Data	48.6%* (n=784)	40.3%* (n=931)	30.8% (n=3,912)	na
Percent of children under age 6 who are read to daily by a parent or family member	developmental			
Physical Environment				
Number of children under age 6 who were found to have elevated blood lead levels(>10ug/dL), 2008, Manchester Health Dept, NH DHHS	49	na	91	na
Percent of housing built before 1950, 2000, Census	43.8%*	na	28.8% all NH	na
Percent of children age 0-4 visiting emergency departments for injuries, 2005, NH DHHS Hospitalization Data	12.5% (n=846)	11.05% (n=1207)	12.7% (n=8505)	na
Hours per week of television exposure	developmental			
Behavior				
Proportions of children over two who consume at least two servings of fruit daily	developmental			75%
Proportions of children over two who consume at least three servings of vegetables daily, with at least one-third being dark green or orange vegetables	developmental			50%
Nutritional intake during pregnancy	developmental			

HEALTHY START (0-6 YEARS) INDICATORS				
	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Health				
Life expectancy ay birth	developmental			
Rate of birth defects	developmental			
Percent of first grade students screened whose BMI was greater than or equal to the 95th percentile, considered obese, 2008-2009 SY, Manchester Health Dept	13.40%	na	na	na
Percent of all births that are low birth weight or very low birth weight, 2006, NHDHHS Birth Data	8.3% (n=134)	7.4% (n=171)	6.6% (n=832)	5.0 for lbw, 0.9 for vlbw
Top 5 leading causes of death children 0-4 yrs old, 2001-2006, NH DHHS Death Data	Perinatal conditions; Congenital malformations, deformations and chromosomal abnormality; Accidents; Cerebrovascular diseases; Malignant neoplasms			na
Access				
Percent of births to mothers who obtained late or no prenatal care, 2006, NHDHHS Birth Data	3% (n=42)	2% (n=52)	1% (n=170)	10%
Proportion of 2-yr-old children who have received all age-appropriate vaccines, as recommended by the Advisory Committee on Immunization Practices (4DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B, 1 varicella), 2006-2007, Manchester Health Dept	80%	na	88.7% all NH	90%
Rate of hospitalization for acute Ambulatory Care Sensitive Conditions per 1,000 0-4 yr old children, 2006, NH DHHS Hospitalization Data	16.2 * (n=110)	13.8 (n=151)	7.1 (n=478)	na
Percent of children under age 6 with confirmed elevated blood lead (>10mcg/dL) per children screened for lead poisoning, 2008, Manchester Health Dept	1.9%	na	0.9% all NH	na
Participation in Early Periodic Screening, Diagnosis, and Treatment (EPSDT) as percent of children eligible	developmental			
Percent of children under age seven who have undergone a psychosocial behavior assessment	developmental			
Percent of children under age seven who have a primary care provider	developmental			
Percent of children under age seven who have a dental home	developmental			
** Significantly different from the rest of New Hampshire excluding Manchester*				

HEALTHY YOUTH: AGE 7-17

KEY ISSUES

- Nearly half of all households with children in Manchester have only one parent. A growing number of households with children are struggling financially and are seeking forms of assistance.
- Area youth face an array of challenges related to drug use, neighborhood violence, and educational achievement.
- Community support to improve youth behaviors associated with healthy living including healthy eating, increased exercise, and decreased screen time should be enhanced.
- Risky behaviors put area youth at risk for teen pregnancy and sexually transmitted diseases; for example, the rate of chlamydia infection among Manchester teens is more than twice that of the rest of the state.
- Access to oral health care has improved for youth in Manchester, but some youth still do not have a dentist or dental insurance.
- Mental health issues are a concern for Manchester youth. For example, 7.5% of Manchester teens reported they attempted suicide within the last year (2007).

OVERVIEW

Today's youth are tomorrow's leaders. They are also our future parents, consumers and workforce and are a vital component of our community. The current health of school age children has effects that reach far into adulthood, and is an important determinant of individual opportunity and social equity.[32]

The journey from childhood through adolescence is filled with opportunities and challenges. Youth are bombarded with choices that affect their health on a daily basis. Adolescents are particularly prone toward risk-taking behaviors and may not always have family-based role models to guide them. Since many health behaviors are learned and established during the critical time of childhood and adolescence, community support (funding and programmatic) for education, program development, and environmental security should be heavily weighted to support this young population.

Manchester's School Nurses *described "Healthy Youth" as a scenario in which youth have good nutrition, exercise, hygiene, sleep, access to health care, a family support system, a home, opportunity to play, safety, good education, and self esteem. They would also not experience violence or abuse, and would avoid risky behaviors.*

Demographics

In 2000 (the most recent year for which Census data exist for the surrounding Manchester HSA towns) 20% of the population of these towns was made up of 5 to 17 years old (12,500 children) compared to 17% of the Manchester City population. In 2007, 14,478 children ages 6 to 17 make up more than 13% of the total City population (2007).[8]

Population of 5-17 year olds, 2000		
Towns	Number in 2000	% of town population
Manchester	18,196	17.0%
Auburn	1,028	22.0%
Bedford	3,892	21.3%
Candia	777	19.9%
Deerfield	834	22.7%
Goffstown	2,942	17.4%
Hooksett	2,085	17.8%
New Boston	942	22.8%
Source: United States Census Bureau, 2000		

Population of 6-17 year olds, 2007			
In Manchester	Number in 2007	Percent of Manchester population, 2007	Across New Hampshire, Percent of population, 2007
6 to 8 years	3,751	3.4%	3.8%
9 to 11 years	2,685	2.5%	3.6%
12 to 14 years	4,306	4.0%	4.1%
15 to 17 years	3,737	3.4%	4.4%
Total 6 to 17	14,478	13.3%	15.8%
Source: American Community Survey, 2007			

Current Health

The most common causes of death among youth ages 5 to 17 in New Hampshire are as follows;[33]

- Accidents
- Malignant neoplasms
- Perinatal conditions
- Intentional self-harm
- Congenital malformations, deformations and chromosomal abnormalities

For the most part, the rate of death from each of these causes does not differ significantly between Manchester, the HSA or the state. Death among youth ages 5 to 17 years is rare. Accidents or unintentional injury, which may result from an unsafe physical environment, are the leading cause of death among Manchester children ages 5 to 17. The tragedy of these deaths is that in many instances they are preventable. In the HSA, 8.6% of youth ages 5 to 17 were seen in emergency rooms for unintentional injuries, not counting motor vehicle accidents, while in the rest of New Hampshire, approximately 12% of youth were seen.[34] Males are seen more often than females.[15] Nationally, the most common cause of nonfatal unintentional injuries among children is falls followed by being struck by or against an object.

The most common reasons children ages 5 to 17 in Manchester, the HSA, and the state are hospitalized are for:[34]

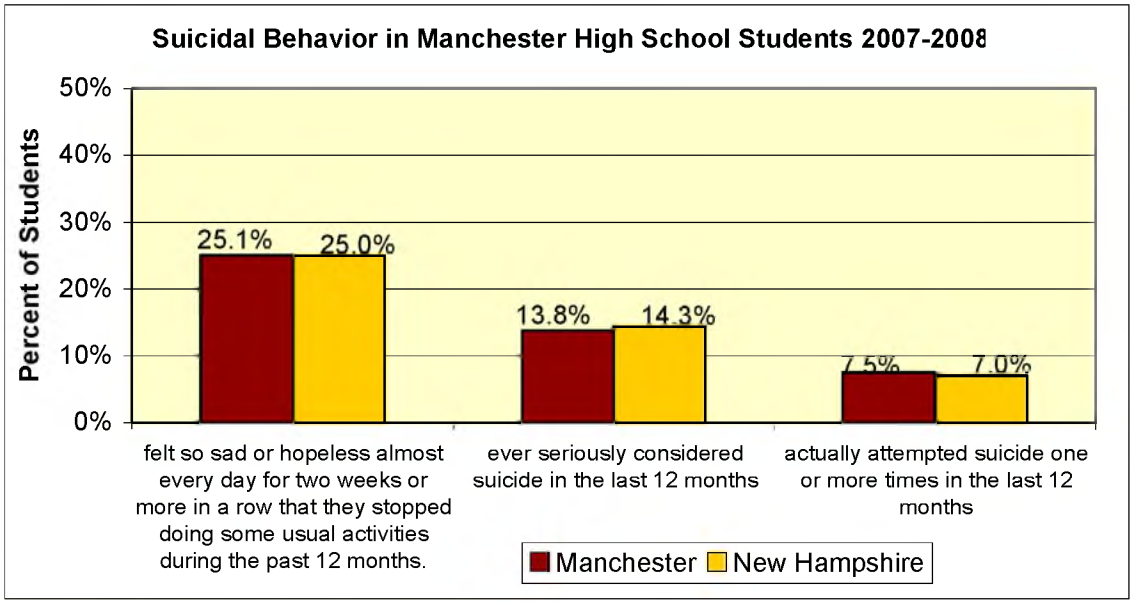
- Acute appendicitis
- Asthma
- Diabetes
- Mood disorders
- Pneumonia

Of the 15,807 students in the Manchester school system in the 2008-2009 school year, 8.5% were listed on school medical alerts lists for asthma.[35] Youth age 5 to 17 years are hospitalized for asthma at a rate of less than 1 per 1,000 in Manchester, the HSA, and the rest of the state. More boys are hospitalized for asthma than girls.[36]

Historically, Type II Diabetes (often a preventable condition) was not a childhood problem and was seen very rarely in children and adolescents. The current higher prevalence of diabetic rates among youth are thought to be associated with increased overweight and obesity and decreased physical activity as shown below:[35]

- Of all first grade children screened at schools in Manchester in 2009, 13.4% of them were identified as meeting the definition of "obese".[35] The Healthy People 2010 goal is 5%.[35]
- More than half (54.5%) of Manchester's high school students reported not getting the recommended amount of physical activity.[37]

Mental health is a significant component of our youths' overall health status. The chart below describes several aspects of mental health in the youth population in Manchester and the state that are concerning to health and public health officials.



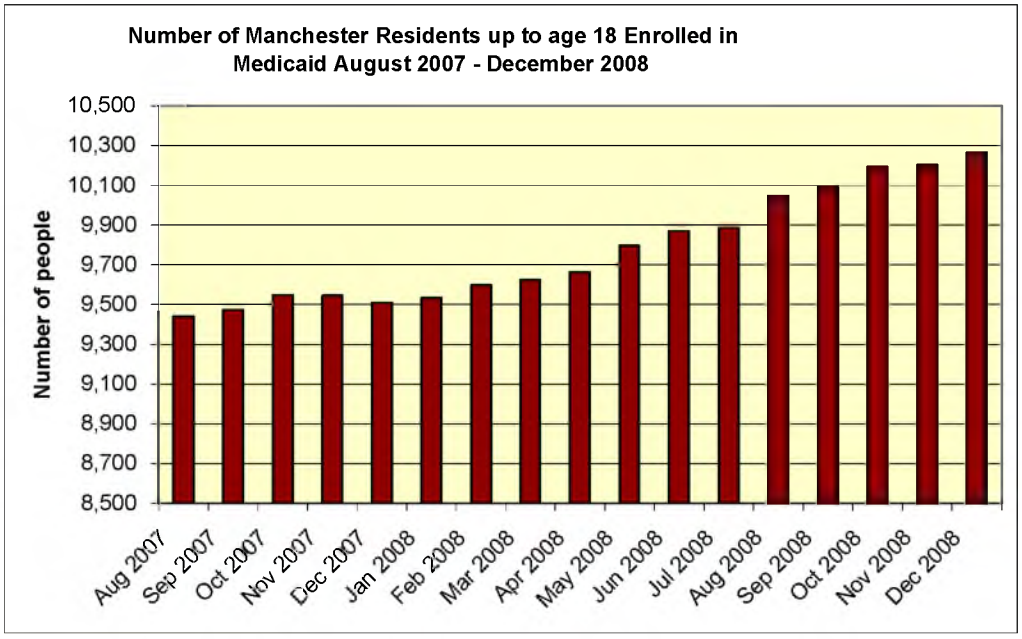
Source: NH Youth Risk Behavior Surveillance System, 2007

In the 2007–2008 Youth Risk Behavior Surveillance System Survey over 25% of Manchester high school students reported that during the past twelve months they had (almost every day for two weeks or more) felt so sad or hopeless that it affected their everyday activities. Also concerning is that approximately 7.5% of Manchester students reported attempting suicide one or more times in the past year. This is much higher than the national Healthy People 2010 benchmark of 1.0%.[37] Data for these measures are unavailable for the other HSA towns.

Access To Healthcare Services

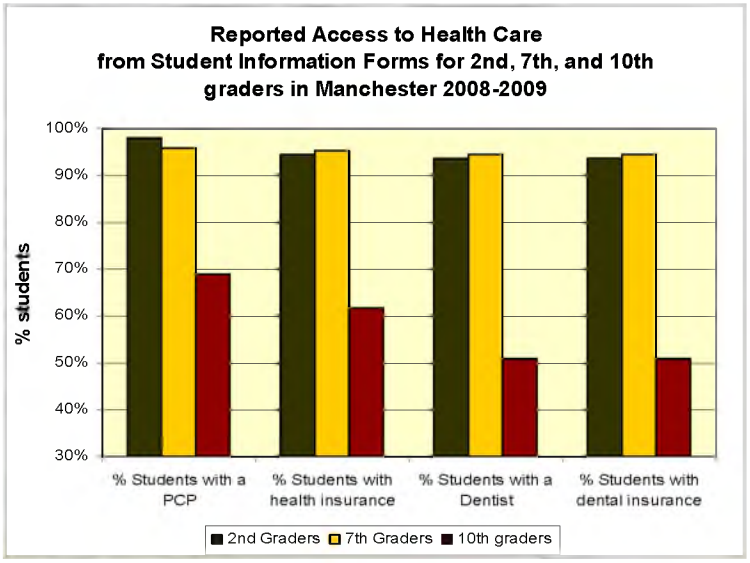
Access to health care is an important predictor of a child's overall health status. Youth need regular contact with a primary care provider in order to get appropriate health information, regular preventive check-ups, and for management of any health conditions.

The state has made it affordable for families to purchase health insurance for their children through its Medicaid program. The number of Manchester youth who are enrolled in Medicaid health insurance has increased over the last two years.[38] However, the lower provider reimbursement rate of New Hampshire Medicaid is an increasingly common barrier to becoming a patient of a defined medical practice and obtaining a regular source of health care.



Source: NHDHHS Medicaid Office

Most of Manchester's second and seventh grade school children (98% and 96%) reported having a primary care provider (PCP) on school health information forms; however this number dropped to 69% among tenth graders.



Source: Manchester Health Department

Fewer children in each of these three grades reported having a dentist.[35] However, since the beginning of the 2008-2009 school year Manchester children have had increased access to oral health services. Dental staff from the Manchester Health Department and Easter Seals New Hampshire provided full dental care (diagnostic, preventive and limited restorative care) to 414 elementary and middle school students (2008-09) and will continue to expand these services. Students are referred to dental services at Catholic Medical Center Poisson Dental Facility or Easter Seals Dental Center.[39] *

Insurance status among students differs by race and ethnicity. Latino first graders were the most likely to be uninsured (29.6%) or not have a primary care provider (29.5%), and White, non-Hispanic first graders were the least likely to be uninsured (9.7%) or have no primary care provider (6.5%) as evidenced by 2004 local school data. Both Black and Latino children surveyed indicated higher percentages having no primary care physician compared to White, non-Hispanic children.[40]

Risks To Future Health

Health Behaviors

Behavior is linked to health at all points in the lifespan, but nowhere is the relationship more profound than during childhood and adolescence. Many health behaviors are adopted at young ages, and these behaviors often persist through adulthood. For example, it is well-established that early smoking initiation predicts longer duration of smoking, heavier daily consumption, and increased chances of nicotine dependence.[41-45] Approximately 80% of adults who currently use tobacco started smoking before age 18. Youth make behavioral choices that affect their health on a daily basis, from the nature of their relationships, to what they consume, to how much they use a computer or cell phone. The table below describes the changes in health risk behaviors from 2005-2007 as reported by the Youth Risk Behavioral Survey (YRBS).

Health Risk Behaviors

	Manchester 2005	Manchester 2007	Change
Physical Activity. Percentage of students who were physically active for a total of 60 minutes or more per day on five or more of the past seven days.	32.3	45.5	↑
Binge Drinking. Percentage of students who had 5 or more drinks of alcohol in a row, that is, within a couple of hours on one or more of the past 30 days.	25.8	26.7	□
Drug use. Percentage of students who used marijuana one or more times during the past 30 days.	23.1	23.3	□
Smoking. Percentage of students who smoked cigarettes on one or more of the past 30 days.	19.8	16.6	↓
Sexual Activity. Percentage of students who have ever had sexual intercourse.	41.6	44.5	↑
Safety Devices. Percentage of students who never or rarely wore a seat belt when riding in a car driven by someone else.	14.2	13.5	□

◆=health-encouraging change in behavior; ◆=risky change in behavior; □ =no significant change in behavior

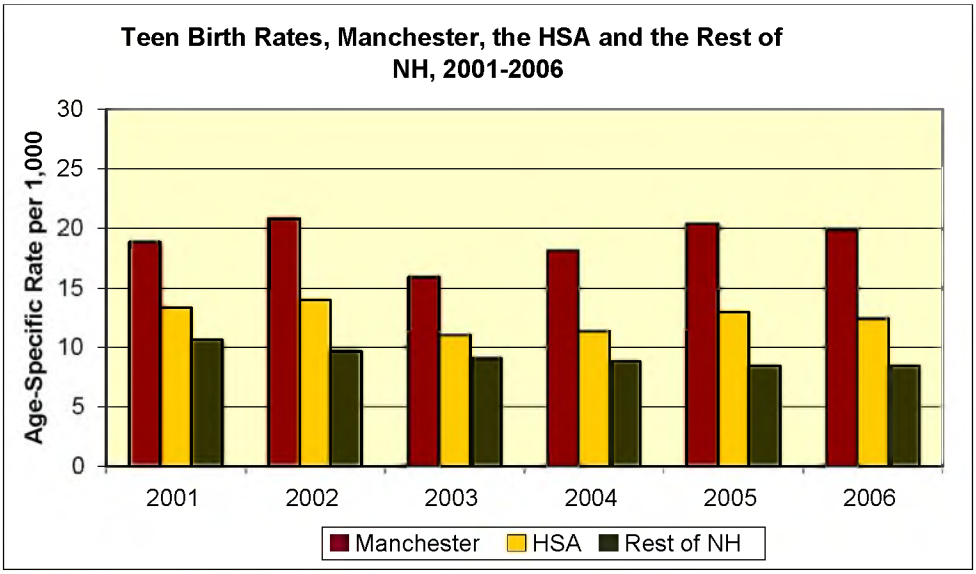
Source: Manchester Youth Risk Behavior Surveillance System (YRBSS), 2007

* *Made possible by the donation by the Kiwanis of a mobile dental van (1999), on-going funding from the NH School-Based Oral Health Program and recent funding from The Manchester Sustainable Access Project.*

Children and adolescents are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol.

- Approximately 27% of Manchester high school students surveyed reported binge drinking (having five or more drinks of alcohol in a row, within a couple of hours) in the last month, a markedly higher percentage than the Healthy People 2010 goal of 2%.
- Manchester's students are engaging in sexual activity and are at risk for teenage pregnancy and sexually transmitted diseases.
- Almost half of Manchester's high school students reported having had sexual intercourse and 38% of those who had sex in the past three months did not use a condom.[37]
- 135 babies (about 9% of all births in the City) were born to teen mothers in 2006.[15]
- 1,628 per 100,000 Manchester teens (more than one in a hundred) were infected with Chlamydia in 2008. In the HSA, 1,027 per 100,000 teens; and in the rest of New Hampshire 583 per 100,000 teens; were infected with Chlamydia. Manchester City and Manchester HSA rates are significantly higher than the rest of New Hampshire.[46]

In Manchester City, the rate of teen births remained significantly higher compared to Manchester HSA and the state (2001-2006). It is important to note, that within the higher City rate of teen births, there is a great disparity in rates across Census Tracts. Cumulative birth data from 1999 to 2003 showed that in Census Tracts 15 and 13 (located in Manchester's Center City) 21.1% and 17.3% of births were to teens; while in the rest of the City 8.6% of births were to teens.[47]



Source: NH DHHS

Physical Environment/Safety

Risks to youth health and well-being may be connected to violence. Youth who exhibit consistent violent behavior are more likely than their nonviolent peers to have other problems such as substance use, early pregnancy, academic problems, and poor mental health.[48] Frequent violent television viewing by children has been associated with aggressive behavior in longitudinal research.[18] Hitting, kicking, stabbing and shooting are seen daily as ways to deal with anger and frustration. "Screen time"

also reduces time spent engaging in family activities, interacting with peers and engaging in physical activity.

- In 2007, 28% of Manchester's high school students reported being in one or more physical fights.[37]
- 113 simple assaults and two aggravated assaults among school age youth in Manchester were recorded by police.[49]
- Police recorded six counts of forcible rape, 18 counts of weapons possession, and 31 counts of disorderly conduct committed by youth age 11 to 17 in Manchester in 2008.[49]

Family and Social Environment

As youth grow and develop, they are very susceptible to the influences of their family and social surroundings. Their families and relationships with other adults and peers are important aspects of determining health outcomes, both immediate and long term.

Some research has shown that social belonging or social "connectedness" is a vital concept that relates to children's health, both in prevention and treatment. It has been suggested that if a child has a strong feeling of connection to family and school, it is a protective factor against certain risk behaviors, such as promiscuity or substance abuse.[50-52] About one-third of Manchester's high school students spend time in extra-curricular (non-sports) activities. Even more impressive is that 40% of high school students feel that they "matter" to their community.[37]

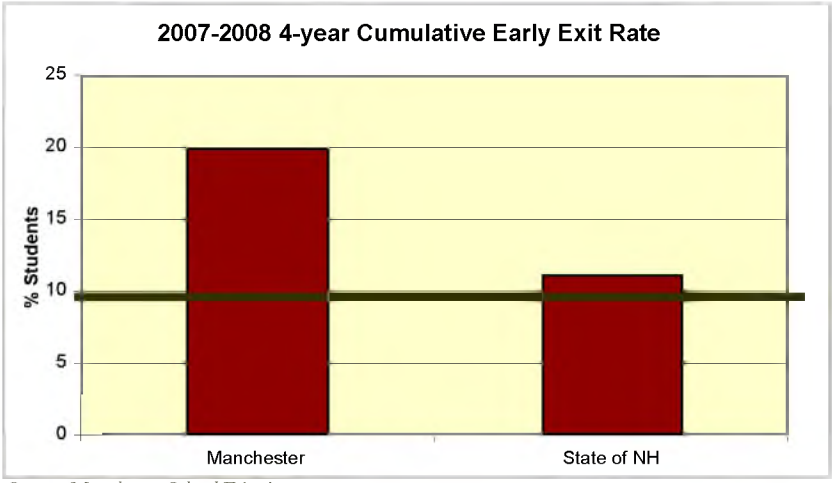
Community Connections

	Manchester 2007	NH 2007
Students who during an average week spend 1+ hours in clubs or organizations (non-sports) outside of school.	27.7%	27.4%
Students who agree or strongly agree that they feel like they matter to people in their community.	39.5%	39.1%
Students who performed any kind of community service as a volunteer in the last 30 days.	38.0%	40.6%
Source: NH Youth Risk Behavior Surveillance System, 2007		

Other aspects of the family and social environment that are a part of the health-determining context surrounding the youth population in Manchester include:

- household makeup - forty-five percent of the 13,332 households with children under 18 in Manchester were single-parent households; 53% were two-parent households (2007);[8]
- child maltreatment - sixty-one founded cases of child abuse or neglect were identified in Manchester (2008);[53] and
- foster care - in Manchester, the number of children needing foster care placement has been declining as a proportion of reported cases. For example, foster care placement declined from 164 in 2007 to 138 in 2008.[53]

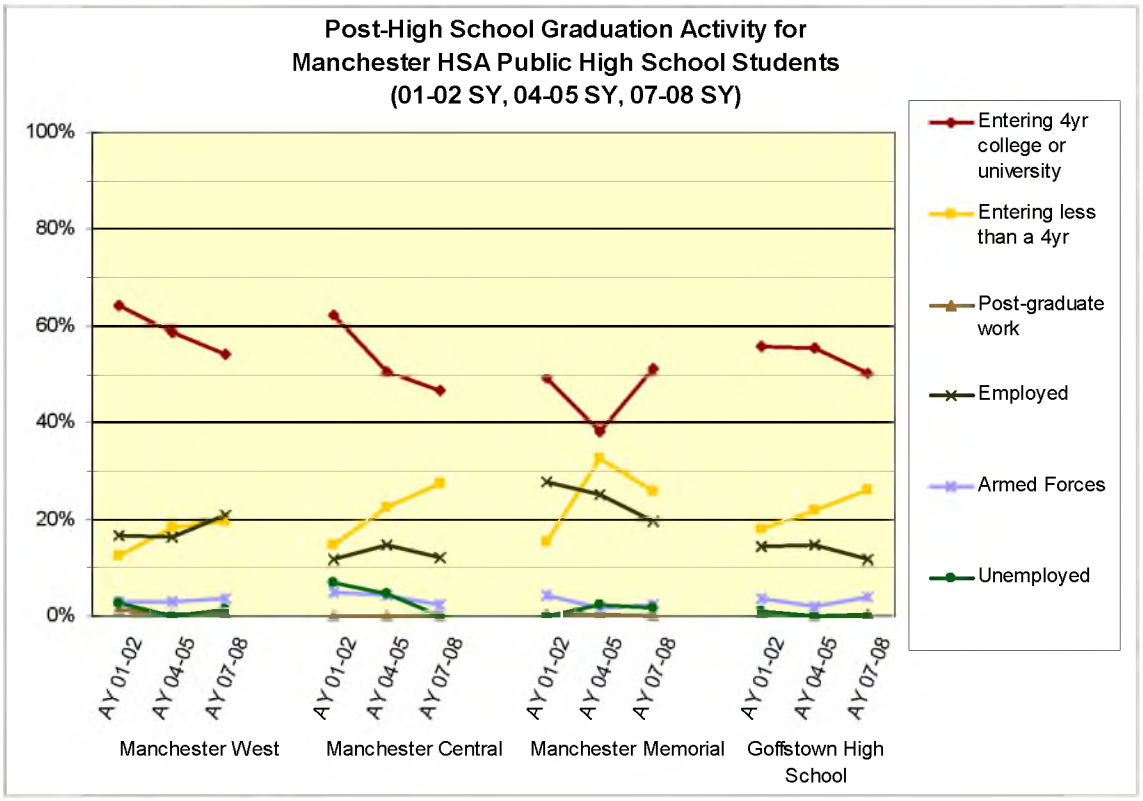
EDUCATION



Source: Manchester School District

For youth, academics and health are closely related—a child's health status can directly affect his or her academic success. Concurrently, educational achievement and the school environment can influence a child's health. Data from the 2003 National Youth Risk Behavior Survey (YRBS) demonstrate "a negative association between health-risk behaviors and academic achievement among high school students after accounting for the effects of sex, race and ethnicity and grade level. This means that as risky behaviors increase, academic achievement goes down."[54] Manchester's youth have had a noticeably higher high school dropout rate when compared to their counterparts in the rest of New Hampshire (20% Manchester vs. 11% state, 2007-2008).[55] Because of the important link between education and health status, the Centers for Disease Control (CDC) have outlined a goal to increase high school completion to at least 90%.

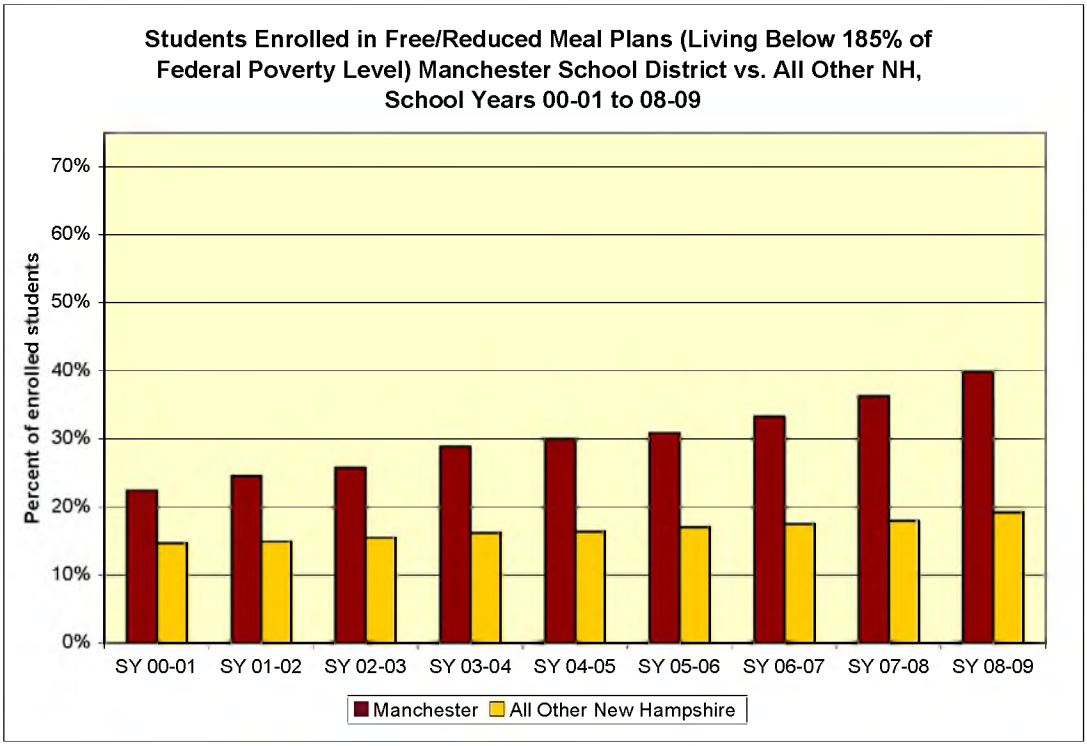
School absenteeism is also associated with participation in a variety of risk behaviors, including alcohol use, tobacco use, other drug use and risky sexual behaviors.[56] Manchester's absenteeism rate (approximately 8%) was similar to the national average (9%) for the 2007-2008 school year.



Source: NH Department of Education

Economic Circumstances

Poverty is a significant determinant of health and can affect children's health throughout their development. Low socioeconomic status for youth is associated with higher hospital admission rates, lower utilization of preventive services, and higher rates of chronic disease.[57-59] In 2007 approximately 35.6% of Manchester's school-aged children (ages 6 to 17) were living at or below 185% of Federal Poverty Level.



Source: Manchester School District

As of February 2009, approximately 50% (n=6,658) of Manchester's elementary school population was enrolled in the Free and Reduced Meal Program, which has income eligibility guidelines for children who live at certain income levels. The enrollment numbers for this program are steadily creeping upward, indicating a growing impoverished youth population.[60] Medicaid enrollment for children is also steadily increasing, with over 10,000 Manchester children enrolled in Medicaid as of August 2008.[38]

Focus Group Participants Weigh In: Healthy Youth—Age 7-17

Teens who participated in our focus group discussion were concerned about their own safety, the economy, and being able to afford healthy lifestyle choices.

- Most of the participants stated that they are concerned about drugs and crime in Manchester. Many of the teens interviewed live in older, multi-family apartments with vacant abutting properties due to foreclosures. The vacant housing attracts vandals and criminal activity.
- Since these teens don't have cars, their only mode of transportation is walking and they stated that they are often exposed to deviant behavior as they move from one location (example home) to the next (example school). *"I do not feel safe walking the streets so I pretend to be on my cell or sometimes I carry a knife."*
- Teen participants were concerned with the culture of their schools which they felt promoted drug use and promiscuity. They wished there were more programs to help kids avoid engaging in these behaviors.
- Of great concern to this age group is the economy. Many of the teens interviewed are supporting themselves and are having trouble finding jobs or other means of financial assistance.
- Healthy eating and exercise was not discussed at great length, but when asked, the teen participants stated that they are not satisfied with what the schools are doing to promote healthy eating and exercise as many of the options are too expensive.

Data Snapshot: Healthy Youth—Age 7-17

HEALTHY YOUTH INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER
Family and Social			
Of all households with children under 18 years of age, the percent that have married couple parents, 2007, American Community Survey	53.0%* (n=7,060)	na	71.8% (n=119,488)
Number of children in founded assessments of child maltreatment managed by DCYF in 2008, Division of Children, Youth, and Families, NH DHHS	184	na	1,681
Percent of students who during an average week spend one or more hours in clubs or organizations (other than sports) outside of school, 2007, Youth Risk Behavior Surveillance System	27.7%	na	27.4% all NH
Percent of students who agree or strongly agree that they feel like they matter to people in their community, 2007, Youth Risk Behavior Surveillance System	39.5%	na	39.1% all NH
Cell phone and smart phone use among youth	developmental		
Participation in after school programs among youth	developmental		
Number of youth on probation	developmental		
Percent of youth age 16 to 19 who are not in school and unemployed	developmental		
Economic Circumstances			
Number and proportion of all youth in schools enrolled in free/reduced meals, 2008-2009, NH Dept of Education	39.9%* (n=5,900)	27.2%* (n=6,740)	19.2% (n=32,403)
Number of active homeless students attending school, 2007-2008 SY, Manchester School Dist, NH Dept of Education	411	na	1,676
Percent of youths under 18 years living at or below the poverty level in the last 12 months, 2007, American Community Survey	24.9%*	na	8.8% all NH
Percent of youth age 16 or older who are employed	developmental		
Education			
Rate of absenteeism	developmental		
Four year cumulative rate of students who were counted as early-exit non-graduates in high schools, 2007-2008, NH Dept of Education	20.0%*	na	11.3% all NH
Percent of graduates entering post-secondary study at 2- or 4-year colleges or universities, 2008, NH Dept of Education	74.7%	na	73% all NH
Physical Environment			
Percent of high school students who play video or computer games or use a computer for something that is not school work for 3 or more hours on an average school day. 2007, Youth Risk Behavior Surveillance System	25.6%	na	25.2% all NH
Policies related to food, nutrition, and vending in the school system.	developmental		
Percent of youth serving facilities that serve food and beverages which have a policy to provide healthy food options	developmental		
Percent of children ages 5-17 years whose parents say that they can easily get to a park, playground, or other safe place to play	developmental		

** Significantly different from the rest of New Hampshire excluding Manchester*

HEALTHY YOUTH INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Behavior				
Percent of high school students who were physically active for a total of 60 minutes or more per day on five or more of the past seven days, 2007, Youth Risk Behavior Surveillance System	45.5%	na	47.4% all NH	
Proportions of children who eat five or more fruits and vegetables daily	developmental			
Percent of high school students who had 5 or more drinks of alcohol in a row, that is, within a couple of hours on one or more of the past 30 days, 2007, Youth Risk Behavior Surveillance System	26.7%	na	29.3% all NH	2%
Percentage of high school students who used marijuana one or more times during the past 30 days. 2007, Youth Risk Behavior Surveillance System	23.3%	na	25.1% all NH	0.7%
Percent of high school students who smoked cigarettes on one or more of the past 30 days, 2007, Youth Risk Behavior Surveillance System	16.6%	na	19.6% all NH	16%
Percent of high school students who have ever had sexual intercourse, 2007, Youth Risk Behavior Surveillance System	44.5%	na	43.9% all NH	25%
Among students who had sexual intercourse during the past 3 months, the percentage who used a condom, 2007, Youth Risk Behavior Surveillance System	62.2%*	na	36.5% all NH	
Percent of high school students who were in one or more physical fight during the past 12 months. 2007, Youth Risk Behavior Surveillance System	28.1%	na	29.6% all NH	32%
Youth under age 18 who were convicted of Part 1 crimes in 2008, Manchester Police Department	167	na	missing	
Juvenile violent crime arrest rate per 100,000 youth age 10-17	developmental			
Health				
Teen birth rate per 1,000 females ages 15-19, 2006, NH DHHS Birth Data	19.8* (n=135)	12.4 (n=154)	8.5 (n=725)	42 (for 15-17 yr olds)
Rate of Chlamydia infection per 100,000 teens age 15-19, 2008, NH DHHS, Communicable Disease Surveillance	1628.3* (n=118)	1027.3* (n=140)	582.6 (n=537)	3000 (for 15-24 yr olds)
Percent of population 5-15 years of age with a disability (sensory, mental, physical, self care), 2007, American Community Survey	9.6%	na	7.2%	
Proportion of children in 1st, 3rd, 5th, and 9th grades who are overweight or obese	developmental			5%
Number of students in the public school system with diabetes (Type I and II), 2008-2009 SY, Manchester Health Dept	67	na		
Rate of self inflicted injury discharges from emergency department per 1000 for children 5-17, 2005, NH DHHS	2.1 (n=39)	1.7 (n=52)	1.6 (n=333)	
Percent of students who actually attempted suicide one or more times during the past 12 months, 2007, Youth Risk Behavior Surveillance System	7.45%	na	7.00%	1%
Percent of youth age 5-17 years who were discharged from the emergency department for unintentional injury, excluding motor vehicle accidents, 2005, NH DHHS	9.3% (n=1,700)	8.6% (n=2,708)	12.2% (n=25,885)	
Leading causes of hospitalization for youth ages 5-17, 2001-2006, NH DHHS Hospitalization Data	Acute appendicitis; Asthma; Episodic mood disorders; Pneumonia; Diabetes			
Leading causes of death for youth ages 5-17, 2001-2006, NH DHHS Death Data	Accidents; Malignant Neoplasms; Perinatal conditions; Suicide; Congenital malformations, deformations and chromosomal abnormalities			

HEALTHY YOUTH INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Access				
Rate per 10,000 of hospitalization for asthma for children 5-17, 2006, NH DHHS Hospitalization Data	6 (n=11)	4.8 (n=15)	4.7 (n=99)	7.7
Second grade students recorded as having no health insurance on Student Information Form, 2008-2009 SY, Manchester Health Dept	5% (+/- 0.5%)	na	na	
Second grade students recorded as having a primary care provider on Student Information Form, 2008-2009 SY, Manchester Health Dept	98% (+/- 0.2%)	na	na	
Second grade students recorded as having a dentist on Student Information Form, 2008-2009 SY, Manchester Health Dept	93.6% (+/- 0.9%)	na	na	
Proportion of all youth who are uninsured	developmental			
Proportion of 8th graders who do not have a primary care provider	developmental			
Number of children with special health care needs	developmental			
** Significantly different from the rest of New Hampshire excluding Manchester*				

HEALTHY LIFE: AGE 18-64

KEY ISSUES

- Manchester residents experience significantly higher rates of all-cause premature mortality (death before age 65) than the rest of New Hampshire.
- Behavioral and mental health is an important concern across all age groups in adulthood. The rate of emergency department visits for psychiatric concerns among residents in Manchester and the Manchester HSA is significantly higher than the rest of NH. Furthermore, the rate is significantly higher among Manchester residents than the Manchester HSA.
- Efforts to increase access to preventive screenings and the medical management of chronic diseases, such as diabetes, are necessary to improve adult health.
- The rate of emergency department visits for illicit drug use among residents in Manchester and the Manchester HSA is significantly higher than the rest of NH. Furthermore, the rate is significantly higher among Manchester residents than the Manchester HSA.
- Social and economic factors, such as lack of health insurance and unemployment, are just as important in determining health status as health behaviors.

OVERVIEW

Healthy life in adulthood is a complex interaction between past and present experiences including biological, cultural and social factors and behavior.[2] It is important to consider these interactions in adulthood to better understand the development of a healthy life and to employ intervention strategies at the appropriate place in the life course. There are several transitional periods in adulthood that play a key role in defining health status and contribute to determining health status later in life.

The period from age 18 to 29 years is a transitional period and a critical time when many behaviors and risk factors are established that will affect health status later in life.[81] These years represent the beginning of adulthood, when young people seek to obtain financial and emotional independence.[82, 83] During this same period of life, however, is when young adults commonly experience a loss of social support programs such as food assistance, school-based programs, and health insurance under a parent's plan, as they no longer qualify for services based on age.[81]

The period from 50 to 64 years is another transitional period. Behaviors, life situation, and surrounding environments for adults in this age group can shape health and well being as they become older. This group (often referred to as the "baby boomer group") has grown significantly in the last decade and is expected to become an even more significant portion of the region's population over the next 20 years.

Manchester City 2007			
	Number	Percent of city population, 2007	Percent of city population, 2000
Residents 18 to 64 years	70,010	64.6%	63.3%
Residents 18 to 29 years	18,912	17.4%	17.9%
Residents 30 to 49 years	31,946	29.4%	31.8%
Residents 50 to 64 years	19,152	17.6%	13.6%
Source: American Community Survey 2007			

Demographics

Population of 18-64 year olds, 2000		
	Number	% of City population
Auburn	3,041	65.0%
Bedford	10,950	59.9%
Candia	2,586	66.1%
Deerfield	2,323	63.2%
Goffstown	11,049	65.3%
Hooksett	7,810	66.6%
New Boston	2,672	64.6%
Source: United States Census Bureau, 2000		

Current Health

Leading Cause of Death

The rate of premature mortality (death before age 65) is significantly higher in Manchester compared to the rest of New Hampshire (256.9 deaths/100,000 people under age 65 Manchester vs. 201.7 deaths per 100,000 rest of New Hampshire, 2006 data).[61]

Nationally, in New Hampshire and in the Manchester HSA, causes of death vary in adulthood by age grouping. For example, in 2006, the top five leading causes of death for Manchester City adults ages 18 to 29 were different from the top five leading causes of death for Manchester adults ages 30 to 64.

In the group of those 18 to 29 years, accidents and intentional self-harm were the leading cause of death followed by cancers and congenital malformations. Both Manchester and Manchester HSA have the same top five leading causes of death for this age group, and they are not significantly different from the rest of New Hampshire.

Leading causes of death data for Manchester, HSA, and NH residents are illustrated on the following pages.

18 to 29 years: Leading Causes of Death			
Manchester, 2006	Death Rate per 100,000 Population	Rest of NH, 2006	Death Rate per 100,000 Population
Accidents	28.5	Accidents	37.4
Intentional Self-Harm	28.5	Intentional Self-Harm	12.1
Malignant Neoplasms (Cancers)	11.4	Malignant Neoplasms (Cancers)	5.5
Assault (Homicide)	0*	Assault (Homicide)	3.3
Congenital Malformations	5.7	Congenital Malformations	1.1
** While homicide was among the leading causes of death for adults 18-29 for the years used to create the ranking, 2000-2006, in 2006 there were no homicides in this age group in Manchester*			
Source: NH DHHS			

In the older age group, those ages 30 to 64, cancers and diseases of the heart were the leading causes of death followed by accidents, intentional self-harm and chronic lower respiratory diseases. Both Manchester and Manchester HSA have the same top leading causes of death, and they are not significantly different from the rest of New Hampshire.

30 to 64 years: Leading Causes of Death			
Manchester, 2006	Death Rate per 100,000 Population	Rest of NH, 2006	Death Rate per 100,000 Population
Malignant Neoplasms (Cancers)	135.4	Malignant Neoplasms (Cancers)	109.1
Diseases of the Heart	72.4	Diseases of the Heart	62.2
Accidents	33.4	Accidents	29.3
Intentional Self-Harm	24.1	Intentional Self-Harm	14.1
Chronic Lower Respiratory Diseases	22.3	Chronic Lower Respiratory Diseases	11.6
Source: NH DHHS			

Health Status

The most reliable alternative measure of morbidity for the HSA population is hospital visit rates. The tables on the following page illustrate the major causes of hospitalization for those ages 18-29 compared to those ages 30-64. In the younger age group, most hospitalizations are for episodic or acute conditions while in the older age group, hospitalizations mainly occur for conditions associated with chronic illness. Thus, prevention of chronic illness, including early diagnoses and screening has been identified as the most important area of focus for the community for the future.

Among Manchester HSA adults ages 18 to 29 years the highest rates of hospitalization are for episodic mood disorders, acute appendicitis, diabetes, cellulitis and depressive disorders in 2006.

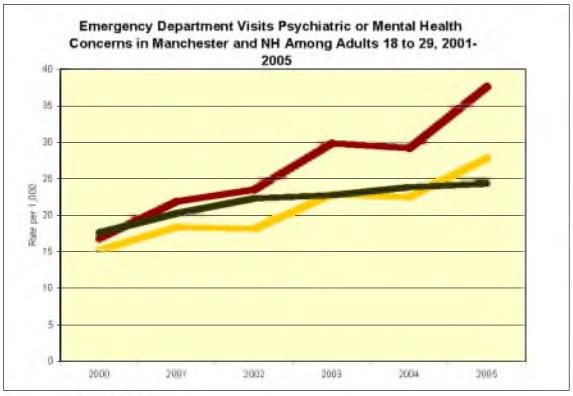
18 to 29 years: Leading Causes of Hospitalization			
Manchester, 2006	Hospitalization Rate per 1,000 Population	Manchester HSA, 2006	Hospitalization Rate per 1,000 Population
Episodic Mood Disorders	3.2	Episodic Mood Disorders	2.6
Diabetes	1.8	Acute Appendicitis	1.4
Acute Appendicitis	1.7	Diabetes	1.1
Cellulitis and Abscess	1.4	Cellulitis and Abscess	0.9
Depressive Disorders	0.6	Depressive Disorders	0.7
Source: NH DHHS, Hospitalization Data			

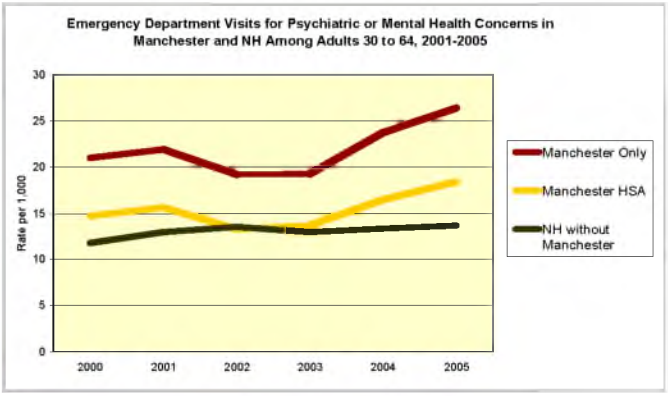
Episodic mood disorders, osteoarthritis, chronic ischemic heart disease, acute myocardial infarction, and respiratory and chest symptoms are the top five reasons for admission to an area hospital for HSA residents ages 30 to 64 years in 2006.

30 to 64 years: Leading Causes of Hospitalization			
Manchester, 2006	Hospitalization Rate per 1,000 Population	Manchester HSA, 2006	Hospitalization Rate per 1,000 Population
Episodic Mood Disorders	3.9	Episodic Mood Disorders	3.3
Osteoarthritis	2.6	Osteoarthritis	2.5
Chronic Ischemic Heart Disease	2.3	Chronic Ischemic Heart Disease	2.1
Acute Myocardial Infarction	1.8	Acute Myocardial Infarction	1.6
Respiratory and Chest Symptoms	1.8	Respiratory and Chest Symptoms	1.4
Source: NH DHHS, Hospitalization Data			

Additionally, and of concern to the community, the leading cause of all hospitalizations among adults under 65 in 2006 was episodic mood disorders which include admissions for alcoholism, suicidal ideation and depression and other diagnoses which may be early symptoms of more chronic mental health conditions. In 2005, Manchester and the Manchester HSA had higher rates of emergency room visits for psychiatric or mental health concerns compared to the rest of New Hampshire.

Although not one of the top five leading causes of hospitalization in 2006, emergency department visits for accidents among Manchester adults ages 18 to 64 were significantly higher compared to the HSA and the rest of New Hampshire. These rates remain significantly higher even when emergency department visits for automobile accidents are excluded from our calculation of rates.





Source: NH DHHS

Access To Healthcare Services

Health Insurance

For adults being without health insurance or being underinsured is a major barrier to obtaining access to preventive health services and health care. Having health insurance is an important factor for establishing a regular medical home and a relationship with a health care provider. When people are uninsured or underinsured, the cost of care is too great for most. Although limited data about the uninsured are available for Manchester or Manchester HSA, the local profile of the uninsured is assumed to be similar to that of the state.[62]

- Nearly one out of every four persons in New Hampshire under the age of 65 went without health insurance for all or part of 2002 and 2003 (23%, n=259,000).[62]
- Younger adults (ages 18 to 34) are more likely to be uninsured (18.3%), cite cost as a barrier to obtaining health care (14.1%), and report having no regular health care provider (15.5%).[63]

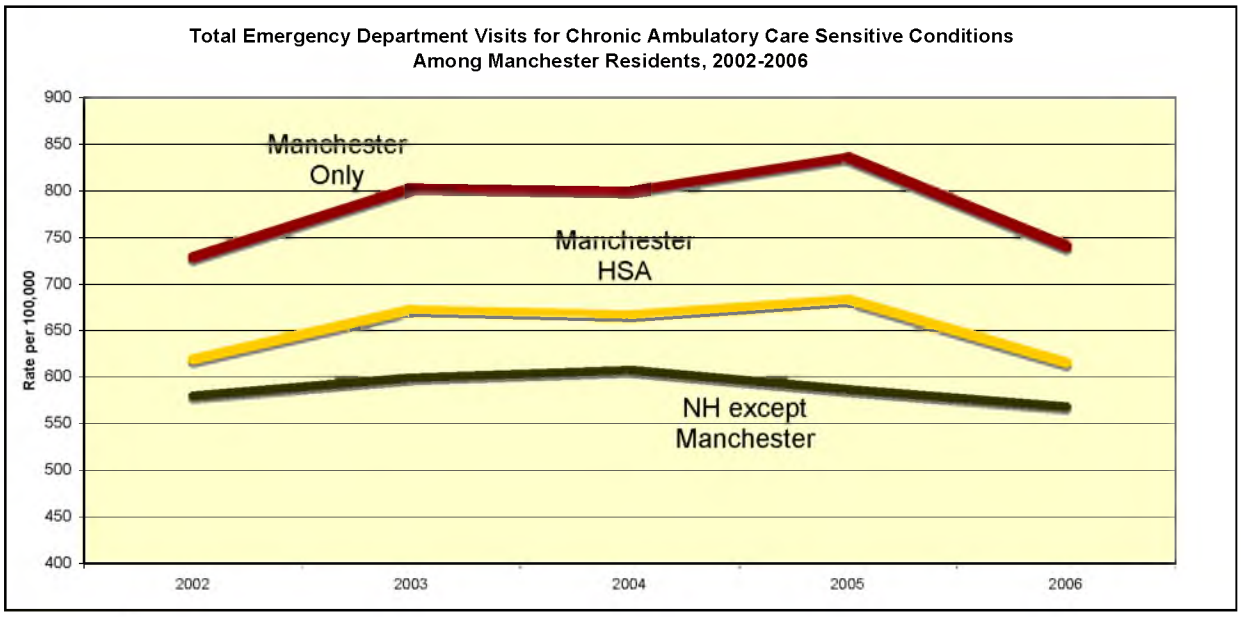
For the Manchester area the following is known:

- The Manchester HSA health care organizations provide health care services to approximately 15% of the state's uninsured population.[64]
- About 10% of Manchester City adults ages 18 years and older reported that they could not access health care because of the cost (2005-2007).[85]

Ambulatory Care Sensitive Conditions as a Proxy for Access

In a community high rates of emergency department visits for chronic ambulatory care sensitive conditions, such as asthma or diabetes; may be an indicator of a lack of prevention efforts, a primary care resource shortage, or other factors that create barriers to obtaining timely and effective care.[87] Chronic ambulatory care sensitive conditions are conditions where timely and effective outpatient care can decrease emergency care and hospitalizations by preventing the onset of an illness or condition or managing a chronic disease or condition.

From 2002 to 2006, 741 emergency department visits per 100,000 residents in Manchester were associated with chronic ambulatory care sensitive conditions. This rate is significantly higher compared to the rest of New Hampshire (568 visits/100,000).



Source: NH DHHS

Dental Insurance

Dental care is associated with higher out-of-pocket costs compared to medical insurance. Typically, fewer people have dental insurance than general medical coverage, and for those who do have dental insurance, coverage is generally less comprehensive than medical insurance.[86]

Risks To Future Health

Healthy Behaviors

This section provides an overview of the most common health risk behaviors among adults ages 18 to 64. These health behaviors contribute to the development of chronic diseases in adulthood that are represented among the leading causes of death and hospitalization for Manchester area adults.

Tobacco Use

The proportion of Manchester adults ages 18 to 34 who currently smoke is 30.5% (2005-2007). This is a concern because decisions made in young adulthood, such as tobacco use, will directly affect current and future health status.[3] Furthermore, a significantly higher proportion of Manchester adults ages 35 to 44 currently smoke compared to those in this age group in the state.

Tobacco Use Healthy People 2010 Target = 12.0%			
	Manchester	Manchester HSA	Rest of New Hampshire
Proportion of adults age 18 to 64 who are currently smoking (2008)	20.1%	18.5%	18.9 %
Proportion of adults 18-34 who are currently smoking (2005-07)	30.5%	28.3%	25.3%
Proportion of adults 35-44 who are currently smoking (2005-07)	33.9%*	28.5%	21.5%
**Statistically significant difference from Rest of NH* *Source NH Behavioral Risk Factor Surveillance System*			

In addition, smoking rates vary statistically by income. For example, 37% of Manchester adults age 18 and older with an income less than $25,000 reported that they smoke compared to only 15.7% for those in the same age group with an income at or above $75,000 annually.

Overweight and Obesity

In Manchester, 64% of adults ages 18 to 64 years of age are either overweight or obese as illustrated in the table below.

Overweight and Obese (HP 2010 Target = 15.0%)		
	Manchester	Rest of New Hampshire
Proportion of adults age 18 to 64 who are overweight as defined by Body Mass Index (2008)	38.5%	37.4%
Proportion of adults age 18 to 64 who are obese as defined by Body Mass Index (2008)	25.5%	25.5%
Source: NH Behavioral Risk Factor Surveillance System		

Overweight and obesity is an important risk factor for heart disease, cancer and diabetes.[65] During the past 20 years there has been a dramatic increase in obesity in the United States. In fact, this rapid increase in overweight and obesity among adults in the United States has been called a national epidemic because it is estimated that over 60% of American adults are either overweight or obese.[65]

Physical Activity

A key factor that makes overweight and obesity more likely is not getting enough physical activity. In 2007, 51% of Manchester HSA adults ages 18 to 64 were not meeting the Healthy People 2010 physical activity objective of getting moderate activity for at least 30 minutes on five or more days per week or participating in vigorous activity for 20 minutes on at least three days per week. This includes nearly 10% of Manchester residents (approximately 11,000 people) and about 7% of the HSA population in this age group who reported not participating in any physical activity at all.

Physical Activity			
	Manchester	Manchester HSA	Rest of New Hampshire
Proportion of adults age 18 to 64 who report no moderate or vigorous physical activity (BRFSS 2007)	9.9%	7.4%	6.6%
Source: NH Behavioral Risk Factor Surveillance System			

Alcohol and Other Drug Use

The proportion of Manchester and HSA adults ages 18 to 64 who report binge drinking (defined as five or more alcoholic beverages on one occasion) was 21.2% for the Manchester and 20.7% for the HSA population.

In 2005, there were 426 emergency department visits for illicit drug use per 100,000 Manchester residents. This rate is significantly higher than the rest of New Hampshire (176 visits per 100,000 population).

Binge Drinking			
	Manchester 2006	Manchester 2008	Rest of New Hampshire 2008
Proportion of adults age 18 to 64 who report binge drinking within the last month	16.8%	21.2%	19.0%
Illicit Drug Use			
	Manchester 2001	Manchester 2005	Rest of New Hampshire 2005
Rate of emergency department visits for illicit drug use among Manchester residents (per 100,000 pop)	279*	426*	176
**Statistically significant difference from Rest of NH* *Source: NH Behavioral Risk Factor Surveillance System*			

Substance abuse continues to be a major health problem in the United States for adults. It is estimated that one in 13 adults are either alcoholics or abuse alcohol heavily and an estimated three million individuals in the United States have serious drug problems.[66]

> *"Long-term heavy drinking increases an individual's risk for heart disease and stroke, several forms of cancer, cirrhosis and other liver disorders, and mental health problems. Alcohol use also contributes to a substantial proportion of injuries and deaths related to motor vehicle crashes, falls, fires, drowning and firearms. Alcohol use is often a factor in homicides, suicides, domestic violence and child abuse. Use of alcohol during pregnancy can result in growth and mental retardation, and birth defects."*[67]

Use of illicit drugs, such as heroin, marijuana, cocaine, and methamphetamine, or nonmedical use of prescription drugs such as pain relievers, tranquilizers, stimulants, and sedatives, can be associated with serious consequences.[68] These include injury, illness, disability, and death as well as crime, domestic violence, and lost school or workplace productivity.[69, 70] Long-term consequences, such as chronic depression, sexual dysfunction, and psychosis, as well as drug use disorders may also result from drug use.[70, 71]

Family and Social Environments

Positive family and social environments are important to building positive individual social supports, and in general, a greater sense of community. Important differences in health status are associated with living alone, whether one owns or rents his home, and with having access to public transportation.[72-75]

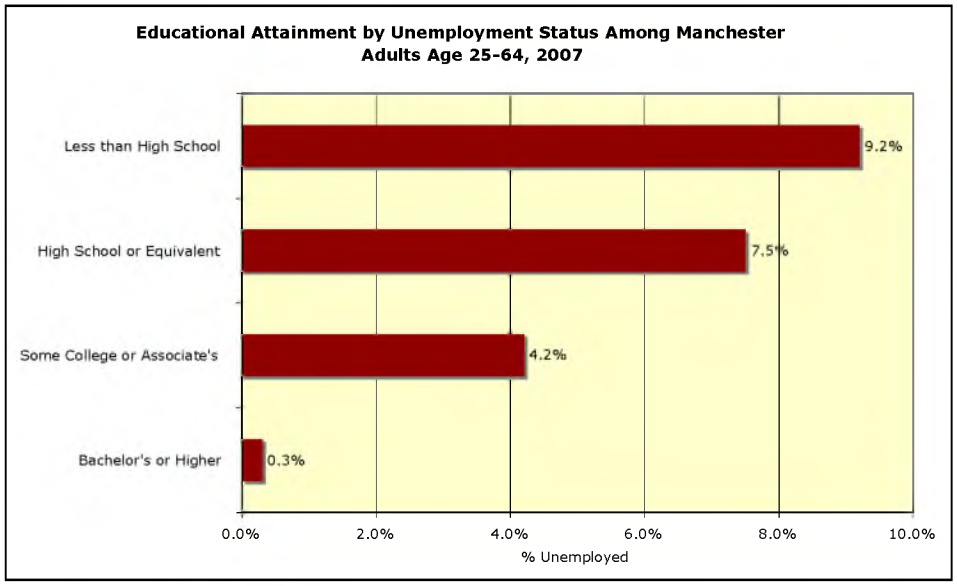
Of the 45,481 households in Manchester in 2007, 23.4% consist of residents ages 15 to 64 living alone. Furthermore, 50.3% of households were renter occupied, and approximately 44% were non-family households.

Households in Manchester			
	Number	Percent of Households, 2007	Percent of Households, 2000
Total Family households	25,484	56.0%	59.0%
Residents age 15-64 years living in owner occupied housing	18,085	39.7%	34.5%
Residents age 15-64 years living in renter occupied housing	22,878	50.3%	45.4%
Total Non-Family Households	19,997	43.9%	40.9%
Households with Residents age 15-64 years living alone	10,673	23.4%	21.4%
Source: American Community Survey 2007			

In 2007, 6.7% of Manchester residents age 16 and older used public transportation or walked/rode a bicycle to work.[8] The lack of a *robust public transportation* system was mentioned as a major barrier several times during the focus groups sessions with Manchester residents. Transportation is vital for many reasons, but it is especially important for traveling to employment outside of the home, access to basic services, such as financial institutions or the supermarket, and connecting with health care services.

EDUCATION

About 14% of Manchester adults age 18 and older had less than a high school diploma (2007). This is important because an individual's level of educational attainment is linked with his or her employability.

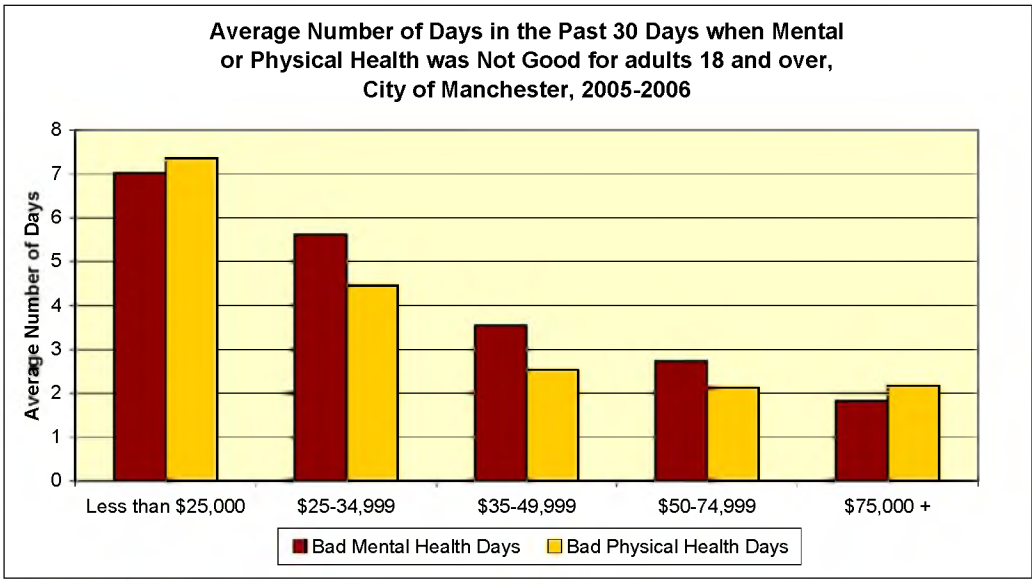


Source: American Community Survey

- About 9% of Manchester adults ages 24 to 64 with less than a high school degree were unemployed as compared with only 0.3% of Manchester adults ages 24 to 64 with a Bachelor's degree or higher (2007).
- Over 15% of Manchester adults ages 18 to 24 had less than a high school degree (2007), which is a decrease from year 2000 (25.9%).
- There were notable differences in education status by gender and education. In 2007, there was a higher proportion of males age 25 to 34 having less than a high school diploma than females of the same age group – 17.9% and 6.6%, respectively. Moreover, females ages 25 to 34 years have a higher percentage of individuals attaining a Bachelor's degree or higher (31.5%) compared to males of the same age group (15.6%).

ECONOMIC CIRCUMSTANCES

When exploring self-rated health status by other determinants of health the most apparent inequity exists by income. Individuals making less than $25,000 annually reported approximately seven days of poor mental or physical health compared to about only two days for individuals making $75,000 or more annually.

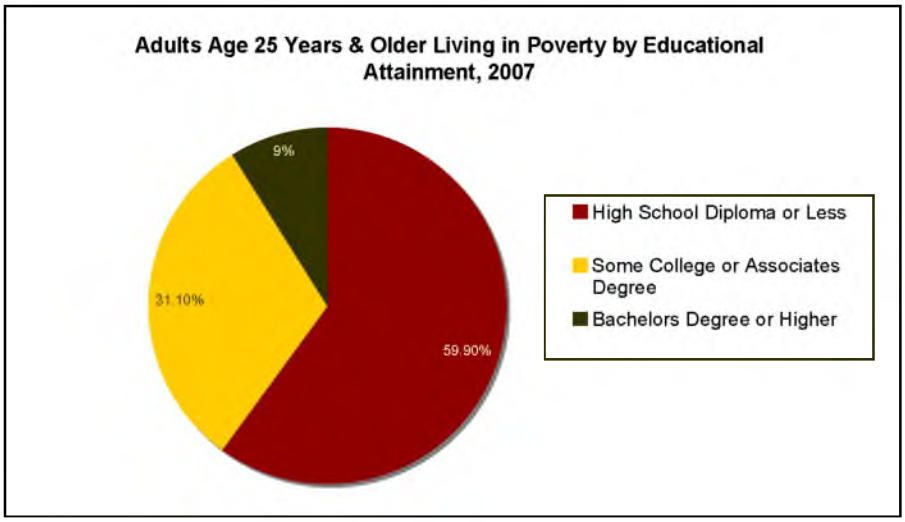


Source: NH DHHS

Thus, of great concern for Manchester is the significant increase in the number of adults living in poverty. In 1990, 7.0% of Manchester adults ages 18 to 64 lived at or below 100% of the Federal Poverty Level compared to 11.5% in 2007.

Poverty is greatly influenced by educational attainment, which in turn often determines employment status and occupation type.

- In 2007, nearly 60% of adults age 25 and older that were living at or below the poverty line in Manchester had a high school diploma or less.
- Only 9% of adults at or below the poverty line had a Bachelor's degree or higher.



Source: American Community Survey, 2007

Additionally, the rate of unemployment has been increasing in Manchester and was higher than the state between December 2008 and May 2009. Similar to the variation observed when assessing educational attainment by poverty status, the rate of unemployment also varies by poverty status. In 2007, 10.6% of Manchester residents age 16 and older that were living below the poverty line were unemployed. Among residents age 16 and older at or above the poverty line, 4.2% were unemployed.

Focus Group Participants Weigh In: Healthy Life—Age 18-64

Most focus group participants interviewed for this assessment in the adult age group were at vulnerable stages in their lives or at higher risk of poor health due to: (a) having a chronic health condition or disability, (b) being new to America and struggling to learn how to manage one's life in a foreign culture, (c) being a veteran.

The issues discussed most frequently across all focus groups were the lack of affordable, quality dental care for uninsured or underinsured residents, and the lack of mental health services in the community.

- There are not enough dentists who accept Medicaid or uninsured patients and if the participants can find a dentist who takes an uninsured patient, the cost of care is astronomical.

> *"If someone is really sick, you can call 911 and get treated, but if you're in a lot of pain because of dental problems, there's no way to get care unless you can come up with the cash."*

- There is a lack of mental health care available through community providers. Several participants stated that they use the emergency departments in the area to access mental health care services that should be available to them in outpatient settings by mental health care providers.
- Several veterans reported that their TRICARE coverage was insufficient, and they were unable to see certain doctors.
- Several participants with disabilities or caring for a family member with a disability reported having a difficult time navigating the medical system.
- The Bhutanese and Bosnian refugee populations who were not connected to any assistance group reported having great difficulty acquiring any kind of insurance coverage and then difficulty again in connecting with the medical system.
- The Somali refugees interviewed were connected with the Somali Development Center (SDC) and reported having no barriers to accessing care; i.e., the SDC helped guide them through the system by bringing them to the appropriate providers, making appointments, providing transportation, and assisting with interpretation.

Data Snapshot: Healthy Life—Age 18-64

HEALTHY LIFE INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER
Family and Social			
Percent of households with an adult householder under age 65 living alone, 2007, American Community Survey	23.5%*	na	15.8% all NH
Number of domestic violence arrests, 2008, Manchester Police Dept	1,154	na	missing
Percent of workers 16 years and older who have no access to a vehicle, 2007, American Community Survey	3.8%	na	1.8% all NH
Proportion of the population without a home or a cellular telephone	developmental		
Number of homeless individuals	developmental		
Rate of incarceration of the population for different groups	developmental		
Rate of volunteerism among adults age 18 to 64 years	developmental		
Proportion of the population who participate in social or civic organizations	developmental		
Economic Circumstances			
Percent of people age 18-64 whose income in the last 12 months is below 100 percent of poverty, 2007, American Community Survey	11.5%	na	6.6%
Percent of housing units occupied by owner, 2007, American Community Survey	49.4%	na	74.1% all NH
Annual average unemployment rate, 2008, NH Employment Security	4.3% (n=2,660)	na	3.8% all NH (n=28,240)
Unemployment rate, month of July, 2009, NH Employment Security	7.7%	na	6.6%
Unemployment rate among 18-29 year old adults	developmental		
Education			
Percent of the population age 18 to 64 who did not graduate from high school, 2007, American Community Survey	11.2%	na	7.9%
Percent of the population age 18 to 64 who have a bachelor's degree or higher, 2007, American Community Survey	23.3%		30.9%
Physical Environment			
Percent of the population age 16-64 that has an employment disability, 2007, American Community Survey	7.90%	na	6.1% all NH

HEALTHY LIFE INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Behavior				
Percent of adults age 18 to 64 who are current smokers, 2008, NH DHHS Behavioral Risk Factor Surveillance System	20.1%	18.5%	18.9%	12%
Percent of adults age 18 to 64 who have participated in binge drinking during the past 30 days, 2008, NH DHHS Behavioral Risk Factor Surveillance System	21.2%	20.7%	19.0%	6%
Percent of adults age 18 to 64 who meeting the recommendation for moderate or vigorous physical activity, 2007, NH DHHS Behavioral Risk Factor Surveillance System	49.0%	49.0%	55.7%	30%
Rate per 100,000 of discharges from the emergency department for self inflicted injury for all ages, 2005, NH DHHS, Hospitalization Data	149* (n=159)	113 (n=201)	111 (n=1,311)	
Rate per 100,000 of discharges from the emergency department for drug abuse for all ages, 2005, NH DHHS, Hospitalization Data	426* (n=483)	305* (n=560)	176 (n=2,129)	

HEALTHY LIFE INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Health				
Percent of adults age 18 to 64 years who reporting that their general health is good to excellent, 2008, NHDHHS Behavioral Risk Factor Surveillance System	85.7%	88.8%	91.2%	
Percent of adults age 18 to 64 years who are obese or overweight, 2008, NHDHHS Behavioral Risk Factor Surveillance System	63.9%	63.4%	62.9%	40%
Overall rate of diabetes per 1,000 people that is clinically diagnosed, 2005, Centers for Disease Control and Prevention	developmental		65	25
Cervical cancer incidence rate per 100,000 women, 2002-2006, NH DHHS, Cancer Data	13.8* (n=40)	11.3* (n=54)	6.2 (n=196)	
Prostate cancer incidence rate per 100,000 men, 2002-2006, NH DHHS, Cancer Data	183.3* (n=432)	177.1 (n=695)	155.3 (n=4,493)	
During the past 30 days, average number of days for which adults age 18 and over report that their mental health was poor or not good. 2005-2007, NH DHHS Behavioral Risk Factor Surveillance System	3.8	3.4	3.2	
The proportion of individuals who experienced a major depressive episode within the last year	developmental			
Rate per 100,000 of Chlamydia infection among 20-24 year olds, 2008, NH DHHS, Communicable Disease Surveillance	2057.9* (n=141)	1184.3 (n=158)	787.3 (n=701)	
Cases of HIV infection in population 18 to 54 years old, 2008, NH DHHS, Communicable Disease Surveillance	7	9	34	
Breast cancer mortality rates per 100,000, 2001-2005 NH DHHS, Cancer Data	25.8 (n=83)	24.8 (n=125)	24 (n=818)	22.3
Age specific death rate per 100,000 for all causes for adults 18 to 64 years, 2006, NH DHHS, Death Data	331.7* (n=237)	267.3 (n=314)	259.6 (n=2,033)	
Age-specific death rate per 100,000 population (premature death), for NH residents, age less than 65 years, 2006, NH DHHS, Death Data	256.9* (n=248)	207.6 (n=332)	201.7 (n=2,141)	
Suicide rate per 100,000 for adults age 15 to 64, 2006, NH DHHS, Death Data	23.8	20.8	12.8	5
Leading causes of hospitalization for adults age 18 to 29, 2006, NH DHHS Hospitalization Data	Episodic mood disorders; Acute appendicitis; Cellulitis and abscess, except fingers and toes; Diabetes; Depressive disorders			
Leading causes of hospitalization for adults age 30 to 64, 2006, NH DHHS, Hospitalization Data	Episodic mood disorders; Acute myocardial infarction; Chronic ischemic heart disease; Osteoarthrosis; Respiratory and chest symptoms			
Leading causes of death for adults age 18-29, 2006, NH DHHS, Death Data	Accidents; Suicide; Malignant neoplasms; Homicide; Congenital malformations, deformations and chromosomal abnormalities			
Leading causes of death for adults age 30-64, 2006, NH DHHS, Death Data	Malignant neoplasms; Diseases of heart; Accidents; Suicide; Chronic lower respiratory diseases			

HEALTHY LIFE INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Access				
Percent of the population age 18-64 who received an influenza vaccination within the last 12 months, 2008, NH DHHS Behavioral Risk Factor Surveillance System	31.4%	32.7%	36.0%	
Percent of women age 18-64 who have gotten a pap smear within the last 3 years, 2008, NH DHHS Behavioral Risk Factor Surveillance System	87.1%	87%	86.1%	90%
Percent of female population over 50 years old who have gotten a mammogram in the past 2 years, 2008, NHDHHS Behavioral Risk Factor Surveillance System	92.6%*	89.8%	84.7%	70% for 40 and older
Unintentional Injury emergency department discharges, excluding motor vehicle accidents for adults age 18 to 29 years, 2005, NH DHHS, Hospitalization Data	21.4%* (n=1,881)	16.9% (n=2,356)	16.7% (n=14,811)	
Rate per 1,000 of hospitalization for acute ambulatory care sensitive conditions for adults age 18 to 29 years, 2006, NH DHHS, Hospitalization Data	5.1* (n=89)	3.5 (n=100)	2.6 (n=466)	
Percent of adults age 18-64 who have a primary care provider	developmental			
Percent of adults age 18-64 who have no health insurance	developmental			
Percent of adults age 18-64 who have no dental insurance	developmental			
Percent of adults age 18-29 who have no health insurance	developmental			
** Significantly different from the rest of New Hampshire excluding Manchester*				

HEALTHY AGING: AGE 65 AND OLDER

KEY ISSUES:

- Variation in needs and health status among different groups of older adults exists and should be accounted for in health care planning.
- Comprehensive data on adults 75 years of age and older is not readily available at the community level.
- Enhanced prevention services for chronic diseases, specifically cardiovascular disease, is needed for older adults. Older Manchester area residents have higher mortality rates from heart disease, lower scores on physical activity and fruit/vegetable consumption and higher levels of obesity compared to the rest of the state population.
- To prolong independence older adults need increased connections to the community, to transportation, and to social supports and services.
- As the number of older adults grows as a proportion of the area population, the need for caretakers, assisted living options, and nursing homes increases. The HSA needs to expand and enhance its health care and service infrastructure to meet these growing needs.

Overview

Among a community's most valuable resources are its history and the collective wisdom and experience of its inhabitants. Manchester's older residents, the primary holders of that history and experience, make up 12.7% of the population.[8] Due to national demographic trends, the proportion of individuals ages 65 and over in Manchester is expected to increase in the coming years.[76] The anticipated growth in this segment of the population will challenge the community to expand and redesign area support services, including health care, to better reflect the unique needs of this older population.

A community that is a healthy place for older adults to live and thrive is a community that allows for independent living while encouraging social connectedness. It is a community that has options for transportation, support, recreation, and health care both in and out of people's homes. It is a community in which healthy food is easily available and all people are able to age safely and in dignity. It is a community in which people care for one another.

Planning for the needs of adults ages 65 years and older begins with the development and implementation of comprehensive preventive services for those ages 50 to 64 years. Adults in their 50s and early 60s may be able to delay, mitigate, or reverse health care issues that arise with aging by using appropriate prevention services and implementing healthy life style behaviors.

Demographics

Manchester City Demographics		
	Number in 2007	Percent of City population, 2007
Residents 65 and over	13,732	12.7%
Men age 65 and over	5,278	4.9%
Women age 65 and over	8,454	7.8%
Source: American Community Survey 2007, Census 2000		

The proportion of people in Manchester ages 65 and over is predicted to increase rapidly in the coming decade because the large post World War II "baby boomer" group is reaching that age range.[8]

Adults 65 and over in Manchester HSA towns, 2000		
	Number	% of town population
Manchester	13,829	12.9%
Auburn	286	6.1%
Bedford	2,103	11.5%
Candia	283	7.2%
Deerfield	253	6.9%
Goffstown	2,043	12.1%
Hooksett	1,062	9.1%
New Boston	208	5.0%
Source: United States Census Bureau, 2000		

Adults ages 65 and older have unique needs and special vulnerabilities when compared to the rest of the population. Additionally, older adults are more likely to live on a fixed income, have limited transportation, or live with some form of disability.

Within the demographic group of older adults, the lives and needs of people in their 60s and early 70s tend to differ from those who are older. On average, those who are 75 years and older – often referred to as "frail elders" - have more chronic health conditions (e.g., are at greater risk for stroke and Alzheimer's Disease), often live with a disability, and have declining mobility and mental acuity issues.[77] In addition, frail elders are dramatically impacted by lack of coordination of care among primary, specialty, and hospital providers. Unfortunately, the data in this chapter does not distinguish the needs and health measures of "frail elders" from those who are 65-74 years of age. However, it is important to keep the potential differences for need for services between these groups in mind when planning to address the community needs of older adults and conducting future assessments.

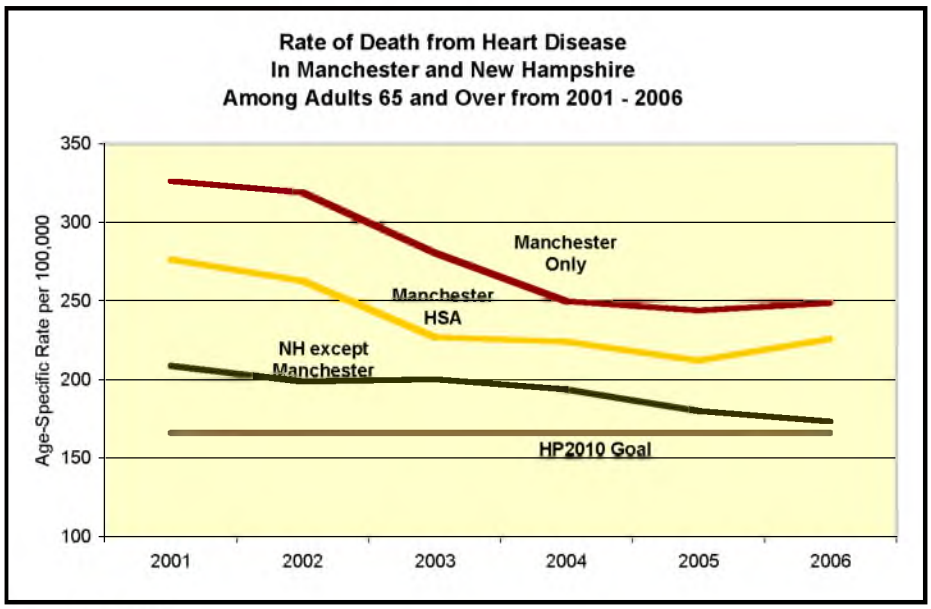
Current Health

Causes of Death

The leading causes of death for adults ages 65 and older in the Manchester HSA, in Manchester and in New Hampshire are from heart disease, cancer, chronic lower respiratory diseases, stroke and Alzheimer's disease.[61]

Heart Disease

While the rate at which Manchester area residents over age 65 die of heart disease has dropped in this decade, it remains statistically higher than the rest of the state. At 249 deaths per 100,000 people age 65 and over, the rate of death from heart disease in Manchester in 2006 far exceeds the HP 2010 goal of 166 deaths per 100,000 population.[61] Furthermore, 967 more Manchester HSA residents died of heart disease from 2001 to 2006 than of the next leading cause of death, cancer (see table on following page).



Source: NH DHHS

Cancer

The most common kinds of cancer in the HSA, as across the nation, are lung, breast, and prostate. See the table below for age adjusted rates of death from lung and breast cancer.[78] Most lung cancer deaths are associated with smoking, thus, the risk of lung cancer can be lowered by avoiding smoking.[79] Risk of breast cancer deaths can be reduced by controlling weight, exercising, and knowing family history among other things.[80]

Manchester Lung/Bronchial and Breast Cancer Mortality Counts and Rates per 100,000 population, 2000 – 2006

		Female				Male			
Age Group	Cancer Type	Cancer Deaths	Rate	95%CI Lower	95%CI Upper	Cancer Deaths	Rate	95%CI Lower	95%CI Upper
65 to 69	Lung	23	161.3	102.2	242.0	36	286.9	201.0	397.2
70 to 74	Lung	33	245.5	169.0	344.7	37	356.8	251.2	491.8
75 to 79	Lung	28	213.7	142.0	308.9	37	432.4	304.5	596.0
80 to 84	Lung	26	243.5	159.0	356.7	25	418.5	270.9	617.8
85 plus	Lung	22	201.4	126.2	304.9	18	462.6	274.2	731.1
65 to 69	Breast	15	105.2	58.9	173.5	-	-	-	-
70 to 74	Breast	15	111.6	62.4	184.0	-	-	-	-
75 to 79	Breast	8	61.1	26.4	120.3	-	-	-	-
80 to 84	Breast	15	140.5	78.6	231.7	-	-	-	-
85 plus	Breast	23	210.6	133.5	315.9	-	-	-	-

** HP 2010 targets for all age groups for lung cancer is 44 deaths per 100,000 and for breast cancer is 22.3 deaths per 100,000*
Source: New Hampshire Department of Health and Human Services and the New Hampshire State Cancer Registry

Chronic Lower Respiratory Diseases

Chronic lower respiratory disease includes chronic bronchitis, emphysema, and asthma. It is one of the leading causes of death nationally as well as locally. Tobacco smoking, which in the previous chapter was identified as common among local adults, is the major cause of chronic lower respiratory disease.[81]

Alzheimer's disease

Alzheimer's disease, the fifth leading cause of death, is a health issue with broad reaching effects on families. The CDC estimates that about 5% of adults age 65 to 74 in the United States have Alzheimer's disease and nearly half of those ages 85 and older may have the disease.

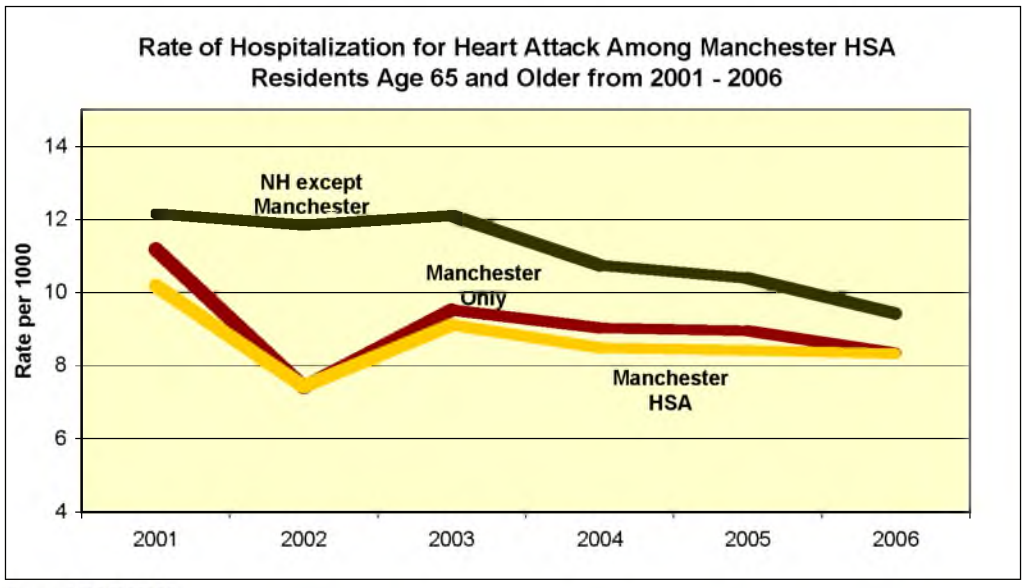
HEALTH STATUS

The most common reasons for hospitalization of HSA adults 65 years of age and older are:

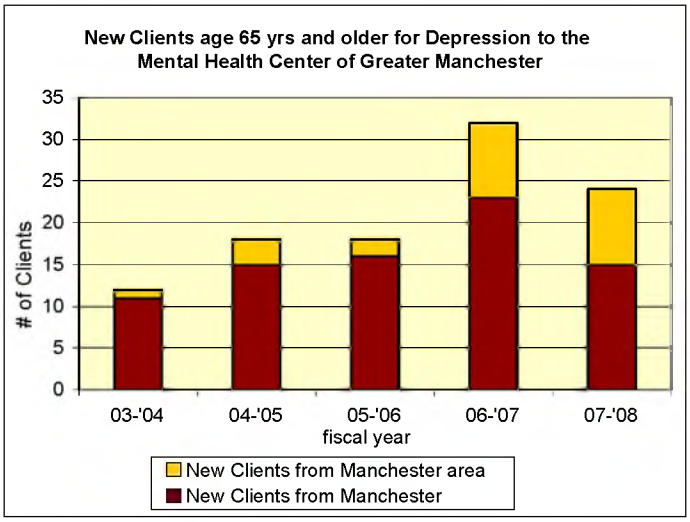
- heart failure,
- cardiac dysrhythmias,
- chronic ischemic heart disease,
- pneumonia,
- heart attacks.

ADULTS AGE 65 AND OVER: GENERAL HEALTH STATUS AS FAIR OR POOR, 2008		
AREA	ESTIMATE	95% CL
Manchester	26.5%	17.1-36.0
Manchester HSA	23.7%	16.8-30.6
The rest of NH	21.3%	19.1-23.5
Source: NH BRFSS		

Since 2002, Manchester HSA residents ages 65 years and over have been hospitalized for heart attacks at a statistically significantly lower rate than older adults in the rest of New Hampshire.



Source: NH DHHS



Source: Mental Health Center of Greater Manchester

Adults 65+ yrs reporting they always received needed emotional support, 2005-2007		
Area	Estimate	95% CL
Manchester	51.6%	44.0-59.2
Manchester HSA	53.0%	47.3-58.7
The rest of NH	54.7%	52.9-56.5
Mean number of days in past month for which mental health was not good, 2008		
Manchester	3	1.3-4.7
Manchester HSA	2.5	1.3-3.7
The rest of NH	1.7	1.4-2.0
Percentage of adults 65 yrs and older who have current depression, 2006		
Manchester HSA	5.5%	1.5-9.4
The rest of NH	2.7%	1.6-3.8
Percentage of adults 65 yrs and older who experience frequent mental distress, 2008		
Manchester	9.7%	3.3-16.2
Manchester HSA	7.8%	3.3-12.2
The rest of NH	5.4%	4.1-6.7
Source: NH Behavioral Risk Factor Surveillance System		

Older adults who live with a disability may have a greater need for support services and health care. Manchester has a slightly higher proportion of older adults with a disability compared to the United States population as a whole. The table below shows data that are relevant to older adults degree of access to health care in terms of self-care and go-outside-home disabilities. The measure "self-care disability" defines the percent of older adults with disabilities that limit their ability to care for themselves. The measure "go-outside-home disability" defines the percent of older adults with disabilities that limit their ability to leave their home.

Disability Among Older Adults in Manchester and the United States				
Adults in Manchester 65 years and Older in 2007	Percent of Males ≥65	Percent of Females ≥65	Percent of Population ≥65	Percent of US pop ≥65
With any disability	38.1	44.0	41.8	40.6
With a sensory disability	14.5	17.8	16.6	16.2
With a physical disability	30.8	37.5	35.0	31.1
With a mental disability	9.9	15.0	13.1	12.3
With a self-care disability	8.3	10.9	9.9	10.4
With a go-outside-home disability	13.8	23.0	19.5	17.5
Source: American Community Survey 2007				

Also relevant to disability in the Manchester HSA in 2007, 57.8% of adults over 64 years were diagnosed with arthritis or a similar condition.[63] That percentage is similar to the rest of the state. The related Healthy People 2010 goal is to reduce the number of adults with chronic joint symptoms who experienced a limitation in activity due to arthritis to 21%.

An important aspect of health and well-being for older adults is mental health. Mental health is not an isolated concern as it also affects various other aspects of physical health and general well-being.

One aspect of mental health that is often not diagnosed is depressive disorders. "Unfortunately, depressive disorders are a widely under-recognized condition and often are untreated or under-treated among older adults."[82] Risk factors for late-onset depression includes widowhood, physical illness, low educational attainment, impaired functional status, and heavy alcohol consumption.[82]

Access To Care

The following table shows measures of preventive health activities and use of the local health care system. In general, a higher proportion of Manchester HSA residents over age 64 access preventive services compared to the rest of New Hampshire. Also, for some of these key indicators, which are alternative ways to measure access to primary care services, Manchester HSA rates have exceeded the HP 2010 targets.

Health Care Use and Prevention			
	Manchester HSA	Rest of NH	HP 2010 Target
Percentage of women 65 years or older who have had a PAP smear within the last three years (2008)	55.3%	51.9%	90%
Percentage of women over age 50 who have had a mammogram in the last two years (2008)	89.8%	84.6%	70%
Percentage of adults 65 years or older who have ever had ever had sigmoidoscopy or colonoscopy (2008)	88.0%	78.6%	50%
Proportion of adults 65 and older who have had cholesterol checked in last five years (2005-2007)	99.8%	98.2%	80%
Adults 65 and older who have had hip fracture hospitalization (2006)	1.3 per 1,000	1.1per 1,000	4.7 per 1,000 (men)
Percentage of adults age 65 and older who have had influenza vaccination within the last 12 months (2008)	80.0%	78.0%	90%
Source: NH Behavioral Risk Factor Surveillance System			

Risks To Future Health

Health Behaviors

The following table summarizes key behaviors and indicators that are associated with health status and future health of the population. While these indicators are important measures by themselves, they also are associated with broader community characteristics that influence these behaviors. For example, ability to eat fruits and vegetables may be associated with: (a) their availability – if elders get to stores such as neighborhood stores that supply these vegetables and (b) cost – if local stores stock fruits and vegetables at an affordable cost. As it is nationwide, future health of the HSA elder population will be associated with these behaviors.

Health Risk Behaviors			
	Manchester HSA	Rest of NH	HP 2010 Target
Proportion of adults age 65 and older who eat five or more fruits and vegetables daily in Manchester HSA (2007)	29.9%	30.8%	
Proportion of adults age 65 and older who have had no leisure-time physical activity in past month in Manchester HSA (2008)	29.2%	32.2%	20%
Proportion of adults age 65 and older who are currently smoking in Manchester HSA (2008)	9.2%	6.9%	12%
Proportion of adults age 65 and older who are obese (2008)	24.9%	23.3%	15%
Source: NH Behavioral Risk Factor Surveillance System			

Physical Environment and Safety

As adults age, injury from falls becomes a concern. Nationally, more than a third of adults ages 65 and over suffers a fall during the year.[83] One common result of these falls is hip fractures. Across the United States there were 8.5 hospitalizations for hip fracture injuries per 1,000 adults over age 64 (2004).[84] In Manchester and the HSA, there were 0.8 hip fracture hospitalizations per 1,000 adults over 64, much lower than the national rate (2004).[85]

Family and Social Environment

Manchester Households with Older Adults			
	Number in 2007	Percent of adults ≥65 in 2007	Percent of adults ≥65 in 2000
Residents 65 and over in family households	7,867	57.3%	55.8%
Male Residents 65 and over living alone	845	6.2%	8.0%
Female Residents 65 and over living alone	3,418	24.9%	26.0%
Source: American Community Survey 2007, Census 2000			

Of the 45,481 households in Manchester, 9.4% of them consist of an adult over 64 living alone which puts them at risk of becoming isolated from the larger community. When older adults live alone, they are more likely to report poor health, poor diet, and poor functioning.[86, 87] Older adults living alone are also of concern for the community because as they age, the likelihood of developing disabling health problems for which they need assistance grows.

Nationally, people ages 65 and older experience violent crimes and property crimes at much lower rates than younger individuals.[88] At the same time, older adults may be more vulnerable than other age groups to certain types of crime. For example, elder abuse or maltreatment, which is usually under-reported and usually happens at the hands of a person the elder trusts, is a serious safety concern for older adults.[89] As evidenced by the table below, 13% of the 1,481 elder abuse cases reported to the state were for Manchester residents.

Reported Abuse for 60 years of age and older by type 7/1/08 to 5/1/09							
	Emotional	Exploitation	Neglect	Physical	Self-Neglect	Sexual	Total
Manchester	29	20	17	16	115	0	197
Entire State	211	202	183	99	778	8	1,481
Source: NH Bureau of Elderly and Adult Services							

Education

Differences in education level contribute to variations in health status across a population. In particular, health literacy (the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions) is generally lower among people who have less education. Older adults are more likely to have limited health literacy.[90] Understanding the population's education level can help communities plan for the health needs of older adults.

Older Adults in 2007		
	High School graduate or higher	Bachelor's Degree or higher
New Hampshire Residents 65 years and over	80.4%	23.5%
Manchester Residents 65 years and over	72.0%	13.3%
Manchester Male Residents 65 and over	74.4%	18.1%
Manchester Female Residents 65 and over	70.5%	10.3%
Source: American Community Survey 2007		

Economic Circumstances

Adults with fewer financial resources are at higher risk of poor health outcomes.[91] While many adults are working past the time where they are eligible for retirement, many other adults age 65 and over survive on a fixed or limited income. In 2007, 6.2% of adults ages 65 and over in Manchester lived at or below the Federal Poverty Level, and 10.2% of the 12,221 households in Manchester that include at least one adult 60 years or over received food stamps.[8]

Focus Group Participants Weigh In: Healthy Aging—Age 65 and Older

Elders who participated in our focus group discussions were concerned about being able to afford dental and vision care, losing their independence and mobility as they aged, and the costs of social service supports.

- In general, older focus group participants had good things to say about the medical care offered in the area.
- All the focus group participants felt well covered by their insurance plans, and many had supplemental coverage to assist with pharmacy costs. As a group, older participants were generally satisfied with their health insurance coverage and reported having no trouble getting appointments for medical care.
- Some participants reported being unable to access affordable dental or eye care.
- Participants reported being concerned that their health status was failing as they aged and described their fears about losing their independence and becoming a burden to their families.
- The issue that area elders talked about most frequently in relationship to their wish to remain independent was transportation. Elders and frail elders want the independence to transport themselves to appointments but often do not have the resources to do so, which creates a feeling that they are burdening their families. They identified the need for a better and more affordable public transportation system, above and beyond what is provided by Easter Seals and Seniors Count (programs that they were aware of and used).
- Participants discussed the need for more social programs and less expensive "Meals on Wheels" type programs.
- Safety was not an issue of concern among these focus group participants as most participants lived in apartment communities where they felt safe.

Data Snapshot: Healthy Aging—Age 65 and Older

HEALTHY AGING INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER
Family and social environment			
Percent of persons age 65 and over that are living alone, 2007, American Community Survey	31% (n=4,263)	na	24.9% all NH (n=41,278)
Percent of persons age 75 and over that are living alone	developmental		
Proportion of households with an individual 65 and over who is dependent upon a caregiver	developmental		
Proportion of households in which at least one grandparent is the primary caregiver of children under 18 years	developmental		
Number of reported cases of abuse of incapacitated adults age 60 years and over, 07/01/08 to 05/01/09, NHDHHS Bureau of Elderly and Adult Services	197	na	1,284
Percent of the population age 65 years and over that has a self-care disability, 2007, American Community Survey	9.9%	na	7.7% all NH
Percent of elderly residing in a nursing home on a given date.	developmental		
Economic Circumstances			
Proportion of adults age 65 and older live below 100% poverty, 2007, American Community Survey	6.2%	na	6.5% all NH
Property ownership among adults age 65 and older	developmental		
Education			
Percent of persons age 65 and over who did not graduate from high school, 2007, American Community Survey	28.0%*	na	19.6% all NH
Percent of persons age 65 and over who have a bachelor's degree or higher, 2007, American Community Survey	13.3%*	na	23.5% all NH
Physical environment and safety			
Manchester census tracts that have a population consisting of at least 25% individuals age 55 and over, 2000, Census	1.02, 7, 8, 11, 12, 22, 25		
Persons age 65 and older in Households by Dwelling Type	developmental		
** Significantly different from the rest of New Hampshire excluding Manchester*			

HEALTHY AGING INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Behavior				
Percent of adults age 65 and older who eat five or more fruits and vegetables daily, 2007, NH DHHS Behavioral Risk Factor Surveillance System	na	29.9%	30.7%	
Percent of adults age 65 and older who have had no leisure-time physical activity in past month, 2008, NH DHHS Behavioral Risk Factor Surveillance System	na	29.2%	31.9%	20% adults 18 and over
Percent of adults age 65 and older who are currently smoking, 2008, NH DHHS Behavioral Risk Factor Surveillance System	12.0%	9.2%	6.7%	
Health				
Adults age 65 and over who experience frequent mental distress, 2008, NH DHHS Behavioral Risk Factor Surveillance System	9.7%	7.8%	5.4%	
Mean number of physically unhealthy days among adults age 65 and over in the last 30 days, 2008, NH DHHS Behavioral Risk Factor Surveillance System	5	4.8	4.7	
Percent of adults age 65 and older who are obese, 2008, NH DHHS Behavioral Risk Factor Surveillance System	25.00%	22.80%	23.30%	15% adults 18 and over
Percent of adults age 65 or older who have been diagnosed with arthritis or a similar condition, 2007, NH DHHS Behavioral Risk Factor Surveillance System	na	57.8%	55.5%	
Percent of adults 65 and older who report a physical, sensory, mental, or self-care disability, 2007, American Community Survey	41.8%	na	35.8% all NH	
Proportion of adults 65 and older who have Alzheimer's disease	developmental			
Rate of hospitalization among adults age 65 and older after a fall	developmental			
Rate per 1000 of hospitalization for hip fractures among adults age 65 and over, 2006, NH DHHS, Hospitalization Data	1.0 (n=14)	1.2 (n=27)	1.1 (n=172)	4.2 females, 4.7 males
Percentage of adults age 65 and older experiencing a major depressive episode during the past year	developmental			
Rate per 100,000 of death from heart disease for adults 65 and older, 2006, NH DHHS, Death Data	248.6* (n=240)	230.1* (n=368)	173.4 (n=1,840)	
Leading causes of hospitalization for the population ages 65 and older, 2006, NH DHHS Hospitalization Data	Heart failure; Chronic ischemic heart disease; Cardiac dysrhythmias; Pneumonia; and Heart attacks			
Leading causes of death for the population age 65 and older, 2006, NH DHHS Death Data	Heart Disease; Cancer; Chronic lower respiratory diseases; Stroke; Alzheimer's disease;			

HEALTHY AGING INDICATORS	MANCHESTER	MANCHESTER HSA	NH WITHOUT MANCHESTER	HP 2010
Access				
Percent of adult females age 65 and older who have had a mammogram within past two years, 2008, NH DHHS Behavioral Risk Factor Surveillance System	92.6*	88.9%	83.4%	
Proportion of adults age 65 and older who have received an influenza vaccination in the past 12 months, 2008, NH DHHS Behavioral Risk Factor Surveillance System	78.0%	80.0%	78.1%	90%
Percent of adults age 65 and older who have ever had sigmoidoscopy or colonoscopy, 2008, NH DHHS Behavioral Risk Factor Surveillance System	85.2%	88.0%*	79.2%	
Proportion of the population age 65 and older who have had cholesterol checked within the past 5 years, 2007, NH DHHS Behavioral Risk Factor Surveillance System	na	99.8%	98.2%	80% adults 18 and over
Physician visits per annum for adults age 65 and older	developmental			
Presence of a full continuum of care	developmental			
Preventive health services for adults age 50-64 years	developmental			
** Significantly different from the rest of New Hampshire excluding Manchester*				

CONCLUSION: HEALTHY PEOPLE IN EVERY STAGE OF LIFE

The age-oriented sections of this Healthy People in Every Stage of Life chapter contain data that are intended to be used to pinpoint problems and to help shape plans and decisions for health improvement for different age groups in the Manchester area. Numerous organizations and departments contributed the data contained in this assessment report. Likewise, numerous organizations and departments should be included in efforts to take steps to improve community health. Examples of partnerships and collaborations of organizations that already exist include the Regional Infant Mental Health Team for very young children, the new Healthy Youth Collaborative for school-age youth, and Seniors Count for older adults.

Manchester HSA residents' health is influenced by myriad factors –individual biology, choices and activities, families, health care, education, employment and income, neighborhoods and communities, and the various social and institutional structures people experience every day. In this community health needs assessment, standard health outcomes as well as numerous behavioral, social and population measures for each age group were examined. Community health needs and health inequity were identified through summaries of both quantitative and qualitative data.

Birth to Six

Reducing the number of low and very low birth weight babies born in Manchester to meet target levels is important since birth weight, a key health indicator, can influence a variety of long-term health factors.

The housing in which young children spend most of their time can cause preventable negative health outcomes. Child blood lead screening and an integrated Healthy Homes effort in the Manchester area could address lead poisoning along with a host of other home-related health concerns for young children and their families. Healthy Homes is a national program that addresses various factors that affect healthy home environments.

In the last decade Manchester has seen improvement in the proportion of children who are fully immunized against vaccine-preventable diseases. Further improvement is still warranted. However, the apparently high rates at which Manchester children are hospitalized for Acute Ambulatory Care Sensitive Conditions may be a sign of a need for increased access to preventive health and primary care services.

Improved measurement and understanding of healthy practices among children and their parents in the Manchester area would help the community develop approaches to further enable parents to instill healthy behaviors and create an environment for healthy child development.

Youth

Manchester youth face an array of challenges as they grow. They experience constant media and social influences, violence and aggression, temptations to make unhealthy decisions, and a surrounding community that does not always give them the support they need. As a community with a desire to improve our youth population's overall health, the way youth experience the world and the specific challenges they face should be considered.

While youth spend their time in many settings, schools are a focal point of their daily experience for most of the year. Improved tracking of absenteeism, academic performance, violence, nutrition, and basic health measures in schools will enable us to make decisions and take targeted action about how best to improve youth health, both in and outside the school setting.

While the rate of births to teen mothers and the rate of Chlamydia infection among teens are high for New Hampshire, Manchester teens were no more likely than other New Hampshire youth to have reported having ever had sex. Overall, they report using a condom significantly more often than youth in the rest of the state. The community may want to consider approaches to improve teen health and well-being related to STDs, pregnancy, and sexual activity.

Data collected for the assessment identified obesity and mental health issues as additional areas of concern among school-age youth.

Healthy Life

Chronic diseases are a major concern for adult health in Manchester. The fundamental causes of chronic disease include individual risk factors, such as physical activity and nutrition, as well as broader social and environmental factors. As this process moves forward, it is important to address chronic disease prevention, in particular for heart disease and cancer, among adults in Manchester.

Mental health, identified in this report as a health-related need, is costly to the community in a variety of ways, through visits to the emergency room, as well as through lost work productivity and possibly weakened social relationships. Plans for adult health in the Manchester area should address mental health issues and ways of improving access to behavioral health care.

Other specific needs addressed in this assessment include issues such as drug use and obesity, as well as broader community health indicators such as premature death, access to health insurance, and overall health inequity based on income.

To improve the health of adults in Manchester and surrounding communities, it would be beneficial to approach adult health in an integrated, inclusive way that acknowledges various determinants of health. The community may want to continue to develop connections among existing organizations to combine expertise and resources and improve our ability to prevent health problems among adults. For example, the establishment of a steering body to guide efforts targeted at adults ages 18 to 29 may be appropriate.

Older Adults

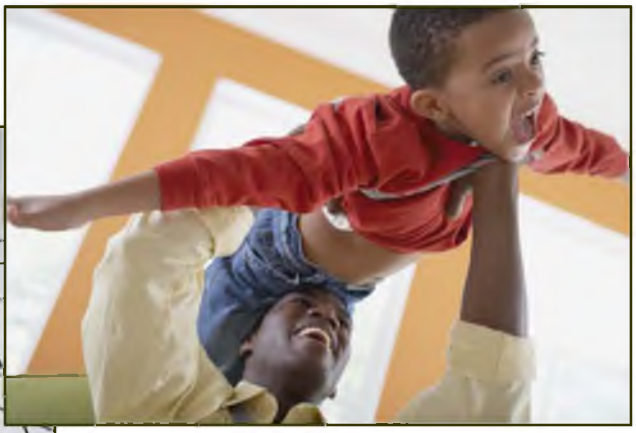
The data collected shows a disparity between men and women over the age of 65. Higher proportions of women ages 65 and over live alone and have only a high school education. Also, cancers affect men and women at different rates. Additionally, the percentage of women over age 65 who have any disability, specifically physical disabilities or go-outside-home disabilities, is higher than the national rate, while the percent of Manchester's men 65 and over who are living with disability is lower than the national rate.

Older adults in Manchester die of diseases of the heart at a higher rate than in the rest of the state, but they are hospitalized for heart attacks and diseases of the heart at a lower rate than the rest of the state.

Other noted needs for older adults include transportation, affordable dental and eye care, and services that allow for independence. Additional population health problems appear to include elder abuse, a lack of exercise and proper nutrition, obesity, and heart disease.

An important approach to addressing the needs of frail older adults in the Manchester area will be to reach out to those who are not connected to services and assistance that is available. Older adults who are isolated can be difficult to provide with assistance or information, and their opinions and needs are too easily neglected in assessment efforts.

Data available for this needs assessment do not differentiate among older adults of different ages or different levels of mobility. That is a shortcoming of this assessment and will be important to rectify in future assessments of older adults.



V. PEOPLE ACCESSING QUALITY HEALTH CARE
(STRATEGIC IMPERATIVE TWO)

Developing a high functioning community-based health care system requires a multi-pronged strategy that assures access to preventive, primary, and specialty care for all area residents, and concurrently assures that residents consistently receive the right care at the right time in the right place.[92]

> *"A synthesis of findings from the literature on the quality of health care provides abundant evidence of poor quality. There are examples of exemplary care, but the quality of care is not consistent. Thus, the average American cannot assume that he or she will receive the best care modern medicine has to offer."*[93] *– Institute of Medicine*

MANCHESTER HSA HEALTH CARE CAPACITY

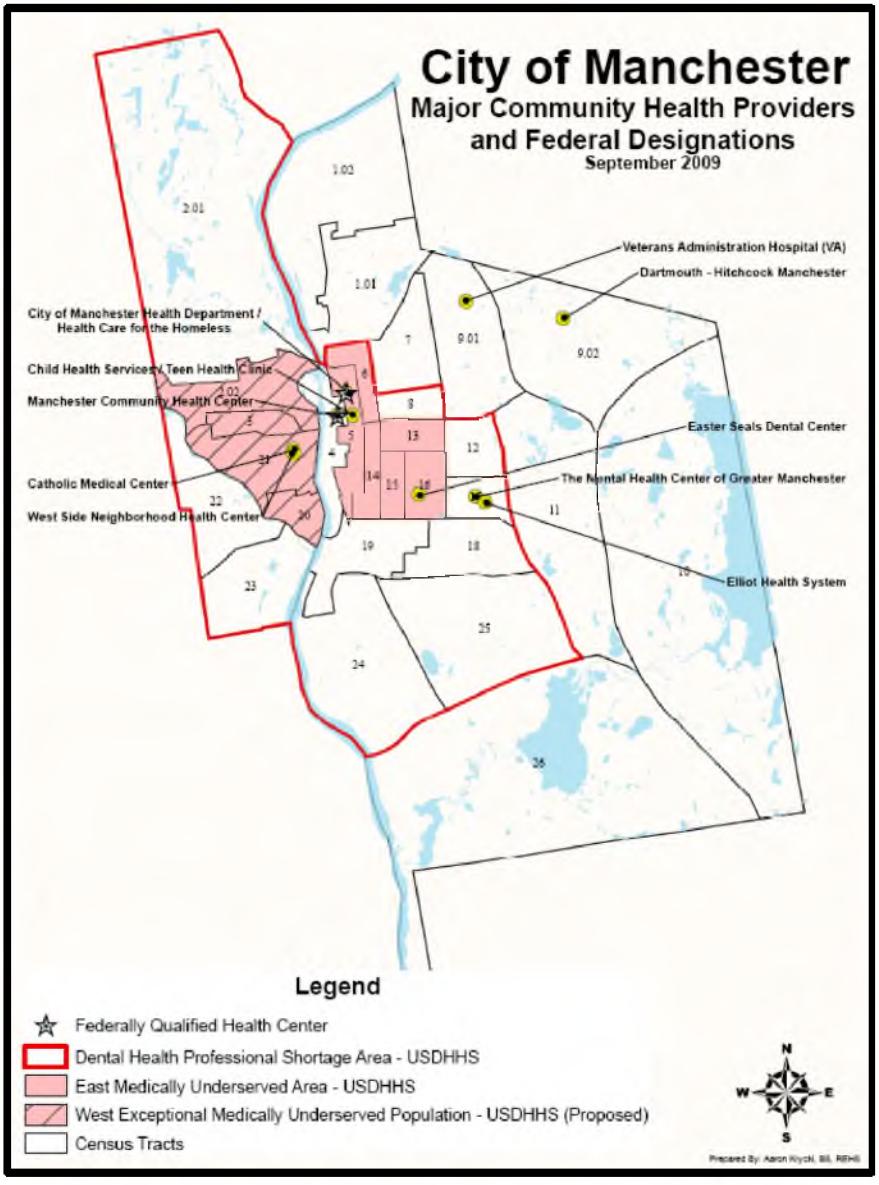
The Manchester Health Service Area (HSA) is fortunate to have a diverse primary health care system. A combination of public and private health care provides a loosely knit system of population-based public health services, social services, and primary, secondary, and tertiary care. Major provider institutions include: Catholic Medical Center (CMC), Dartmouth-Hitchcock Manchester (D-H), Elliot Health System (EHS), Child Health Services (CHS), Teen Health Clinic (THC), the Manchester Community Health Center (MCHC) and the Mental Health Center of Greater Manchester (MHCGM). Many other organizations, for example, the Manchester Health Department and the Health Care for the Homeless Project also provide some complimentary health care services to the local population.

The HSA capacity to provide oral health care is also growing. During 2009 alone the CMC Poisson Dental Facility expanded its fixed chair capacity from two chairs to three, D-H has made oral health services available through a portable dental unit, Easter Seals has opened a Dental Clinic with two fixed chairs, and the Manchester Health Department has partnered with community organizations to expand oral health services to children through the schools.

EHS continues to be the only provider of oral maxillofacial surgery in the area, and the private providers, Small Smiles, has provided access to dental care for many youth who use Medicaid.

While there is seemingly adequate health care capacity in the HSA, the 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. In fact, the federal government has recognized priority neighborhoods in Manchester as medically underserved. By definition, Medically Underserved Areas (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care.

As of September 2009, six census tracts on the east side of Manchester make up its MUA. An additional four census tracts on the west side of the City have been proposed for designation as an MUP. In addition, with a ratio of one dentist for every 4,601 residents, 21 census tracts were designated as a Dental Health Professional Shortage Areas (DPSA) due to the low dentist to resident population ratio. The map below illustrates these designation areas (pending approval of HRSA as of September 2009).



MANCHESTER HSA GETS GOOD MARKS FOR QUALITY

The health care community of the Manchester area is not only committed to improving access to health care, but is also continually working to improve the quality of the care that is provided. As illustrated in the table below, the quality composite scores for hospitals serving the Manchester HSA are often higher compared to the state average.

MANCHESTER HSA HOSPITAL QUALITY REPORT SCORES (2008)*

Acute Myocardial Infarction (Heart Attack)	Aspirin at Arrival	Aspirin at Discharge	Beta Blocker at Discharge	ACEI or ARBs for LVSD	Smoking Cessation Counseling	Composite Score
Catholic Medical Center	99%	100%	100%	99%	100%	99%
Dartmouth-Hitchcock Medical Center	98%	99%	99%	94%	99%	97%
Elliot Health Center	100%	100%	99%	100%	100%	99%
State Average	99%	99%	100%	96%	100%	98%

Congestive Heart Failure	LVF Assessment	ACEI or ARBs for LVSD	Smoking Cessation Counseling	Discharge Instructions	Composite Score
Catholic Medical Center	99%	100%	100%	90%	91%
Dartmouth-Hitchcock Medical Center	100%	96%	95%	82%	84%
Elliot Health Center	99%	94%	100%	73%	81%
State Average	98%	96%	98%	89%	89%

Community Acquired Pneumonia	Antibiotics Within 6 Hours	Blood Cultures Prior to Antibiotics	Appropriate Antibiotics	Pneumococcal Vaccination	Influenza Vaccination	Smoking Cessation Counseling	Composite Score
Catholic Medical Center	99%	98%	97%	94%	100%	100%	93%
Dartmouth-Hitchcock Medical Center	85%	90%	92%	88%	87%	80%	73%
Elliot Health Center	94%	89%	93%	98%	100%	100%	88%
State Average	96%	95%	94%	94%	93%	96%	86%

Surgical Care Improvement Project (SCIP)	Phophylactic Antibiotic Received Within One Hour Prior to Surgert	Prophylactic Antibiotic Selection	Prophylactic Antibiotic Discontinued within 24 Hours After Surgery	Recommended VTE Prophylaxis Ordered	Recommended VTE Prophylaxis Received	Controlled 6am Postop Serum Glucose	Appropriate Hair Removal	Composite Score
Catholic Medical Center	98%	98%	94%	98%	98%	95%	100%	92%
Dartmouth-Hitchcock Medical Center	96%	99%	92%	99%	98%	97%	99%	89%
Elliot Health Center	90%	98%	93%	94%	94%	0/0*	98%	84%
State Average	96%	98%	94%	94%	92%	91%	99%	87%

* no patients were medically eligible to receive this treatment

** This table was developed from the NH Quality Care Reports published by the Foundation for Healthy Communities and Northeast Health Care Quality Foundation which summarize hospital data from January 2008 through December 2008. These indicators are benchmark indicators for quality of care for hospitals from around the state for the specific common diagnoses of heart attacks, heart failure, pneumonia, and surgical infections.[94] (Dartmouth-Hitchcock Medical Center numbers include data from the Mary Hitchcock Memorial Hospital in Lebanon).*

Many quality improvement initiatives are being initiated by the area health providers. A few examples of such projects include the monitoring of physician practice-based immunization rates, timely intervention and screening of diabetics, implementation of electronic medical record (EMR) technologies, and community reporting of benchmark data.

MANCHESTER DOES WELL ON ACCESS TO PREVENTIVE SCREENING MEASURES

Manchester area providers do well compared to the rest of the state in providing screening services to the Manchester City and HSA population. Improvements are needed in providing influenza vaccination.

Access				
	Manchester	Manchester HSA	NH Without Manchester	HP2010
Had routine check up in past year, NHDHHS BRFSS 2005-2007	76.9%	76.3	71.5%	
Percent of the population age 18-64 who received an influenza vaccination within the last 12 months, 2008, NHDHHS BRFSS	31.4%	32.7%	36.0%	
Percent of women age 18-64 who have gotten a pap smear within the last three years, 2008, NHDHHS BRFSS	87.1%	87%	86.1%	90%
Percent of female population over 50 years old who have gotten a mammogram in the past two years, 2008, NHDHHS BRFSS	92.6%*	89.8%	84.7%	70% for 40 and older
Had Cholesterol checked in past five years, NHDHHS BRFSS 2005-2007	95.4	96.5	95.9	
** Significantly different from the rest of NH* *Source: NH DHHS, Behavioral Risk Factor Surveillance System*				

UNDERUSE OF PRIMARY CARE

Underuse of primary care is a quality concern for the Manchester area. The Institute Of Medicine (IOM) national roundtable summarized three major themes of health care quality for which our society pays a substantial price: overuse, underuse, and misuse of health care services.[93] We use the themes of underuse and misuse to talk about the quality of the primary care system in Manchester HSA.

> *"Lack of health insurance is a major contributing factor to underuse."*[93]

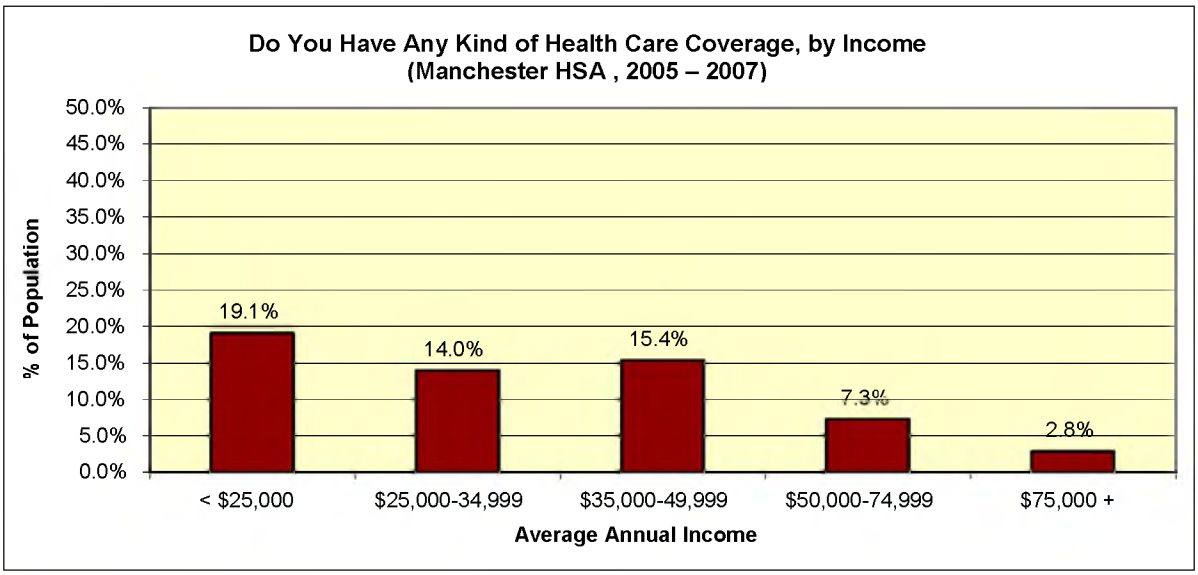
Not having health insurance or a medical home is associated with underuse of primary care. Persons with no health insurance are less likely to receive medical care, to receive medical care in a timely fashion, or high-technology interventions. They are also more likely to die from treatable conditions compared to their insured counterparts.[95] Persons without health insurance also receive fewer preventive services and less regular care for chronic conditions.[96]

In addition to the challenge of obtaining health insurance, Manchester's residents have other barriers to accessing quality care. Having a relationship with a regular medical provider, (i.e., having a medical home) has been shown to be a valuable contributor to access to quality health care services. A "medical home" is a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health care, including promotion and wellness services as well as acute and chronic care management. Once a medical home has been established for an uninsured or underinsured individual, that individual is more likely to gain access to services, including preventive care and regular physician visits.[97] Having a consistent source of care has also been associated with lower use of the emergency department and shorter hospital stays. In the Manchester HSA, having health insurance, being able to pay for care, and having a regular source of care are associated with income, age, and in some cases, gender.

Lack of Access

Lower Income

Not having health insurance and not being able to access care because of cost is associated with lower income.



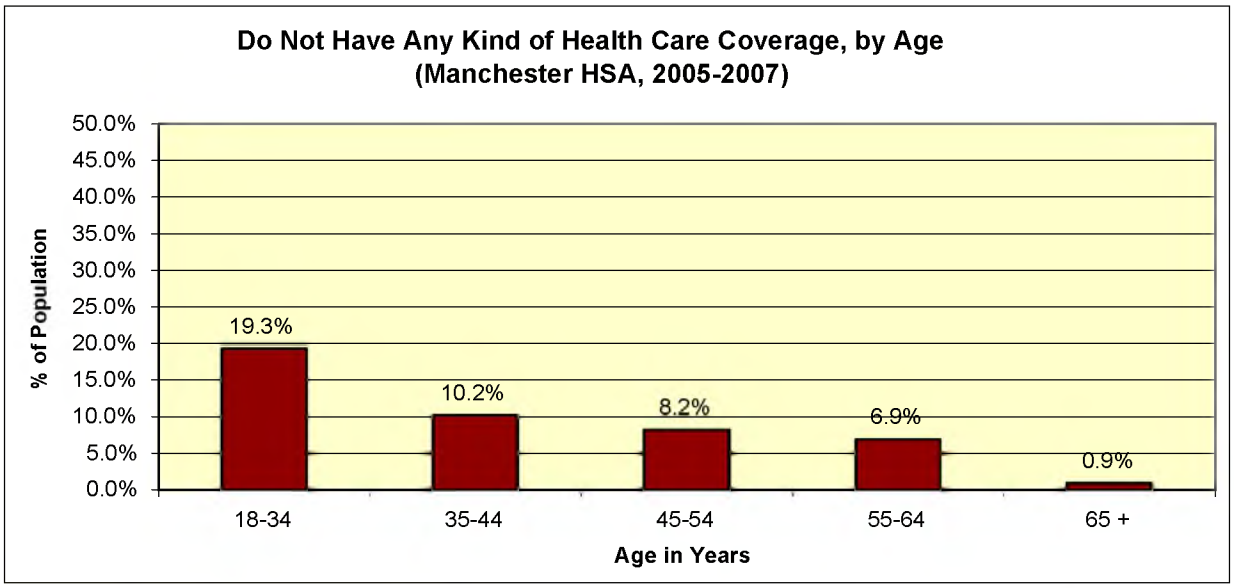
Source: NH Behavioral Risk Factor Surveillance System

Nearly twenty percent of the poorest HSA residents - those with incomes below $25,000 per year - reported that they had no health care coverage compared to 7% of HSA residents with incomes of $50-74,999 and 3% of residents with incomes of $75,000 or above (2005-2007).[63]

- Additionally, approximately 23% of HSA residents with incomes below $25,000 reported that they could not get health care services because of the cost of care compared to 14% for those with incomes between $35,000-49,000; and 3% of those with incomes of $75,000 or greater (2005-2007).[63]
- As might be expected, those in the lower income groups were more likely to report that they did not have a personal care physician compared to those in the higher income groups (for example, 21% of those with incomes below $25,000 reported no personal health provider compared to 15% ($25,000-34,999), 10% ($35,000-49,999), 7% ($50,000-74,999) and about 5% ($75,000+).[63]
- Finally, 32% of the HSA population with incomes below $25,000 reported having only fair/poor health compared to 26% of those with incomes of $25,000-34,999, 7% of those with incomes between $35,000-$49,999, 8% of those with incomes between $50,000-$74,999 and only 3% of those with incomes of $75,000 or greater (2005-2007).[63]

Age

Not having health insurance and not being able to access care because of cost is also associated with age (being younger).



Source: NH Behavioral Risk Factor Surveillance System

Being younger is also associated with having no health care coverage. About 19% of Manchester HSA adults, ages 18 to 34 years reported having no coverage compared to 10% of those ages 35 to 44, 8% of those 45 to 54, 7% of those 55 to 64 and about 1% of those 65 and older (these residents are assumed to be covered by Medicare).[63]

Additionally, 15% of HSA adults ages 18 to 34 report not being able to get care because of cost compared to about 11% for those 35 to 44, 9% of those 45 to 54, 4% of those 55 to 64 and 1% of those 65 and older.[63]

And about 15% of HSA adults ages 18 to 34 report having no personal health provider compared to about 14% for those 35 to 44, 7% of those 45 to 54, 5% of those 55 to 64 and 5% of those 65 and older.[63]

However, those who are younger report having better health. Only about 7% of HSA residents ages 18 to 35 reported that their health was fair/poor compared to about 9% of those ages 35 to 44, 14% of those 45 to 54, 13% of those 55 to 64 and about 22% of those 65 and older.[63]

Gender

Not having health insurance and not being able to access care because of cost is associated with gender. In the Manchester HSA, a significantly higher proportion of males reported that they did not have health insurance compared to females (12.8%, CI 11.6-14.0 compared to 10.4%, CI 9.5-11.2).

However, a significantly higher proportion of females (11.3%, CI 10.5%-12.2%) reported that they were not able to access care because of cost compared to males (8.1%, CI 7.2-9.0). In addition, a significantly higher proportion of males (12.7%, CI 9.6%-15.7%) compared to females (7.1%, CI 5.2%-9.0%) reported that they did not have a personal care provider.

Race and Ethnicity

Not having health insurance and not being able to access care because of cost is associated with Race and Ethnicity.

In 2004, the New Hampshire Minority Health Coalition published "The Health of African Descendents and Latinos in Hillsborough County".[98] It reports that:

- 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; and
- 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.[99] 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.

Burden on Community

Lack of insurance is a burden that affects more than just the individual – it also affects the entire community.

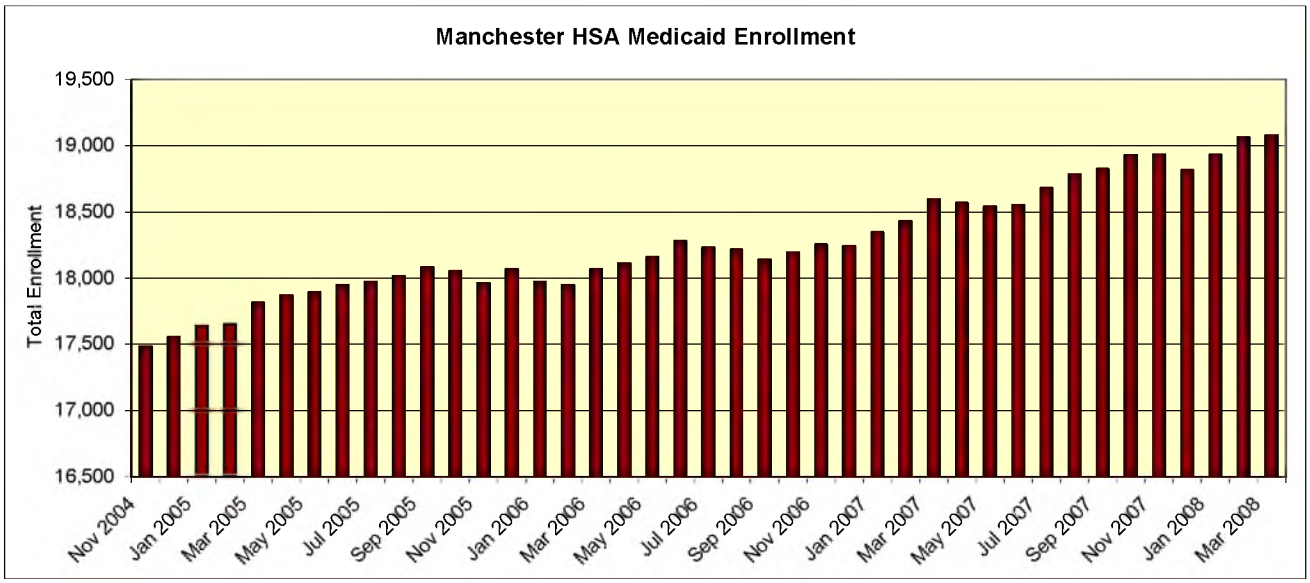
> *"The presence of a sizable or growing population of uninsured persons may impose destabilizing financial stresses on the health care providers that serve all community members and on the public and private sources that finance local health care."*[100]

The Institute of Medicine (IOM) reports that having one or more uninsured members in a family can have adverse consequences for everyone in the household.[101] Manchester primary care providers (including mental health providers) reported caring for 17,119 unique patients who were uninsured in 2008. This number represents about 8% of all patients seen during this time (please note this number is an estimate as we can not determine if patients have been double counted across community organizations).

Patients by Payer Mix						
	Primary Care					
	MCHC	D-H	CHS*	Elliot PCPs	CMC PCPs	MHCGM
Number of Unique Patients (unduplicated 2006-2008)	7,587	64,312	1,856	79,396	32,811	22,342
Payer Distribution						
Percent Medicaid	30%	15%	52%	8%	3%	28%
Number of Medicaid Patients	2,304	9,399	966	6,428	984	6,340
Percent Medicare	7%	8%	0%	16%	23%	14%
Number of Medicare Patients	543	5,124	9	12782	7,547	3,213
Percent Commercial	14%	72%	7%	72%	69%	38%
Number of Commercial Patients	1,078	46,146	124	57158	22,640	8,400
Percent Self-Pay and No Insurance	48%	6%	41%	4%	5%	20%
Number of Self-Pay and No Insurance	3,662	3,643	756	3,028	1,641	4,389
** CHS numbers include main program and Teen Health Clinic*						
Source Manchester local health care organizations						

Medicaid

Medicaid is a program that funds defined health care services for low-income families and individuals who meet certain eligibility criteria. Medicaid is jointly funded by the state and federal government; however, the rates of reimbursement do not cover the full cost of care by most providers. Between November 2004 and April 2008, the number of HSA persons enrolled in the Medicaid program has increased by about 9% (from 17,482 persons in 2004 to 19,082 in 2008). The increased growth of this under-funded program is creating a financial burden for the entire region that needs to be shared between all health care provider organizations that serve the community. Between 2005 and 2008 the City of Manchester experienced a 15% increase in the number of children enrolled in the Medicaid program with over 10,000 children reported to be enrolled in 2008.



Source: NH DHHS

Uncompensated Care Costs

Community providers incur financial losses every time they take care of a Medicaid patient (due to poor provider reimbursement) or a patient who is uninsured (due to costs of care not being paid for by any insurer). These losses are defined as "uncompensated care". The amount of uncompensated care provided by the HSA health care organizations is another indicator that reflects the growing rate of growth of the uninsured and underinsured populations in the HSA.

Uncompensated Care Costs

	Free Care (Uncompensated)	Medicaid (Above Reimbursement)*	Medicare (Above Reimbursement)	Interpretation (Uncompensated)	Totals
Manchester Community Health Center					
FY04	$784,037	$44,197	$25,923	$68,395	$922,552
FY05	$724,354	$0*	$12,435	$76,513	$813,302
FY06	$895,417	$0*	$19,312	$110,365	$1,025,094
FY07	$872,725	$0*	$14,308	$140,877	$1,027,910
FY08	$907,752	$333,627	$76,903	$118,217	$1,436,499
Dartmouth-Hitchcock					
FY04	$960,983	$2,651,959	$2,138,378	$61,715	$5,813,035
FY05	$1,234,914	$2,923,624	$2,467,544	$64,916	$6,690,998
FY06	$2,195,330	$3,674,913	$3,550,244	$129,921	$9,550,408
FY07	$2,460,469	$4,206,485	$4,320,846	$116,637	$11,104,437
FY08	$2,273,400	$4,706,871	$4,967,233	$213,533	$12,161,037
Child Health Services					
FY04	$166,430	$1,006,570	not applicable	$24,774	$1,197,774
FY05	$170,762	$932,240	not applicable	$30,865	$1,133,867
FY06	$151,802	$922,198	not applicable	$31,815	$1,105,815
FY07	$176,270	$1,037,599	not applicable	$28,907	$1,242,776
FY08	$246,004	$975,016	not applicable	$29,657	$1,250,677
Mental Health Center of Greater Manchester					
FY04	$423,162	not tracked	not tracked	$33,925	$457,087
FY05	$434,734	not tracked	not tracked	$18,520	$453,254
FY06	$461,934	not tracked	not tracked	$42,577	$504,511
FY07	$1,306,478	not tracked	not tracked	$55,091	$1,361,569
FY08	$1,317,306	not tracked	not tracked	$62,327	$1,379,633
Catholic Medical Center					
FY04	$5,211,298	$3,170,650	$6,680,639	$22,622	$15,085,209
FY05	$2,978,197	$4,140,131	$8,860,785	$27,795	$16,006,908
FY06	$4,603,877	$5,058,360	$10,624,876	$54,716	$20,341,829
FY07	$4,891,039	$6,556,228	$11,500,427	$54,111	$23,001,805
FY08	$5,666,411	$5,708,464	$16,687,495	$58,588	$28,120,958
Elliot Health System					
FY04	$5,057,339	$3,755,889	$5,861,532	$42,953	$14,717,713
FY05	$6,184,954	$4,421,925	$5,154,347	$40,905	$15,802,131
FY06	$6,627,200	$5,357,769	$7,165,160	$77,970	$19,228,099
FY07	$7,272,925	$7,934,263	$14,304,696	$86,828	$29,598,712
FY08	$7,695,558	$11,011,448	$13,393,257	$133,703	$32,233,966
TOTAL	**$74,353,061**	**$80,530,426**	**$117,826,340**	**$2,059,738**	**$274,769,565**

**Medicaid settlement for costs above what has already been paid is still under review*

Source: Community Provider Organizations Uncompensated Care Provided by Manchester Health Care Organizations: FY 2004 – FY 2008

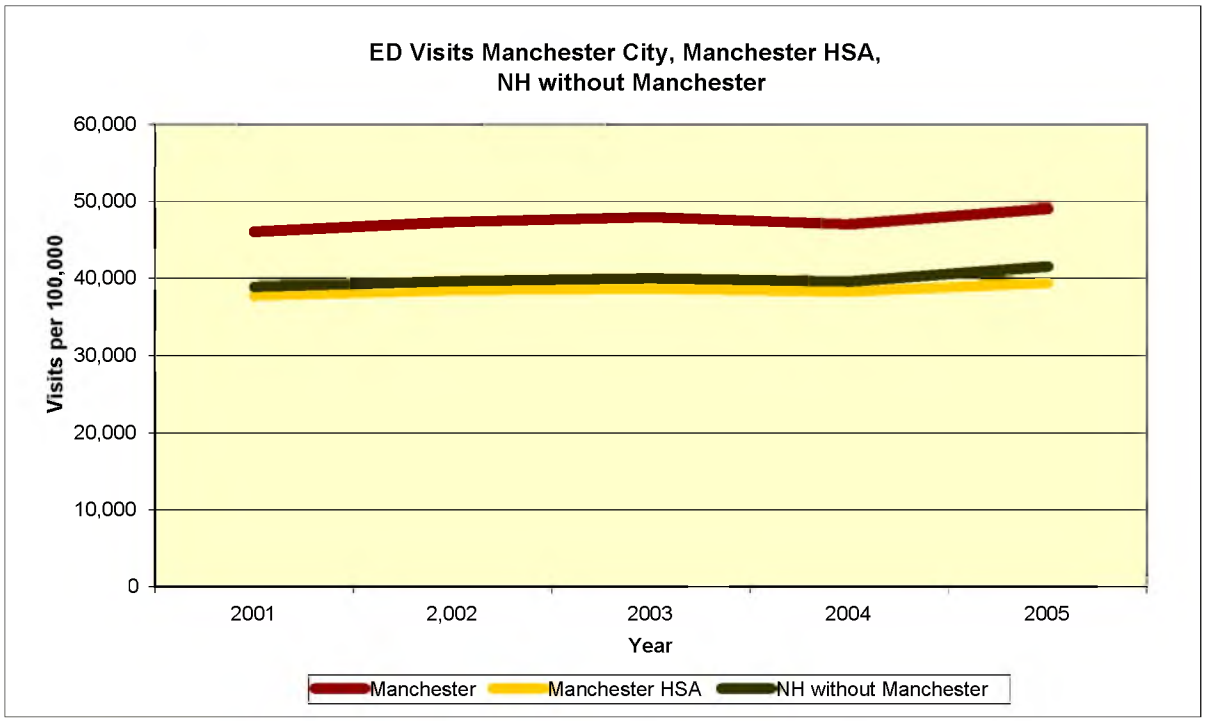
From 2004 to 2008, the costs to the HSA health care organizations for providing uncompensated care increased by about 50%. During this time, the HSA health care organizations (MCHC, D-H, CHS, MHCGM, CMC, EHS) contributed a total of $274,769,565 in uncompensated care to the community. This represents $74,353,061 in free care, $80,530,426 for costs of care provided for

Medicaid patients above and beyond what is reimbursed by the Medicaid program, $117,826,340 for the cost of care provided to Medicare patients above reimbursement by the Medicare program, and $2,059,738 for interpretation services.*

MISUSE—ACCESSING CARE IN THE WRONG PLACE, AT THE WRONG TIME, AT HIGHER COST

Misuse in the form of medical errors and accessing care in the wrong place has adverse affects not only on the patient but also the health care system. Medical errors have been associated with preventable death and adverse drug events. Delaying a medical visit until late at night when the only available provider is the emergency department (ED) not only puts the health of the patient at risk, but also increases the cost of care exponentially as the average cost of an ED visit is about five times more than a primary care visit.

The combination of inadequate insurance and lack of a medical home often results in inappropriate utilization of health care services. In fact, "lack of accessible primary care is the factor most commonly named in determining why patients, regardless of their insurance status or acuity, seek care in the ED."[95] As illustrated in the figure below, overall ED visits (for all causes) for Manchester residents have consistently occurred at significantly higher rates compared to the rest of the state for the years 2001 through 2005. However, visits for all HSA residents compared to the state (HSA includes Manchester) did not differ significantly during this time. These data suggest that Manchester residents may have more trouble accessing primary care than do those who reside in the towns surrounding Manchester.



Source: NH DHHS

* *Free care is defined by the community health care organization as the total unreimbursed cost of the free or reduced fee care provided due to a patient's financial situation.*

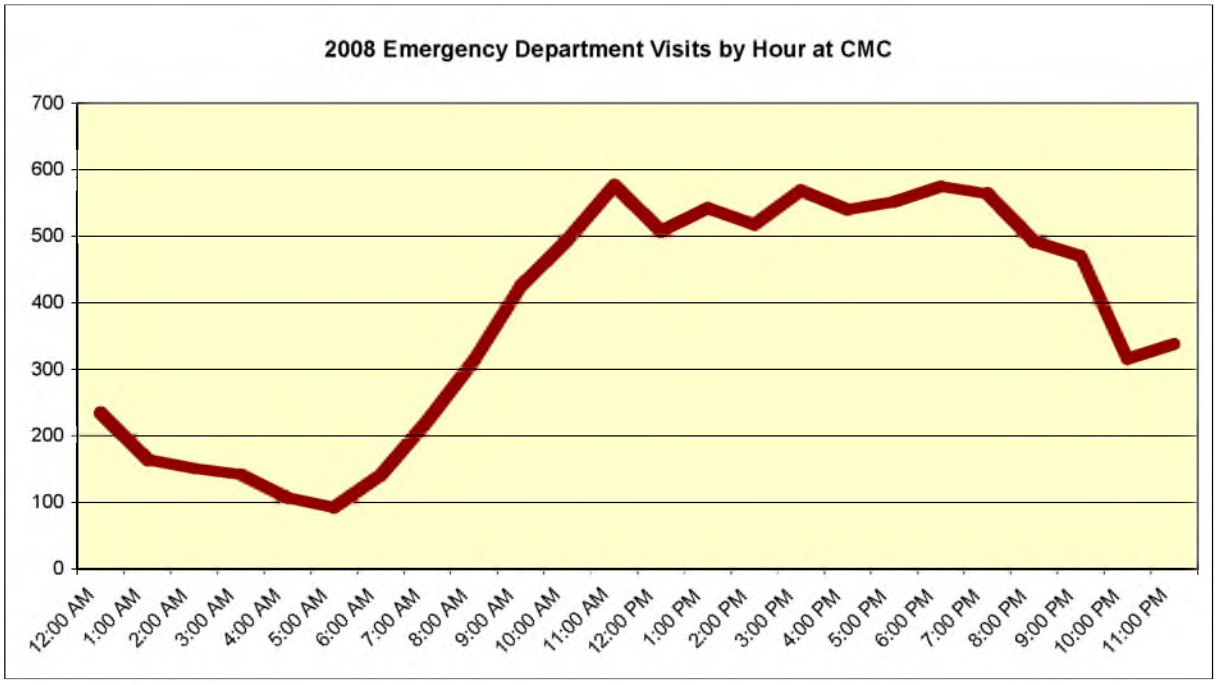
Local Emergency Department (ED) Visits

Recent data from the two HSA community hospital EDs illustrate that many residents are using the EDs to obtain services or care that often could be provided in a primary care setting which is more cost effective for the entire community.

In 2008, CMC and EHS EDs provided 88,100 ED visits to 56,109 unique individuals (an average of 1.6 ED visits per person per year). Of these 88,100 ED visits 10,856 resulted in patient admission to the hospital.

Also, 26% (n=19,793) of these ED visits are classified as level one (LI) or level two (LII) visits (visits for care that could have been obtained in a primary care physician's office)

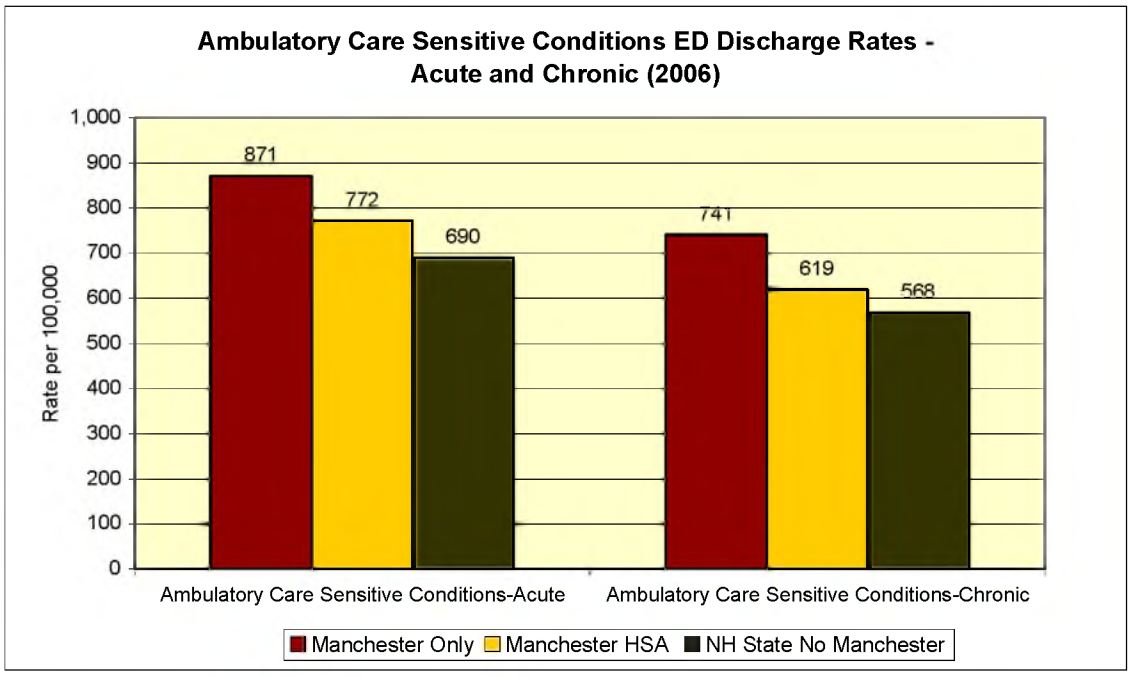
- 89% (n=17,220) of these LI & LII visits were for persons who lived in the HSA.
- 70% (n= 13,515) were for persons residing in Manchester.
- 19% (n=3,705) were for persons living in the towns surrounding Manchester included in the HSA as defined by this report.
- 36% of the 19,793 LI & LII visits (n=7,222) were for self-pay patients (those who are uninsured or underinsured).
- ED usage at Catholic Medical Center peaks between 11:00am and 7:00pm which may speak to the need for expansion of primary care hours during the day, open scheduling across community providers, and or education of patients on how to appropriately use primary care and area EDs.



Source: Catholic Medical Center

Like the Level I and II ED visits, Ambulatory Care Sensitive Conditions (ACSC) are defined as medical conditions that are less likely to require inpatient hospitalization if timely and appropriate primary care is received.

These local data depicting high use rates of the area EDs for non-urgent care is supported by 2006 data provided by NHDHHS. An indication that the health care organizations in the area may not be functioning as a coordinated system for the population for which they are responsible is the significantly higher rates of ACSC discharges (for Manchester area residents) compared to the ACSC discharge rates for the rest of the state's residents as illustrated in the figure below.



Source: NH DHHS

AREA RESIDENTS WEIGH IN: ACCESS TO QUALITY HEALTH CARE SERVICES

Health Care Availability Overview

In general, focus group participants and key leaders from the HSA towns outside of Manchester recognized that several options exist for accessing health care services in the Manchester area. Participants mentioned by name The Greater Manchester Mental Health Center, Easter Seals, The Senior Center, West Side Neighborhood Clinic, Manchester Community Health Center, Child Health Services, Elliot Health System, Catholic Medical Center, Dartmouth Hitchcock-Manchester, Urgent Care, Poisson Dental Center, 211 information line, and several physicians in private practices as being available to provide them services.

However, despite having access to these many providers, participants stated that the cost of care (particularly for medications and dental care) and getting access to oral health, substance abuse, mental health and vision care was very difficult, especially for those lacking insurance, or those insured by Medicaid or Medicare. In addition, access to specialty care services was an issue for those living outside of Manchester. Making and keeping appointments and coordinating administrative processes for billing were mentioned as often being difficult.

Issues of Access

Forty-five percent of focus group participants reported having problems accessing care in the past twelve months. The table below displays the problems described by participants in order of prevalence.

Access	%
Difficulties getting transportation	11%
Long waiting times in office	11%
Lack of convenient hours	8%
Could not find a doctor accepting new patients	7%
Difficulties in making appointments	6%
Don't know where to get health care	5%
Can't get off from work	3%
Difficulties getting child care	2%
Do not understand medical directions	2%

Transportation

The access issue mentioned by most participants was transportation. Focus group participants are aware of the medical transportation systems in the area (public transportation, ServiceLink, Caregivers, Easter Seals, etc.), but stated that these services do not adequately address their needs. The participants said the bus routes are too far apart, not handicapped accessible, and schedules are too difficult to match to medical appointments in a timely fashion.

> *Towns Surrounding Manchester*: Several town leaders mentioned transportation for the elderly as an issue. Elderly have a difficult time traveling within their towns, as well as out of town to medical appointments in Manchester or Concord, especially specialty care appointments which are most often out of town.

People Don't Know Where to Get Health Care Services

Several focus group participants stated that they were not aware of the services available in their community and did not know where to turn for advice.

> *Towns Surrounding Manchester*: Leaders interviewed from the towns surrounding Manchester brought this issue of awareness up several times especially in regard to mental health services, specialty care services, and in general, knowing what services were available in the area.

Securing Interpretation Services is a Challenge

Securing medical interpretation services remains a challenge for participants who represented minority and immigrant populations. One woman stated that immigrants do not go to the doctor because they are not understood by the person on the phone who says, "I cannot understand you." She also reported that the immigrant community needs to rely on friends or family members to help with medical interpretation and that this affects care.

Participants from Somalia stated that they are able to get their needs met with help from the staff at the Somalia Development Center (SDC). Several respondents in this group stated that "all their needs are taken care of by the SDC". SDC schedules appointments, handles transportation, provides translation at the appointments, and picks up prescriptions. Additionally, the SDC will call the ED if needed in the middle of the night.

Mental Health Care

Mental health care access was most important to participants dealing with mental health issues and disabilities and for those needing treatment for mood disorders, suicide and substance abuse. Participants dealing with mental health issues talked about the challenge of finding appropriate services for their adult dependent children, the lack of training for those in law enforcement and criminal justice systems, and the shortage of mental health professionals available to respond to individuals experiencing a mental health crisis in the ED.

Several respondents talked about how difficult it is to support someone through a mental health crisis. They stated that after an acute episode involving ED or hospital care, they had experienced incidents of being referred back to the community to seek follow-up care which had not been readily available to them in the first place. Additionally, it was noted that there is no detoxification center in the area and that there is lack of access to adequate mental health care and medication in the area prison system.

> *Towns Surrounding Manchester:* Several leaders from the HSA towns surrounding Manchester noted that gaining access to mental health providers is often difficult as there may still be a stigma attached to obtaining this type of care. Leaders thought it would be helpful to have mental health services provided through primary care in the local area. Additionally, leaders mentioned a general lack of awareness about where to get mental health care services.

Oral Health Care

The high cost of oral health care for either preventive or restorative work was a concern addressed in every focus group. Community members are aware of the importance of good oral health and how it impacts their general health status, but many go without routine care. Many focus group participants did not have dental insurance, or if they had Medicaid, could not find dental practices in the area who

would accept this payment. Participants stated that they could make appointments when they needed them, but simply could not afford the cost. Therefore, they put off care unless they had a crisis or if they did go for an appointment, have only the necessary services and forego more expensive care, such as x-rays. One Manchester resident stated that she travels more than 60 miles north of the HSA for oral health care because the cost of cleanings is cheaper.

Towns Surrounding Manchester: Leaders from the HSA towns surrounding Manchester stated that access to oral health care services because of cost was an issue both for children and for adults.

Several of the participants had diabetes and were acutely aware of the impact of poor oral health on their insulin levels. They too had experienced barriers to obtaining oral health care. Most participants were aware that oral health services are provided by the Poisson Oral Health Clinic, although, they reported that they had had difficulties getting appointments there. Almost all participants were aware of the oral maxillofacial surgical unit at the Elliot Health System.

Specialty Care – Towns Surrounding Manchester

It was noted by leadership from the HSA towns outside of Manchester that there were long waits for specialty care services, including access to dermatologists and neurologists.

Use of the Emergency Department

The median number of visits that the focus group participants (or someone in their family) made to the emergency department during the past year was one, and the maximum number of visits was ten. Of those participants who utilized an emergency department, 54% reported that they had considered seeing a doctor in his or her office before going to the emergency department.

The participants were asked to describe their decision-making process leading to the ED visit. In the case of non-critical visits, all but one of the participants stated that he or she went to the ED only after first calling their doctor's office. This person went to the ED because he or she had tried calling his doctor, but did not get a response.

Services for Those with a Disability or Mental Health Issue

In the focus groups with individuals dealing with a disability and/or a mental health issue, there was concern about the availability of services and getting assistance for individuals with disability when they become 21 years old. Up to that point, the local school districts assume much of the cost for helping individuals function somewhat independently. However, when they turn 21 years old, their benefits shift to the NHDHHS. Caregivers and individuals alike are deeply concerned with the state's inability to meet their needs. One caregiver said "it will result in more emergency room visits".

Issues of Cost

According to data from the 2007 National Health Interview Survey, 8% of Americans (23.1 million) delayed medical care at least once in the previous year due to the cost of care. Additionally, 6% (17.3 million) did not receive care at all because of the cost of care. Thirty-four percent of the focus group participants reported having trouble seeing a doctor in the past 12 months due to cost. Among participants, the biggest cost barriers were related to no insurance (18%), cost of insurance (11%) or they could not afford a doctors visit (11%).

Cost Barriers	%
Trouble Seeing a Doctor Because of Cost	34%
Specific Cost Barriers	
No insurance	18%
Can't afford medications	11%
Can't afford to visit the doctor	11%

Cost of Insurance

Many participants had experienced a recent job loss or they were concerned of an imminent separation from work for a family member. Several participants said they couldn't afford to purchase their health insurance through COBRA because their unemployment benefits were too little. The lack of health insurance coverage was recently documented in a publication from Families USA.[102] This report gives a state-by-state profile on the status of insurance coverage and documents that as the income levels of individuals go down, uninsured rates go up. Specifically, of the 279,000 uninsured New Hampshire residents nearly three-quarters (72.4%) went without health coverage for six months or longer (2007-2008). According to this report, the majority of the uninsured are full-time workers (69.7%) or part-time workers (9.5%).[102]

Cost of Prescriptions

Several participants had a hard time paying for medications and made difficult choices to address their medical priorities. One participant stated that he lied for several months to his doctor about the quantity and frequency of use of his insulin. His wife was recently laid off from work and he could no longer afford the co-pay for the office visit and his medication. He was desperately afraid of running out. In an attempt to stretch out his supply, he was taking less and less. Finally, he told his doctor about his fear of being dropped from the practice because he could not pay the co-pay and his struggle to buy the medication. Another participant faced a similar situation. As a recent cancer survivor and pulmonary patient, she could not afford the mounting expenses to treat both conditions. Caught in the "donut hole" with Medicaid and the need to spend down, she decided to stop taking the medication for her cancer. Acting completely rationally she said, "I need to breathe more". She continues to explore alternative ways to purchase cheaper drugs either on-line or in Canada.

In terms of getting prescriptions filled, several respondents mentioned they missed the pharmacy at DH-M. It was very convenient as they could fill their prescription when at the facility for their appointment.

Growing Gap between Those with and Those without Insurance Coverage

Several participants stated that they felt a strong resentment toward the government, toward populations perceived to be getting care and services more easily (e.g., new immigrants) and the health care system in general. Given the downturn in the economy, several participants stated that

they felt that they had no options or a place to turn to help them pay for the cost of their medical care, prescriptions, or dental work. For those who had applied for assistance, many were denied benefits because their income was too high based on their most current earnings.

Issues of Quality

Most focus group participants were very satisfied with the quality of care they receive from their medical providers. A handful of participants said they had experiences with uncaring staff at the emergency department (ED), but attributed this to the staff being overworked.

Several participants talked about feeling alone dealing with either their medical problems or with that of a family member. In one focus group, a participant stated that a family member was sent home after major surgery with a feeding tube and no visiting nurse or help in place to provide care. Participants thought that this sense of isolation occurs, in part, because the provider office visits are often too short, and leave the patients little time to explore their concerns. Several participants stated that they did not have the knowledge to ask the right questions to prepare themselves for discharge from a medical stay. Also, several participants stated that they needed help with coordinating services, making decisions about care for more complicated conditions, exploring options for themselves or a loved one, and helping with information and referral.

DATA SNAPSHOT: PEOPLE ACCESSING QUALITY HEALTH CARE

The table below summarizes the main themes talked about by Key Leaders and Focus Group Participants in regard to what the community is doing well and where it could do better in regard to issues of *Health Care Availability* and *Access to Transportation* and *Interpretation Services*.

INDICATOR	MAIN THEMES
Health Care Availability	WHAT WE ARE DOING WELL • Immunizations • Health providers do a good job providing access to the uninsured • Kudos to providers • Mobile Community Health Team is a success • Healthy families are ok • Poisson Dental Clinic WHERE WE COULD DO BETTER • Increase the number of oral, mental, and vision care providers who accept Medicaid and Medicare, and offer sliding fee scales • More primary care providers in towns surrounding Manchester • Expand school-based dental services in towns surrounding Manchester • Increase services for aging population • How to pay for services for the uninsured? • Emergency Department volume is a big concern especially in relationship to inappropriate use of these services • More public education about the appropriate use of health care services, including Emergency Department services • Develop disincentives for Emergency Department use • Develop a day center for the homeless • Improve economic access • Cost is an issue for chronically ill, terminally ill, and vulnerable populations • Wrap around for those who need it for a finite period • Medicaid creates a disincentive to work • We need day care, job training, and health insurance for everyone and then wean them off during 2-3 year period • Better access to specialty care especially in the towns surrounding Manchester • Increase capacity of the Manchester Community Health Center
Health Care Access (Transportation and Interpretation)	WHAT WE ARE DOING WELL • Connections to International Center are helpful • Language line • Health Department welcome center • We are trying to meet community needs for interpretation and translation services • Attorney in district court translated forms into several languages • Easter Seals transportation • Health systems shuttle buses

	WHERE WE COULD DO BETTER • We need more funding for interpretation and translation services • Interpretation is an unfunded mandate • Interpretation is expensive • Translation for disabled is expensive • Interpretation for Deaf • Transportation issues are unique for different populations • It is hard for people to get to work and to appointments when they have to rely on the public transportation system • The elderly in and outside the City struggle with the issue of transportation • Transportation is a big issue for towns outside the public transportation system of Manchester • City transportation services as designed are not meeting the needs of the public • The City needs more funding for refugee resettlement • NH refugee resettlement office should be located at NHDHHS. Child care is impossible to afford for those on TANF who need to work 30 hrs/week to maintain this benefit • Emergency planning and responders for towns outside of Manchester should be enhanced

CONCLUSION

Historically, public health has focused on the prevention and control of infectious diseases. Advances in medical technology, combined with effective population-based public health interventions have influenced a transition from a focus on communicable disease to a focus on managing chronic conditions. Patients requiring ongoing care for chronic conditions need to be supported with an integrated, coordinated system ranging from primary care to specialist consults and community-based interventions are needed to compliment these services. Thus, it is essential that the community and all of its providers collaborate to prevent chronic disease and produce more desirable health outcomes.

Key leaders in Manchester recognize that our medical system is focused on treatment rather than prevention, and that assuring positive health outcomes for area residents will necessitate a commitment to system redesign framed by quality measured and health outcomes data.

As for enhancing the ancillary services that must be developed if Manchester hopes to create a comprehensive quality primary care system "Manchester struggles with being small and big" simultaneously. It was noted by key informants and local residents that the City seemed too big to rely on the transportation and translation and social services it currently has, but on the other hand is too small to raise enough money to build the infrastructure needed to support the population in these areas.

VI. HEALTHY PEOPLE IN HEALTHY NEIGHBORHOODS (STRATEGIC IMPERATIVE THREE)

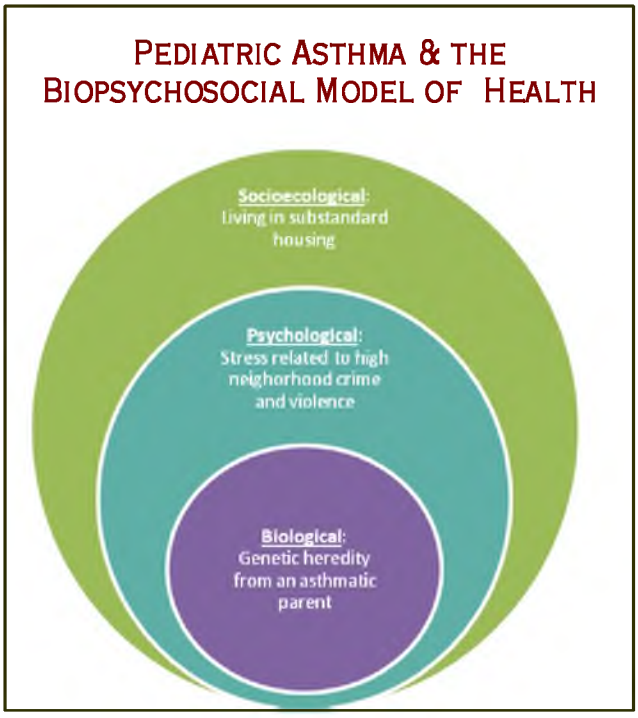
"Investing in our schools, improving housing, integrating neighborhoods, better jobs and wages, giving people more control over their work – these are as much health strategies as disease prevention and education efforts."

(Dr. David R. Williams, Harvard School of Public Health and RWJ Foundation Commission to Build a Healthier America)

WHERE YOU LIVE EFFECTS YOUR HEALTH

An individual's health status is greatly influenced by where he/she lives, works, plays, shops, and learns. Understanding the place-based factors affecting health is necessary for creating health promoting neighborhoods for all Manchester residents.[103-105, 106]

The Institute of Medicine defines health as "a state of well-being and the capability to function in the face of changing circumstances." Based on this definition, health is more than the presence or absence of disease. It is rooted in interactions among individual characteristics and the surrounding environment, such as a person's place of residence or his social support network.



A more formalized expansion of this concept is known as the "Biopsychosocial Model of Health" (Figure A).[107] In the example of pediatric asthma summarized in Figure A, the biological factor of genetic heredity is affected by increased stress related to the exposure to violence, which has proven to increase asthma exacerbations or attacks, and substandard housing that increases the risk of exposure to known asthma triggers, such as cockroaches or mold.[108, 109] This model illustrates clearly the connection between the traditional biomedical approach of medicine (which is focused on the diagnosis, treatment and management of disease) and the population-based, ecological approach of public health (which aims to include social, cultural and psychological, and environmental influences on health).

These models direct us to examine the places or environments in which people spend their time in order to fully understand community health. "Environment" has many important interpretations and

definitions – from everyday resources such as clean air and water to the social impacts within neighborhoods, such as poverty or crime. In this chapter the neighborhood environment where people live, work, learn, and play was discussed in terms of *traditional environmental health* concerns, such as air, water and food sources, the *built environment* that focuses on improving a community's physical design and structure, and the *social environment* that aims to address socioeconomic concerns, such as the growth in poverty and fostering community cohesion.

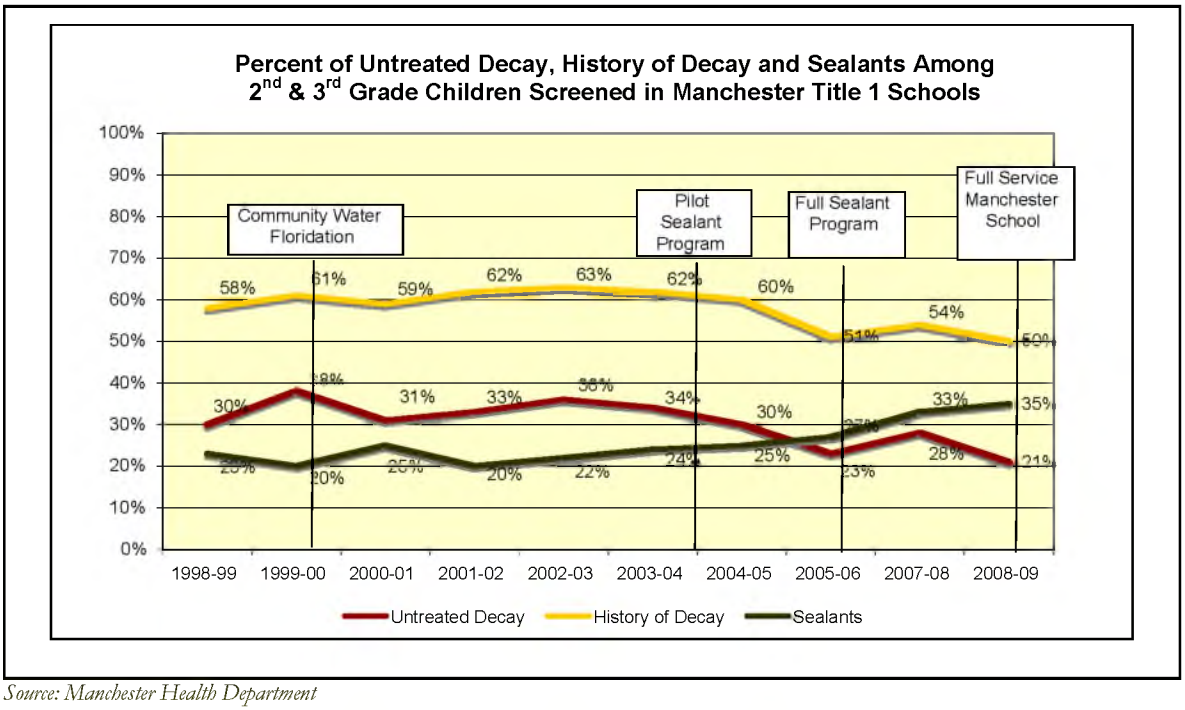
The information in this chapter primarily focuses on the City of Manchester and includes data about the other HSA communities when possible. While the severity may be different in the communities outside of Manchester, the variables described exist in all HSA communities to a certain extent, and these factors are critical elements to consider for the future development of population health improvement strategies.

TRADITIONAL ENVIRONMENTAL HEALTH

The traditional field of environmental health encompasses the health consequences of the interaction between people and their natural environment. Examples of such factors include safe and adequate food, clean drinking water, and good air quality. The Manchester Health Department, in addition to several City departments and community partners, is actively involved in protecting community health as it relates to the natural environment.

Enhancing the Publics' Water Supply

The public water supply that serves Manchester as well as residents within some of the surrounding communities was fluoridated in 2000 to improve the oral health of Manchester residents by decreasing dental decay. A fluoridated water supply is considered one of the top ten greatest achievements of public health in the 20th Century. In Manchester, a combination of community water fluoridation and a full dental sealant program has contributed to a reduction in untreated dental decay and the overall history of decay among elementary school aged children.



Source: Manchester Health Department

Food Safety

A major aspect of ensuring a safe food source is achieved through routine restaurant inspections. All licensed food service establishments are inspected twice per year. The goal of the inspections is to prevent and/or remedy critical violations in food preparation practices that pose a particular health threat to patrons or employees. The following table shows the number of establishments that had two or more critical violations on their food safety inspections each year.

Food Safety Imspections and Violations

Inspection Year	Number of Inspections	Inspections With 2+ Critical Violations	% with 2+ Critical Violations
2006*	716	103	14.4%
2007	1622	236	14.6%
2008	1978	320	16.2%
2009*	536	87	16.2%
total	4852	746	15.4%

**Partial Years - 2006 beginning 6/1/2006. 2009 ending 5/21/2009.*
Source: Manchester Health Department

Correcting violations of food preparation is important because violations increase the community's risk of exposure to food borne illnesses, such as Salmonella or E. coli. Illness from food borne pathogens may also result from individual or farm practices, as well as restaurant, grocery store, or catering activities. The table below lists cases of food borne illnesses investigated by the health department.

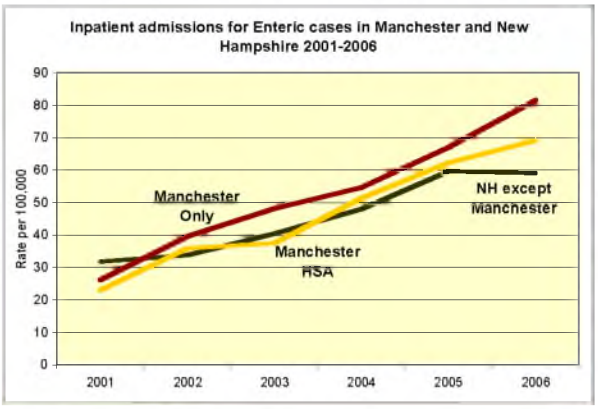
Cases of enteric disease (food- or water-borne illness) are caused by eating or drinking contaminated food or water or by contact with infected feces or vomit. Cases of these diseases provide an indirect measure of food safety practices; however, enteric disease is highly underreported due to its common, and often delayed, symptoms, such as nausea and diarrhea.

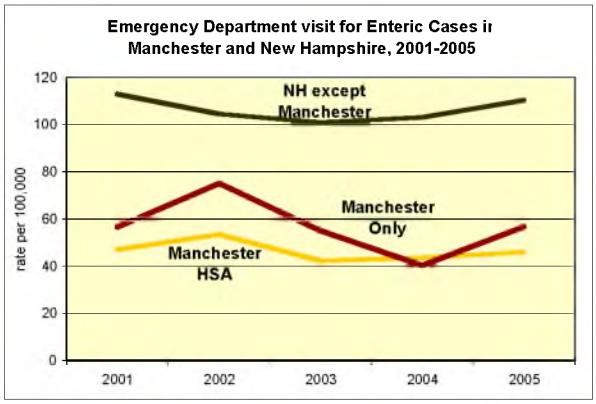
Food borne Illness Investigations in Manchester, 2005-2009

Food borne Illnesses	2005	2006	2007	2008	1/09 to 5/09
Campylobacter	26	10	19	13	12
E. Coli 0157	2	4	1	3	2
Giardia	51	11	4	3	11
Hepatitis A	9	16	6	6	7
Salmonella	12	11	35	13	13
Shigella	0	1	1	0	1

Source: Manchester Health Department

Safe food and water sources are important because enteric diseases can be serious health risks and result in hospitalization. The graphs below show that residents in the rest of the state visit emergency departments more than Manchester area residents for enteric diseases. Since 2001, inpatient admission for enteric disease has increased significantly both in Manchester and statewide.





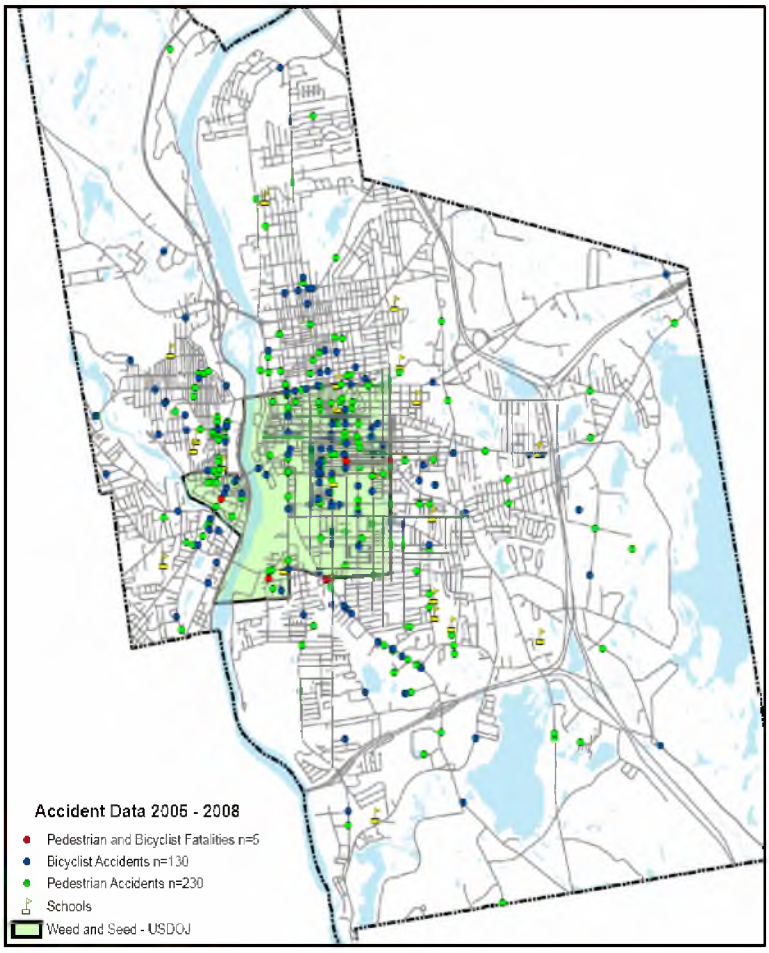
Source: NH DHHS

THE BUILT ENVIRONMENT

Health promoting neighborhoods provide and facilitate connections to essential resources for their residents. Examples of essential resources are quality health care and safe places for physical activity. In general, a health-promoting neighborhood is important for community well-being and livability.

The built environment refers to structural elements within the community, such as sidewalks, streets, walking paths, parks, and public and private buildings. An example of a concern related to the built environment and healthy community design is ensuring that a community has access to safe places for physical activity and healthy food options. For instance, if a corner store is serving as the neighborhood's main source of food and it does not provide fresh fruits and vegetables, the built environment makes it challenging, if not impossible, for the families within the neighborhood to achieve good nutrition.

MANCHESTER PEDESTRIAN ACCIDENTS 2005-2008



Source: Manchester Health Department

NEIGHBORHOOD SAFETY

Another example of how the built environment influences health is in its relationship to safety. Health-promoting neighborhoods are livable and walkable. Poor structural design can lead to unsafe areas for walking and/or bicycling. From 2005 to 2008, there were five pedestrian/bicycle fatalities, 130 bicycle accidents, and 230 pedestrian

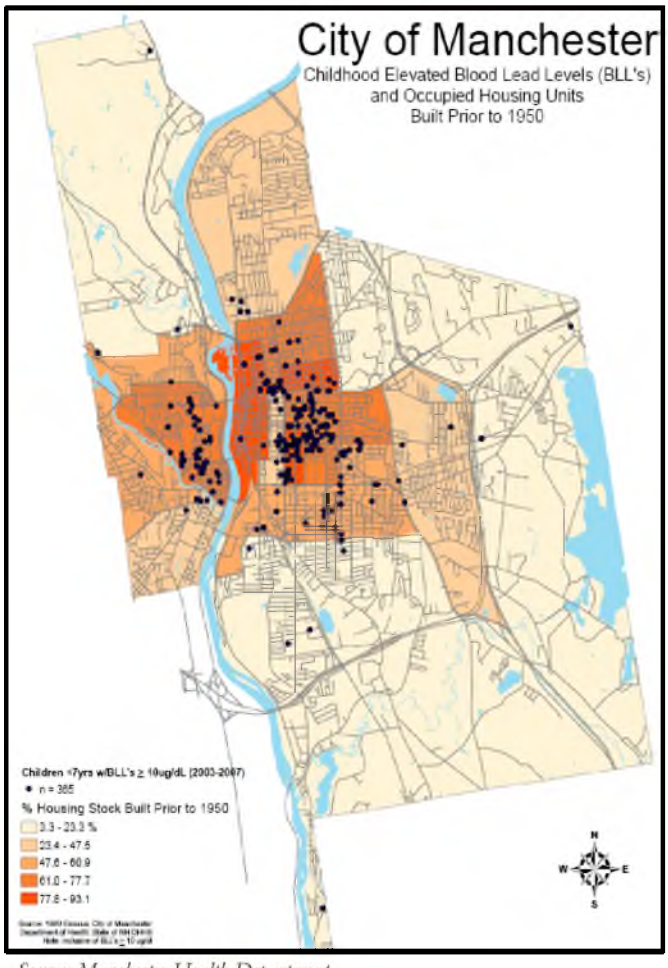
accidents in Manchester. The highest concentration of accidents occurred in the center City area. Of particular concern is that this area contains several elementary schools that are considered neighborhood "walking schools," which means that they have limited bus service, thus more students are out on the sidewalks making their way to school on foot. This fact makes it especially important to ensure adequate areas for walking and biking to support safe routes to school for all of Manchester's children.

> *"Good health begins at home. Ensuring that the nation's homes are safe, healthy, affordable, accessible and environmentally friendly will have a direct, immediate and measurable effect on the health of the nation."*
>
> *- Dr. Howard Frumkin, Director of CDC's National Center for Environmental Health*

Safe Homes

Homes are considered an important part of the built environment. A healthy home is a place that promotes and supports safe, decent and sanitary housing conditions that protects from disease and injury. The national Healthy Homes program identifies seven principles to make homes safer. Healthy homes should be dry, clean, pest-free, safe, contaminant-free, ventilated, and well-maintained.[110]

Some of the most common environmental influences that affect people in their homes include radon, asthma triggers, and lead. Older housing stock that was built before 1950 is more likely to expose residents to lead. Lead is highly toxic and exposure may result in cognitive impairments and behavioral problems. Young children are most vulnerable to lead poisoning from their surrounding environment and should be screened for elevated lead blood levels at one and two years of age. Older children, ages 36 to 72 months, should also be screened if they were not previously screened at ages one and two years of age. As illustrated by the map, housing built prior to 1950 is clustered in the center City area of Manchester on both the east and west sides of the Merrimack River. This pattern is mirrored by the locations of elevated blood lead levels among children ages 7 and younger.

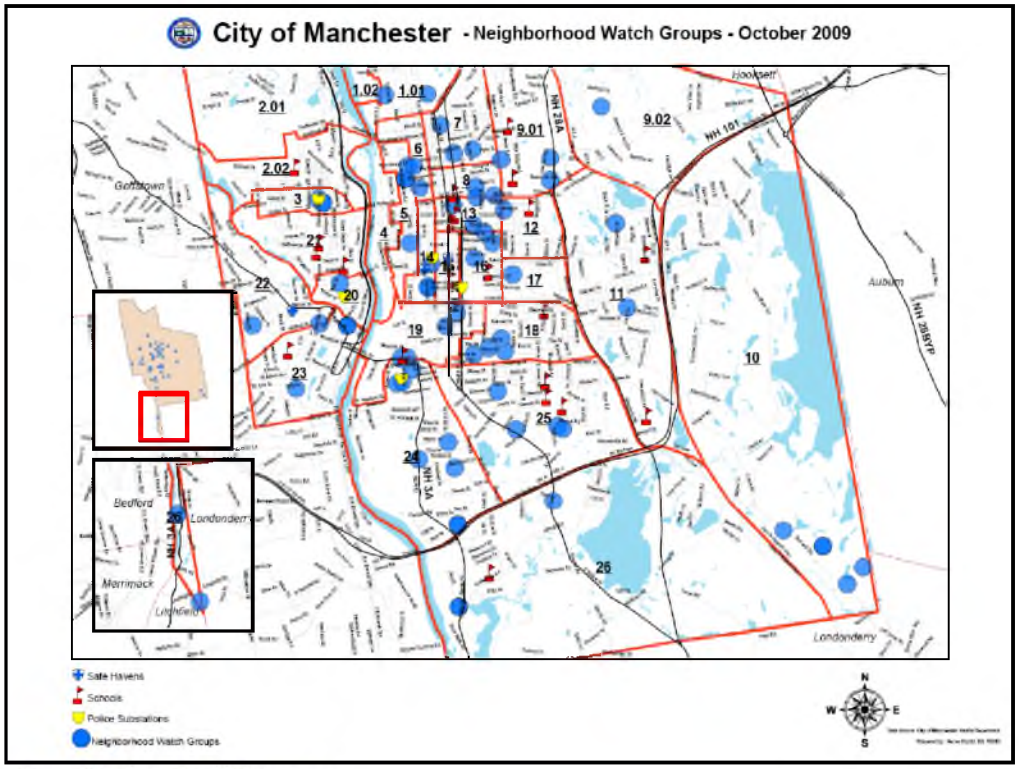


Source: Manchester Health Department

THE SOCIAL ENVIRONMENT

The health and well-being of populations are influenced by the social environment as well as the physical environment in which they live. A key element of a positive social environment is "collective efficacy", which is defined as the linkage of mutual trust and shared expectations for intervening on behalf of the common good within the neighborhood context.[111]

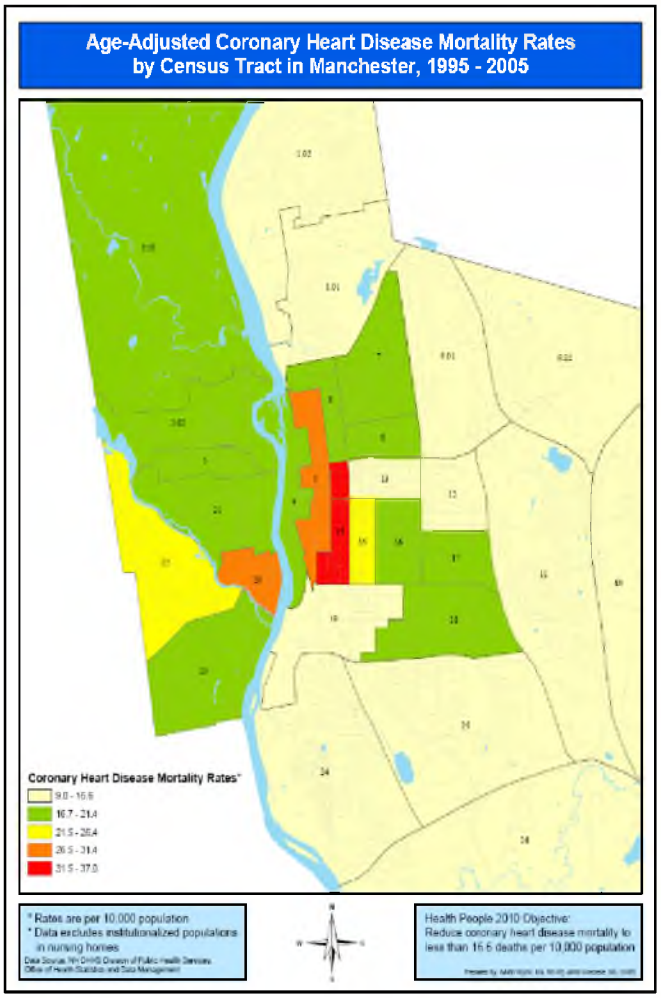
A lack of collective efficacy contributes to disorder in neighborhoods and may increase stress and lead to adverse health outcomes, such as high blood pressure or asthma exacerbations/attacks.[111] Efforts aimed at increasing collective efficacy reduce violent crime and improve neighborhood disadvantage.[111] Residents of neighborhoods with increased collective efficacy are likely to be more active and connected to positive social support networks that promote healthy behaviors. One example of an effort to improve collective efficacy is the establishment of neighborhood watch groups within Manchester. There are nearly sixty active neighborhood watch groups in the City.



Source: Manchester Health Department

Disadvantaged Communities

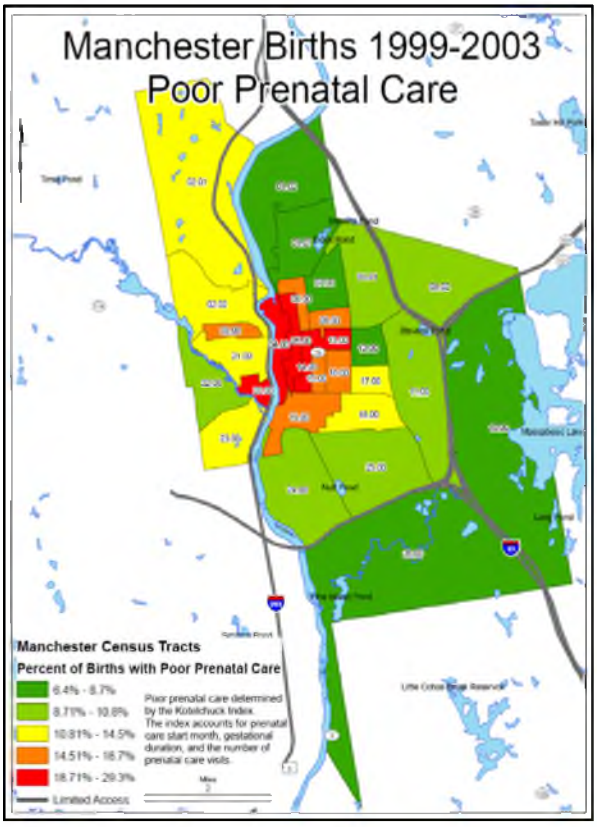
Places with poverty rates at or above 20% are considered "poverty areas" by national definitions.[112] While people who live in poverty reside in all areas of the City, a higher proportion of them are geographically concentrated within the center City area in Census Tracts 5, 6, 14, and 15, combining for an average poverty rate of 31% of the population.[113] This is meaningful for the needs assessment because Manchester residents who live in poverty areas may be negatively affected by aspects of their surrounding environment.[57, 114]



Areas of the City with a higher proportion of people living in poverty tend to have a higher rate of poor health measures such as increased rates of heart disease deaths and poor prenatal care.[115] From 1995 to 2005, in neighborhoods with high rates of poverty, Manchester residents had significantly higher rates of coronary heart disease mortality (27.6 deaths per 10,000) compared to Manchester neighborhoods that had lower rates of poverty (13.9 deaths per 10,000).[61] Similar patterns are observed when analyzing the distribution of poor prenatal care for Manchester births during 1999-2003.

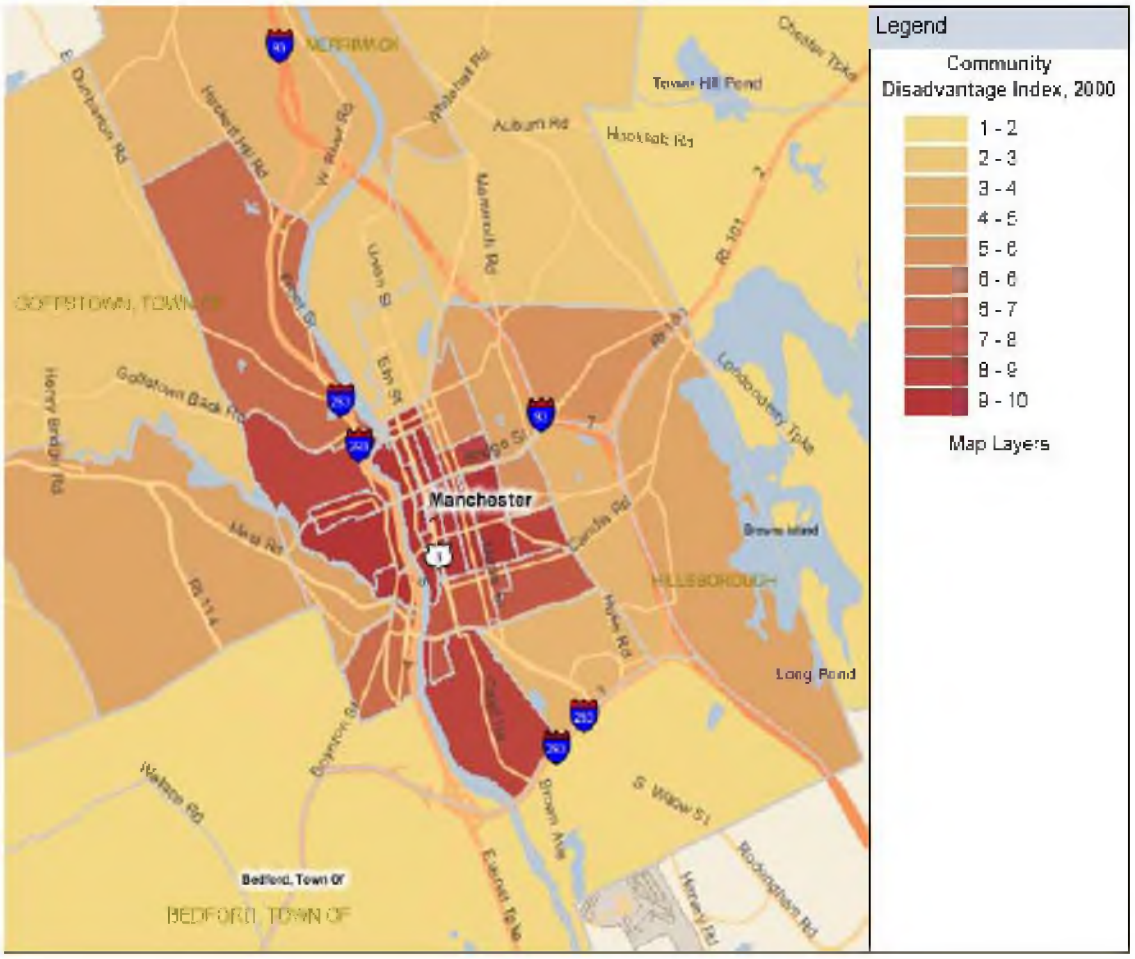
The geographic variation of the adverse health outcomes across the City outlined above may in part be explained by differences in each neighborhood's social conditions that are related to economic hardship. For instance, violence negatively contributes to a community's psychosocial health by increasing stress experienced by residents within these communities. One type of chronic stress that has been investigated in relation to the well-being of urban populations is neighborhood disadvantage, characterized by the presence of a number of community-level stressors, including poverty, unemployment, substandard housing, and high crime and violence rates.[73]

The Community Disadvantage Index provides a tool for measuring neighborhood disadvantage. This index consists of a combination of three measures calculated at the Census Tract level – percent of persons at or below 100% of the Federal Poverty Level, percent of persons receiving public assistance, and the percent of female-headed households with children. The scores range from 0 to 10 with a score of 10 indicating the most disadvantaged Census Tracts in the United States. For instance, a score of nine can be interpreted as a Census Tract that is more disadvantaged than 90% of other Census Tracts in the country. When considering this index in Manchester, the center City area is the most disadvantaged, and Manchester, in general, is more disadvantaged than surrounding communities.



Source: NH DHHS, Manchester Health Department

Community Disadvantage Index, 2000
City of Manchester and Surrounding Communities



Source: Manchester Health Department

AREA RESIDENTS WEIGH IN: HEALTHY PEOPLE IN HEALTHY NEIGHBORHOODS

Residents who participated in focus groups expressed a variety of opinions regarding how their surrounding environment in Manchester encourages or discourages health and healthy behavior. The positive environmental influences on health that were identified included the City's smoking ban, improved parks and trails, options for recycling, and lead abatement. Recommendations to improve the built environment included more paths and trails, improved sidewalks for walking and biking, improved trash removal from neighborhood streets, establishment of a downtown supermarket, and efforts to address run-down or unsafe buildings.

Transportation and Housing

Many participants reported that public transportation in Manchester did not adequately address the needs of the local residents. Transportation was mentioned in almost all focus group sessions as a barrier to accessing care, and was highlighted by several key City leaders as an issue of vital importance. Participants reported that the hours and location of bus stops are not convenient, which is very important because there is evidence that public transportation barriers have adverse effects on the populations that depend most on them for health services access, namely the poor and older persons.[116] This is particularly true in urban areas such as Manchester, where safety is also a concern for those having to use public transportation when it is available.

> *"My family came to this country to give my kids a chance at a better education, but we live in an old apartment that is making them sick. My family has been dealing with lead paint problems since 2005in our apartment. My child has learning problems as a result. We have moved to different apartments, but they have the same problem. We get good care from the doctor, but no help with the apartment."*

And for some participants, the affordability and quality of housing were pressing issues. Participants stated that many affordable apartments were old and had lead paint in them, and they would like to see an increase in Section 8 housing.

Intentional Community Design of the Ideal City

> *The ideal community is a city that attracts families and businesses. It is a "destination city".*
>
> *– Quote from a Key Leader Interview*

The concept of intentional community design developed through discussions with focus group participants and key leaders as they discussed the concepts that were important to the development of healthy neighborhoods. This concept includes intentional development of places, programs, and policies that cultivate and maintain a local environment that fosters access to health care and other services, and physical and social safety. This ideal community design will also foster and support healthy behaviors and prosperity. The attributes related to community design talked about by most of the leaders were a thriving economy, access to care and services and safety.

Focus group participants had many ideas regarding what makes a community the best place to live. The number one idea was a safe community with no drugs and a good police force. In all the focus groups, at least one participant mentioned that having a safe community makes it the best place to

live. Participants, also mentioned that a sense of respectfulness and of being able to help neighbors out in time of need were features that contribute to an ideal community. Another theme that was mentioned centered on children. Many participants mentioned good schools, parks and affordable, family-friendly activities as aspects of an ideal community.

Key leaders identified over twenty different topics that describe an ideal city. According to the key leaders interviewed, an ideal city is a place that:

- is designed so that its physical infrastructure promotes all aspects of quality of life within neighborhoods;
- is supported by a thriving economy and local businesses;
- has the capacity to provide for persons of all ages, access to health care and services that are used appropriately by the local population;
- has safe neighborhoods;
- has a sense of pride and values oriented toward family and community;
- prides itself on its cultural diversity and opportunities; and
- provides good and affordable housing to its economically diverse population.

Manchester leadership felt that the population needs to ask itself the question – "Why would I want to come to Manchester?" And they thought that the work of answering this question would guide the future design of the City and its surrounding towns. Key leaders stated that a "destination city" should be built on the sense of pride and accountability and leadership of its population.

The ideal community would be designed to support family and community oriented lifestyles and activities within the city itself and its neighborhoods. Specifically, the physical infrastructure would maximize residents' ability to enjoy the beauty of the natural environment - including the river that runs through the City center - as well as meet and enjoy their fellow residents. Thus, safe, clean, esthetically pleasing, and vibrant neighborhood spaces for recreation and congregating were noted as being very important to the design of the ideal community. Likewise, having a good and effective transportation system to link persons to services and neighborhoods to each other was mentioned as being vital to the physical design of the future Manchester. Community leaders also depicted how the ideal design of physical spaces and transportation would help enhance social networks and a sense of trust among the diverse populations of the local area residents.

A major theme threaded through the key leader interview responses was the belief that an ideal city should be "ideal for all":

(a) that all residents have a sense that their labor means something to the larger population;

(b) that all neighborhoods are attractive and vibrant and provide opportunities for recreation and social outreach; and

(c) that Manchester provides a place for all to enjoy a full life that is stimulated by educational and religious opportunities, cultural diversity, and a rich cultural history.

Additionally, and most importantly, the key leaders believed that all of the City's children have the opportunity for a bright future based on their having been raised in this ideal place and that they would think of Manchester as the place to "move back to" to raise their own children.

DATA SNAPSHOT: HEALTHY PEOPLE IN HEALTHY NEIGHBORHOODS

The table below summarizes the main themes talked about by Key Leaders and Focus Group Participants in regard to what the community is doing well and where it could do better in regard to creating *healthy environments* and promoting *personal safety and violence.*

INDICATOR	MAIN THEMES

Healthy Environments	WHAT WE ARE DOING WELL
	• People love it here
	• Trash pick up is good, as are hazardous waste days
	• Air and water quality are ok
	• Adopt a trail program in Deerfield
	• Live Better Institute at the Elliot Health System
	• Health Coaches at some work sites
	• Addressing issues of childhood asthma
	
	WHERE WE COULD DO BETTER
	• Lead paint
	• Trash pickup in depressed neighborhoods could be improved, especially in back alleys
	• Improved snowplowing
	• Better inspections of new subdivisions outside of the City
	• Light pollution in surrounding towns
	• Increase home ownership
	• Affordable housing
	• Housing for working poor and disabled
	• Improve the built environment
	• Improve safety so that the population accesses opportunities in the City for recreation and exercise
	• Be tougher on land lords
	• Free bus service
	• Radon
	• Community Design
	  • Planning department needs vision for solutions
	  • Create a culture for "health"
	  • Put more priority on health education/promotion and prevention
	  • Provide more open dialogues about the health risks of being overweight or obese
	  • Healthy cooking classes for residents
	  • Better food in neighborhood stores
	  • Bring in a large downtown grocery store
	  • More green spaces offering more sports and recreational opportunities for adults as well as children, and low-cost gym memberships
	  • More parks, sidewalks, playgrounds, walking trails, swimming pools, tracks, and ball fields
	  • Employ traffic-calming measures to improve safety

Personal Safety & Violence	WHAT WE ARE DOING WELL • Neighborhood watch groups • Commend Chief Mara • The police are doing a great job building relationships • The Mayor is doing a good job – very proactive • CAPS program • Weed and Seed program • Greater Manchester Wrap Around WHERE WE COULD DO BETTER • Violence, drug and gun crimes are getting worse • Younger and younger children getting into trouble • Domestic/family violence – there is silence around this issue • Improve mental health services • Family-oriented programs • Bring preventive programs into the schools • Change the culture – violence is NOT ok • Decrease homelessness • City needs to deal with vacant and foreclosed properties which are magnets for crime and vandalism • Better funding for mental health center • Do something about poverty • Determine if school bullying is an issue. • Increase awareness about the link between high crime rate areas and poor health areas • Increase student resource officers in schools • Do a better job maximizing resources • Decrease fragmentation of services • Clean up night clubs and bars • Fund health officers for towns outside of Manchester • Offer for after-school programs for unsupervised youth • Offer more parenting programs for young parents

CONCLUSION

Health-promoting neighborhoods are vital to supporting and improving the health of Manchester area residents. To improve community health and achieve health equity, we must work toward a shared vision of an ideal community for all Manchester area residents. The seven major attributes described by key leaders should serve as the foundation for building neighborhoods that provide a better quality of life for all residents in Manchester and the surrounding communities.

In regards to current capacity in Manchester to develop healthy neighborhoods, there are several existing local committees that have started to focus on the environment as a way to improve population health and quality of life. Examples of these interdisciplinary committees include, but are not limited to, the Safe Routes to School Task Force that has been assembled to lead efforts in improving the built environment around the Henry Wilson Elementary School and other schools in Manchester, the Weed & Seed Strategy that is a crime reduction and quality of life initiative to improve the social environment within neighborhoods, and the Social Fabric Committee of the Public Health Preparedness Advisory Council that is working to build social connectedness and efficacy among Manchester's most vulnerable populations.

It would be beneficial for improving Manchester's status as a healthy place if these various entities are able to work together based on a shared vision. Also, it would be beneficial for these community groups to engage in interdisciplinary planning with key stakeholders from entities such as the economic development, planning, parks and recreation, and law enforcement. This may require the establishment of a Healthy People in Healthy Neighborhoods Committee to act as a steering body for better coordination of efforts addressing the neighborhood environment in Manchester; including efforts that may be less directly associated with health status, such as projects proposed in City Master Plans.

In addition, further assessment of data at the neighborhood level should continue to be explored. As highlighted above, variations among health and quality of life occur within Manchester's neighborhoods, and more data at the sub-geographic level, such as for census tracts, will provide a better understanding of health equity and disparity. For example, five-year estimates for the American Community Survey will be available next year, which will enable the City to analyze these data at the Census Tract level. However, data related to health behaviors, such as the Behavioral Risk Factor Surveillance Survey, is currently not available for Census Tracts. Furthermore, data for the surrounding communities related to the place-based factors highlighted above would improve our understanding of the differences and similarities that exist between neighborhoods in the HSA.

Lastly, neighborhood level data and environmental health information are important for identifying and prioritizing issues/areas of need and for determining appropriate interventions that are tailored to these needs and root causes. For instance, reasons for lack of physical activity among children in the center City area of Manchester are likely multi-pronged. For example, safety issues, such as a high traffic volume as well as a lack of adequate sidewalks may both be issues for the center City population. Such concerns would require different intervention strategies, which would likely result in a combination of policy changes, infrastructure improvements, and increasing social support.

VII. PEOPLE PREPARED FOR EMERGING HEALTH THREATS (STRATEGIC IMPERATIVE FOUR)

The Centers for Disease Control and Prevention (CDC) has a national Health Protection Goal that states, "People in all communities will be protected from infectious, occupational, environmental, and terrorist threats."[117]

A community can be vulnerable in a variety of ways. Not only can it be susceptible to a disaster or a disease outbreak, but it can also be vulnerable in regard to social factors (such as economic hardship) that influence the community's resilience and ability to deal with adversity. This needs assessment attempts to examine Manchester's vulnerabilities in two ways: from the perspective of multi-faceted needs among groups of people which may limit our community resiliency as well as from the perspective of how prepared local people are to respond to potential public health threats.

Information in this chapter focuses on residents of Manchester and includes data about the other Health Service Area (HSA) communities when possible. The circumstances described exist in all HSA communities to varying extents.

Some Manchester area residents experience difficult circumstances and inequity in ways that make them vulnerable and if tracked, may signal problems in the community. Residents who face difficulty because of, for example, losing their jobs, experiencing cultural barriers, or living in unsafe settings could be more vulnerable in emergencies or disasters. They may also be more vulnerable to poor health. In both cases, vulnerable individuals present a potential challenge to the community that may not be felt until problems arise. Identifying factors that make local residents vulnerable will improve the community's ability to take action to strengthen its resilience. The following factors are among those that make can community members vulnerable:

- poverty
- unemployment
- food insecurity
- housing
- cultural barriers
- education
- crime/public safety

Manchester has been engaged in public health preparedness since before 2001. Since 2002, the Manchester Health Department has served as the point of contact for the Manchester All Health Hazards Region (AHHR), which includes the municipalities of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester and New Boston. As such, the Department has led planning activities to ensure the region is prepared to protect its residents from possible public health threats. The following section describes components of this community's readiness to respond to disaster.

WHAT CAN MAKE THE COMMUNITY VULNERABLE?

Poverty

Located in a predominately rural and affluent state, Manchester is an urban community. In turn, Manchester faces challenges and vulnerabilities that are similar to those found in cities across the United States. For example:

- Over 3,000 of Manchester's 25,484 families are living below the poverty line.[8]
- The fastest growing impoverished age group is children under the age of 18. In 2007, one in four of Manchester's children were living below 100% of the poverty threshold and two out of five students were enrolled in free or reduced meals in the beginning of 2009.[8, 60]
- While Manchester makes up 8.3% of the state's population, it accounts for about 15% (n=16,481) of New Hampshire's Medicaid Enrollees. The other seven towns in the Manchester HSA have an additional 3,210 Medicaid enrollees.[118]
- In 2008, over 1,100 unduplicated homeless individuals of all ages were served by the Mobile Community Health Team Project.[8]

Manchester Families and Residents Living Below the Federal Poverty Level

	1989	1999	2007
All Families	**6.3%**	**7.7%**	**11.9% +/-3.7**
With Related Children <18 Years	9.9%	12.3%	20.2% +/-6.6
With Related Children <5 Years Only	14.3%	17.2%	25.5% +/-11.5
All People	**9.0%**	**10.6%**	**14.0% +/-3.4**
Under 18 Years	12.6%	15.0%	24.9% +/-8.3
18 Years and Over	7.9%	9.3%	10.7% +/-2.3
18 to 64 Years	7.0%	8.8%	11.5% +/-2.7
65 Years and Over	12.2%	11.7%	6.2% +/-2.9

Source: US Census and American Community Survey

Population Living in Poverty, Manchester HSA Towns, 1989 and 1999

Place	Population Living Below the Federal Poverty Level, 1989	Population Living Below the Federal Poverty Level, 1999	Population, 2000 (for whom poverty can be calculated)
New Hampshire	6.4%	6.5%	1,199,322
Manchester	9.0%	10.6%	104,398
Auburn	4.3%	1.8%	4,665
Bedford	2.2%	2.2%	17,851
Candia	3.8%	2.6%	3,890
Deerfield	5.6%	3.2%	3,652
Goffstown	3.1%	2.8%	14,973
Hooksett	2.8%	2.7%	10,849
New Boston	4.9%	4.3%	4,107

Source: US Census 1990 and 2000

The aspects of Manchester described earlier make the community more vulnerable to poor health. Over the last fifty years, health officials and researchers have continued to build evidence that poverty contributes to poor health.[119, 120] When people live in poverty or with limited economic resources, they often have limited access to aspects of daily life that encourage health and a good quality of life such as good nutrition, safe places to live, work and be active, health care, good education, and transportation. Furthermore, if people live with limited economic resources, they may encounter higher levels of crime, stress, and social disadvantages.

Measures of Health Status and Health Care, Comparing Low-Income Population to Full Population

	Manchester Residents with Annual Income < $25,000	Manchester	Manchester HSA	State of NH Without Manchester
Behavior And Health Status				
Proportion of adults who are current smokers, 2005-2007	37.0%	24.8%	21.8%	19.1%
Proportion of adults with no moderate or vigorous physical activity, 2005 and 2007	19.5%	12.9%	10.3%	9.1%
Proportion of adults who are overweight or obese, 2005-2007	65.5%	63.5%	62.5%	61.0%
Access To Care				
Proportion of adults who have a primary care provider, 2005-2007	81.9%	89.3%	90.1%	88.5%
Proportion of adults whose general health status is excellent, very good or good, 2005-2007	63.5%	85.5%	88.2%	88.4%
Proportion of adults with emotional support, always, 2005-2007	28.5%	45.8%	46.6%	49.1%

Source: NH Behavioral Risk Factor Surveillance System

In Manchester the Behavioral Risk Factor Surveillance System (BRFSS) reveals an association between people's level of income and their perceived mental and physical health. Combined community data from 2005-2007 shows that individuals in Manchester who make less than $25,000 a year reported that they experienced bad mental health an average of seven out of the last 30 days and bad physical health an average of 7.4 of the last 30 days. In the same survey, individuals who make between $50,000 and $74,999 reported an average of 2.7 days of bad mental health and 2.1 days of bad physical health out of the last 30 days.[63] This contributes to the idea that poverty is associated with poorer community health in Manchester.

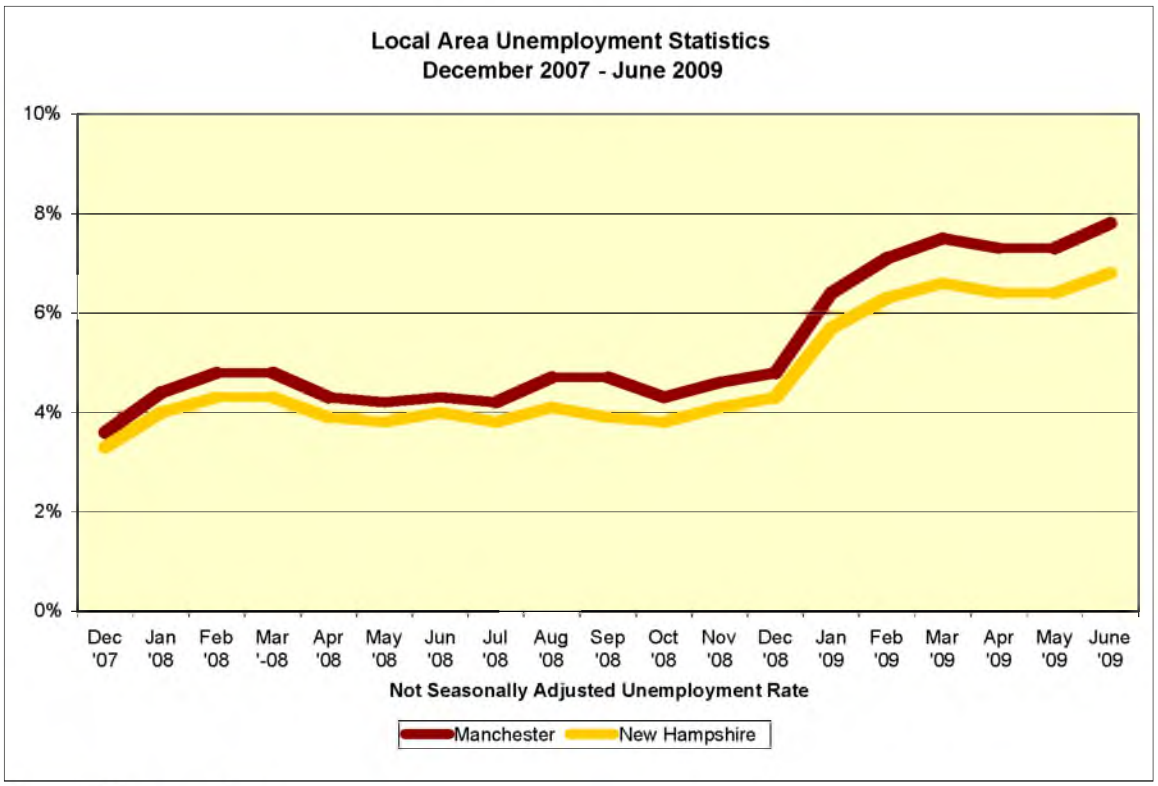
Unemployment

Unemployment has recently become a growing problem in Manchester. When adults are unable to find enough work, they and their families are more likely to experience poverty. Participants in many of the focus groups described particular concerns with job security in Manchester.

2009 Unemployment in the Manchester Health Service Area							
Place	January	February	March	April	May	June	July
New Hampshire	5.7%	6.3%	6.6%	6.4%	6.4%	6.8%	6.6%
Manchester	6.4%	7.1%	7.5%	7.3%	7.4%	7.9%	7.7%
Auburn	*	*	*	*	*	*	*
Bedford	3.7%	3.9%	4.3%	4.6%	4.7%	5.4%	5.3%
Candia	*	*	*	*	*	*	*
Deerfield	5.5%	6.2%	6.8%	6.3%	6.1%	6.5%	6.3%
Goffstown	4.3%	4.8%	5.2%	4.8%	4.8%	5.3%	5.2%
Hooksett	4.9%	5.6%	6.2%	5.3%	5.6%	6.4%	6.1%
New Boston	*	*	*	*	*	*	*

**data unavailable*
Source: New Hampshire Employment Security's 2009 Local Area Unemployment Statistics Report

Families that have limited access to financial resources may experience some degree of food insecurity, meaning they have limited or uncertain availability of nutritionally adequate and safe foods.[26] Food insecurity includes not having enough food and not having enough nutritional food to provide a healthy diet. Some families are more likely to experience food insecurity than others. Factors that are most often associated with food insecurity are having an income below the poverty line and having a household with children headed by a single woman.[121] In Manchester, 10.3% of households have children under age 18 and are headed by women with no husband present (versus 6.5% for all of New Hampshire).[8]



Source: NH Employment Security

Housing

Similarly, the City has vulnerabilities related to housing. When people are living with limited financial means, they are limited in the housing options they can afford and may live in housing that is in poor condition. They are more likely to rent their homes, and may pay a significant proportion of their income for housing.

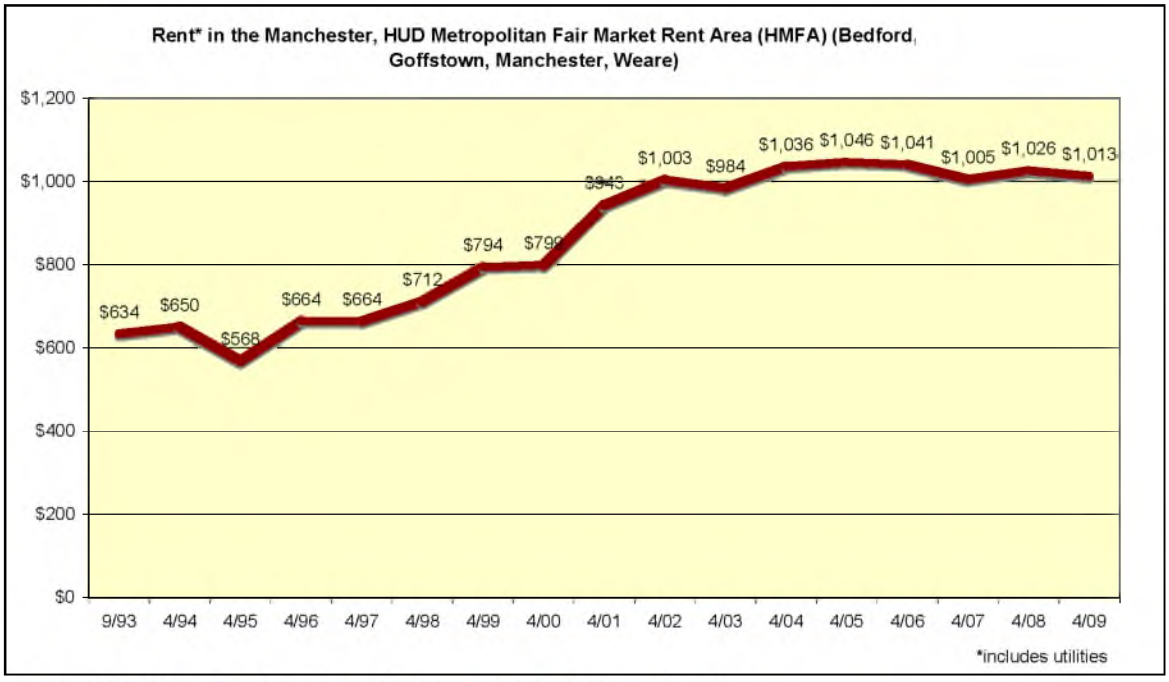
Of the 48,905 total housing units available in Manchester, 52.9% of them were built before 1950. In 2008, there were 43,461 occupied housing units in Manchester in 2008. Of these occupied housing units:[122]

- approximately 51% of housing units were renter-occupied;
- of rented housing units, 50.4% of them cost 30% or more of their household income for rent; and
- about 44% of housing units were occupied by people who had moved within the preceding three years.

Household Income and 2-Bedroom Rent in 2008

Estimates of Affordability	Median Monthly Gross Rent for 2-Bedroom Unit	Household Income Required to Support 2-Bedroom Rent	Percent of 2-Bedroom Units that are Affordable to 3-Person Family Earning 50% of Median
Statewide	$1,044	$41,800	62.2%
Manchester NH HUD Metropolitan Fair Market Rent Area (HMFA)	$1,026	$41,000	59.6%

Source: 2008 Residential Rental Cost Survey, New Hampshire Housing Finance Authority



Source: 2008 Residential Rental Cost Survey, New Hampshire Housing Finance Authority

Primarily using federal funds from Housing and Urban Development (HUD), the Manchester Housing Redevelopment Authority (MHRA) is able to make 1,261 public housing apartments available in Manchester. MHRA also subsidizes rent for 1,850 households. All households that MHRA assists must meet the federal HUD requirements related to income and criminal background. MHRA measures unmet need for housing assistance primarily through their waiting list. From November of 2008 to April of 2009, the MHRA housing assistance waiting list jumped from 9,500 households to 9,870.[123]

Education

Because people's level of education can impact their socioeconomic status, employment, and health status, education is a useful representation of community vulnerability and resilience.[124, 125]

Educational Attainment			
	Manchester 2006	Manchester 2007	New Hampshire 2007
Population 25 years and over	72,399	73,897	895,981
High school graduate	33.7%	33.8%	31.0%
Some college, no degree	19.5%	21.5%	17.9%
Bachelor's degree	18.5%	15.2%	21.0%
Graduate/professional degree	7.3%	7.6%	11.5%
Source: American Community Survey 2007			

Data from the schools and various services available in Manchester also reveal other potential needs and vulnerabilities amongst community members related to nutrition, education, health care and public safety.

Various signs of Potential Vulnerability in the Community In Manchester:		
	When	Number
Number of unduplicated participants in the Special Supplemental Nutrition Program For Women, Infants And Children (WIC)	2007	13, 584
Number of active students in Manchester school system known to be homeless	2007-2008 school yr	411
Calls to 211 requesting referrals related to dental care in last 10 months	6/2008-4/2009	47
Calls to 211 requesting referrals related to homeless individuals or families in first quarter of 2009	1/09-3/09	55
Reports of abuse to Bureau of Elderly & Adult Services of incapacitated elders age 60 and over in Manchester	7/2008-5/2009	197
Assessments of alleged child maltreatment by the Division for Children, Youth and Families (DCYF) in Manchester	2008	932
Households who applied and qualified for fuel assistance from Southern New Hampshire Services by the end of the winter	2007-2008	10,426
Individuals who receive Food Stamps (with or without additional public assistance) from NH Division of Family Assistance	March 2008	5,646
Individuals who receive Food Stamps (with or without additional public assistance) from NH Division of Family Assistance	March 2009	6,773
Sources: NH DHHS, Manchester School District, Heritage United Way 211, Southern New Hampshire Services, NH Division of Family Assistance		

Crime and Public Safety

Crime and public safety are important indicators of community vulnerability. The presence of crime suggests weaknesses in the community and can be associated with poverty. Furthermore, crime data may shed light on the health of residents who live in environments where crime is a concern. Crime and violence in a neighborhood have been associated with increased levels of heart disease, asthma, mobility disability and other health outcomes among people who live in the area.[126-128] Participants in a few of the focus groups were concerned that crime and violence seem to have increased in Manchester, and some individuals were worried that it will continue to increase in the poor economy.

2007 Part 1 Crime Statistics

City	Pop.	Murder	Forcible Rape	Robbery	Assault	Burglary	Larceny	Motor Vehicle Theft	Arson
Manchester	108,874	4	22	182	94	825	2190	238	45
Auburn	5,235	0	1	0	2	14	31	2	0
Bedford	21,389	0	1	4	15	42	173	9	1
Candia	4,200	0	0	1	2	13	34	2	0
Deerfield	4,220	0	0	0	1	4	35	1	0
Goffstown	17,810	0	2	0	9	48	212	5	8
Hooksett	13,705	0	4	2	1	31	227	14	1
New Boston	5,121	0	0	0	3	9	17	0	0

Source: Manchester Police Department and FBI, Crime in the United States 2007

Cultural Barriers

While culturally diverse residents add to the strength of our community in many ways, they may face challenges with regard to employment, health care, housing, and community interaction. In turn, they may be more vulnerable in the event of emergencies and may not be able to access the help they need. They may experience health inequity.

When heads of households have limited English proficiency, it can contribute to the family having difficulty navigating the health care system and accessing health information and preventive care. As shown in a previous chapter, over 5% of households in Manchester are linguistically isolated. More than 17% of children over age five speak a language other than English at home.[8] The New Hampshire Department of Education reports that 5.8% of enrolled Manchester students in the 2007-2008 school year had limited English proficiency. Language barriers may negatively affect a family's socioeconomic status, level of education, and stress levels, and in turn their health status (as described above).

In addition to language barriers, residents may experience cultural barriers that lead to poorer health status. Cultural barriers may limit an individual's access to appropriate health care and affect interactions with health care professionals. They can also limit a person's access to healthy food and adequate physical activity, for example, if culturally acceptable forms of physical activity are not available or safe. Language, culture, religious and racial barriers to a healthy life and health care can create inequity among groups in our community. These factors are very important considerations as people work to improve the health status of all groups of people living in the Manchester HSA.

One way to measure the strength or weakness of a community is to consider social connections among community members as well as ways in which community members are involved in civic activities. Community involvement and connectedness can help reduce vulnerability to poor health or emergencies by getting people more connected to a support system and to information that can help them. Participants in two of the focus groups discussed that when neighbors help neighbors and people get involved in the community, it makes Manchester a better place to live.

> *"During the depression it was neighbors helping neighbors. I now barter services with my neighbor. I watch her kids and she does my ironing. If everyone cares for each other and is looking out for each other, there is a learned respect for one another. Being involved with the community pushes me to help more people and reach out more. When you start helping others, it is infectious."*

Manchester residents have opportunities to attend parades, block parties, festivals, and various other open cultural events. They have an accessible local government and a variety of civic, charitable, and social organizations with which to volunteer. The City has an attractive downtown and numerous parks. The number of registered voters has grown over the past decade to 57,135 in 2008.[129] In 2007, nearly 38% of Manchester youth reported participation in community service activities, and nearly 28% were involved with clubs or organizations outside of school.[37]

The Division of Chronic Disease Prevention and Neighborhood Health within the Manchester Health Department has been working collaboratively with the Manchester Police Department and other community organizations to strengthen resident involvement in crime prevention and neighborhood revitalization efforts. They are doing so under the umbrella of the Manchester Weed & Seed (W&S) strategy, a program from the United States Department of Justice. The W&S strategy is a comprehensive effort aimed at "weeding" out crime and aligning community resources to "seed" an improved quality of life for all Manchester residents. The strategy helps to reduce the vulnerability of Manchester residents. It has been active for seven years.

The W&S approach is unique when compared with traditional crime prevention approaches because the strategy is based on collaboration, coordination, community participation, and leveraging resources with a focus on promoting the long-term health and resilience of the community. Residents of W&S neighborhoods are actively involved in problem-solving in their community.

Neighborhood Watch Groups are another example of an initiative in Manchester that encourage community participation and helps prevent crime. To date there are fifty-eight Community Watch Groups across the City.

HOW IS MANCHESTER PREPARING FOR EMERGING HEALTH THREATS?

The Manchester Health Department currently facilitates the Public Health Preparedness Advisory Council, which is the planning body for regional public health preparedness activities. The Council includes membership from the region's hospitals, each of the Manchester All Health Hazards Region (AHHR) municipalities (i.e., health, police, fire and emergency management). Other members of the Council include the Greater Manchester Chapter of the American Red Cross, the Mental Health Center of Greater Manchester, Rockingham Ambulance, and the Visiting Nurse Association of Manchester and Southern New Hampshire. The robust community partnerships that have been developed through this council have enabled the Manchester AHHR to execute its public health preparedness goals.

The Manchester AHHR's efforts have primarily centered on developing and exercising public health preparedness plans. The region has completed the development of a regional all-hazards plan. The plan includes several annexes that focus on specific emergencies or response functions:

- pandemic influenza
- risk communication
- medical surge (expanding health care capacity in an emergency)
- points of dispensing (mass clinics ready to be opened in emergencies)
- mass fatality management

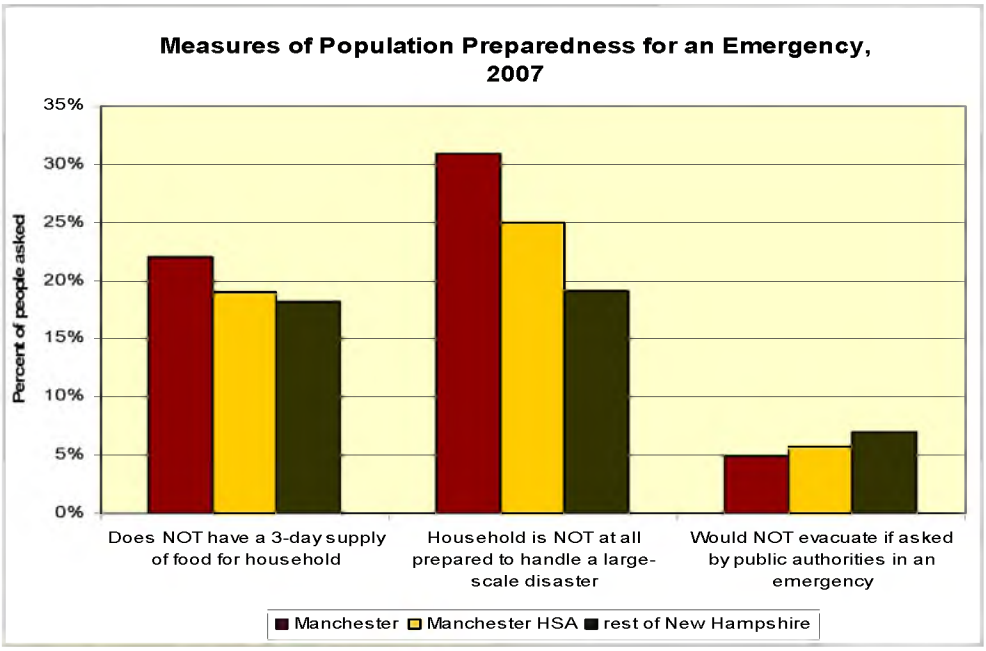
In the past two years, the Manchester AHHR has provided eleven public health preparedness trainings. The trainings have focused on medical surge; continuity of operations planning; highly pathogenic avian influenza; isolation and quarantine; psychological first aid; 2-1-1 NH; Communicator! NXT (a health alert system); eStudio (a group collaboration and communication tool) as well as Homeland Security Exercise and Evaluation Program (HSEEP).

The Manchester AHHR has conducted numerous HSEEP-compliant exercises. Since 2007, the Manchester AHHR has held tabletop exercises on school closings, pandemic influenza and isolation and quarantine. Call-down drills, in addition to drills involving the set up of the AHHR's acute care center and activation of its emergency call center have also been implemented.

Additional indicators of regional public health preparedness from the Manchester Health Department include the following:

INDICATOR	NUMBER
Points of Dispensing available in an emergency	7
Back-Up Points of Dispensing	5
Medical Reserve Corps Volunteers (completed required training)	11
Community Emergency Response Team Volunteers	50
Source: Manchester Health Department, May 2007	

In 2007 the state BRFSS asked New Hampshire residents about their level of emergency preparedness. The survey found that in a disaster, 61.2% of Manchester's residents would plan to get authoritative information from a radio while 26.9% would use a television.



Source: NH Behavioral Risk Factor Surveillance System

As of 2007, a noteworthy proportion of the population in Manchester did not feel prepared for a large-scale emergency. While the local government and many organizations have worked together to prepare the City infrastructure and medical response capacity for various kinds emergencies, many of the residents themselves are not or do not feel ready for such events.

CONCLUSION

The community has been busily coordinating efforts and preparing for emerging health threats in the Manchester area. At the same time, many local residents personally do not feel prepared for emergencies. Many individuals in the Manchester area live in circumstances that make them more vulnerable in the case of emergencies. Many of those same vulnerabilities also increase the likelihood of poor health outcomes. Better understanding of the factors that make people vulnerable in emergencies or to poor health is needed in order to reduce those vulnerabilities, target public health efforts where they are most needed, and improve health equity across the community.

Examining various types of determinants of health will allow the community to better understand the factors that make people and the community more resilient. Achieving health equity and community resilience requires a broad, inclusive view of what makes a community strong.

VIII. THE COMMUNITY PROVIDES INPUT TO THIS NEEDS ASSESSMENT

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

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

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

WHAT WOULD YOU TALK TO THE MAYOR ABOUT?

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

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

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

INTENTIONAL COMMUNITY DESIGN AND LEADERSHIP

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

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

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

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

…Communities are built on existing networks and evolve beyond any particular design, the purpose of the design is not to impose a structure but to help the community develop.[131]

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

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

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

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

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

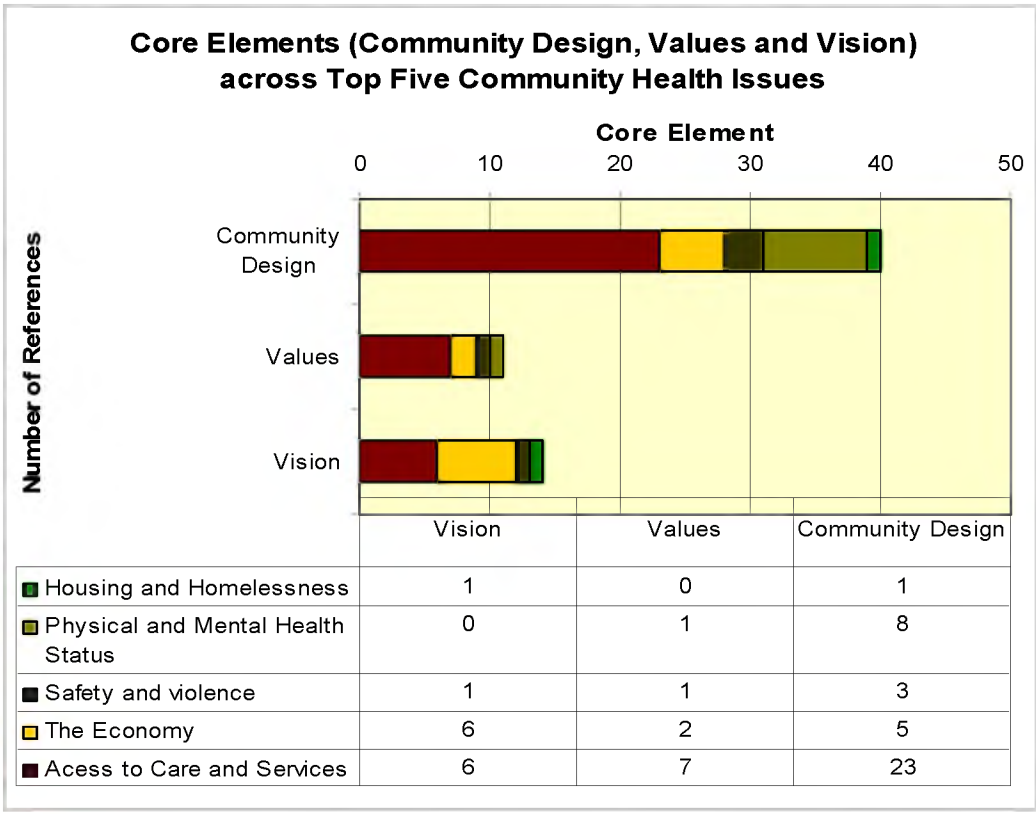
Community Design

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

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

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

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



	Vision	Values	Community Design
Housing and Homelessness	1	0	1
Physical and Mental Health Status	0	1	8
Safety and violence	1	1	3
The Economy	6	2	5
Acess to Care and Services	6	7	23

VALUES

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

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

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

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

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

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

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

Leadership and Vision

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

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

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

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

SPECIFIC COMMUNITY HEALTH ISSUES

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

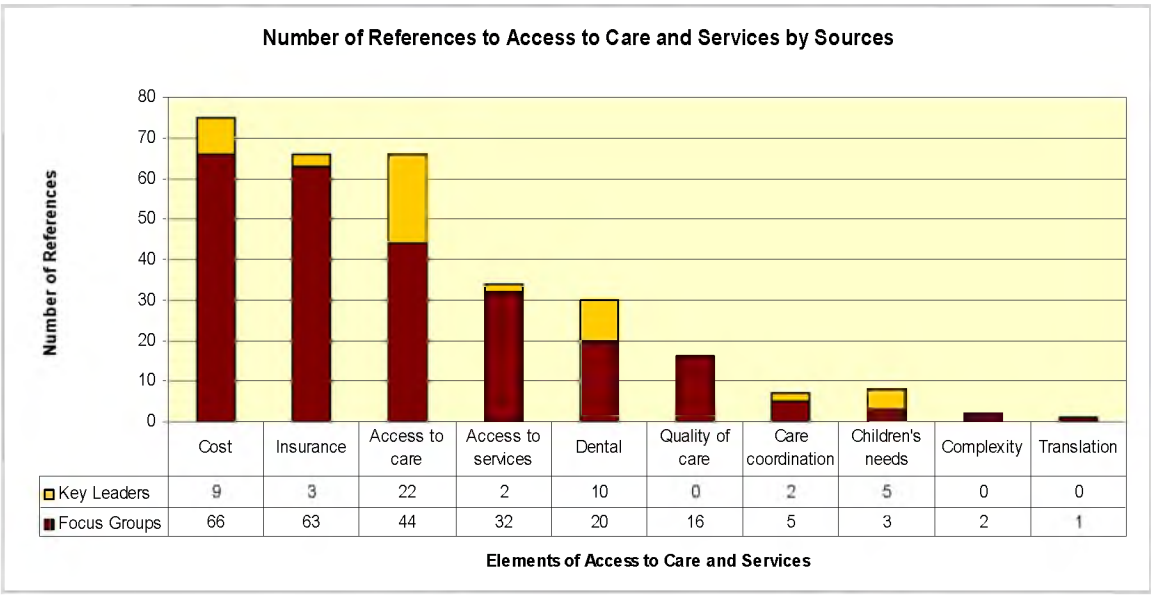
Ranking of Issues by Sources		
Focus Groups (n=13)	Ranking	Key Leaders (n=19)
Access to care and services (n=13)	1	Access to care and services (n=15)
The economy (n=12)	2	The economy (n=11)
Safety and Violence(n=6) / Physical and Mental Health Status (n=6)	3	Safety and Violence (n=10)
	4	Physical and Mental Health Status (n=9)/ Housing and homelessness (n=9)

Access to Care and Services

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

> *"This community delivers care in a fragmented manner. The solution is not just about how many offices or providers you have or how many hours your practice is open… the solution is to be more innovative and find better ways to collaborate."*
>
> *(Steve Paris, Medical Director, Dartmouth-Hitchcock - Manchester)*

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



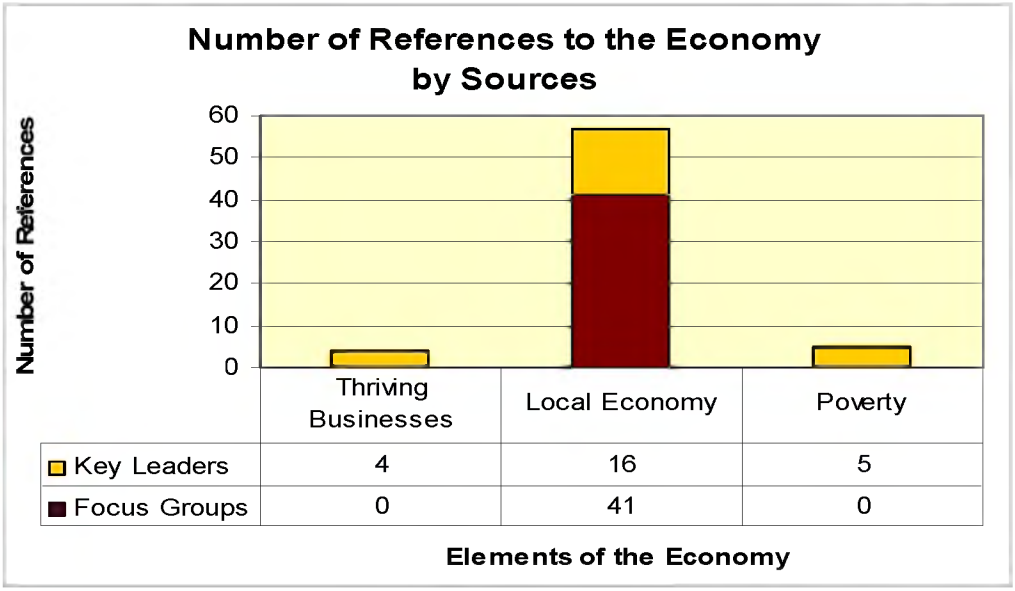
Focus groups mentioned each identified element, while key informants discussed a narrower range of issues. In addition, the only topic raised by the majority of key leaders was access to care, while access to care, access to services, cost of care, insurance, and quality of care were discussed within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

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

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

The Economy

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



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

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

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

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

(Fred Rusczek, Director, Child Health Services)

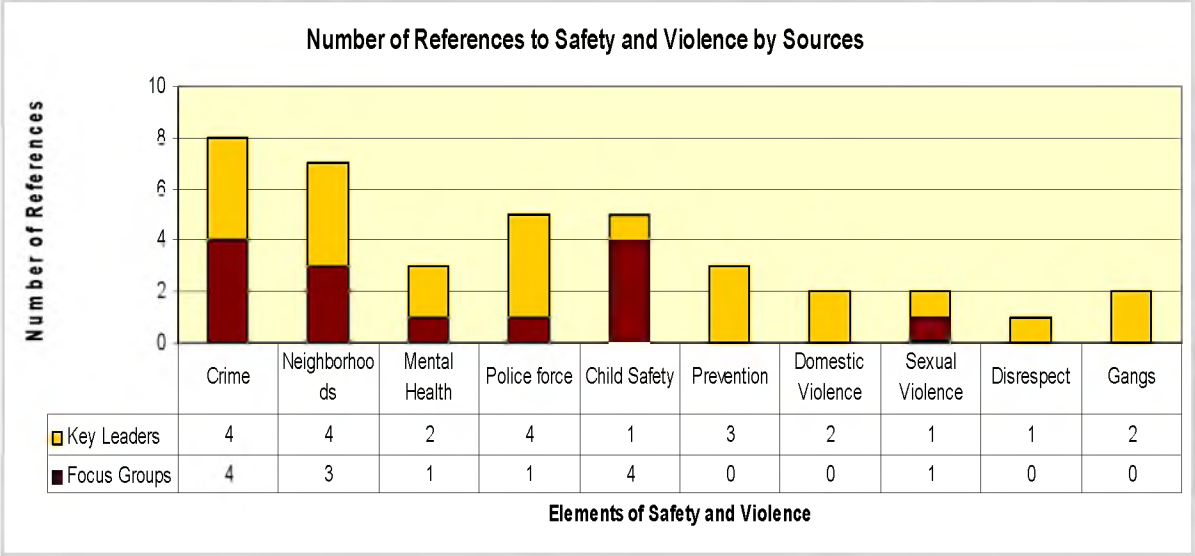
Only key leaders discussed thriving businesses as an important issue or explicitly mentioned poverty. Leaders discussed the effects of economy from a higher level, mentioning how the economic downturn has stressed City budgets and businesses as well as families and individuals. One leader expressed a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

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

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

Safety and Violence

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



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

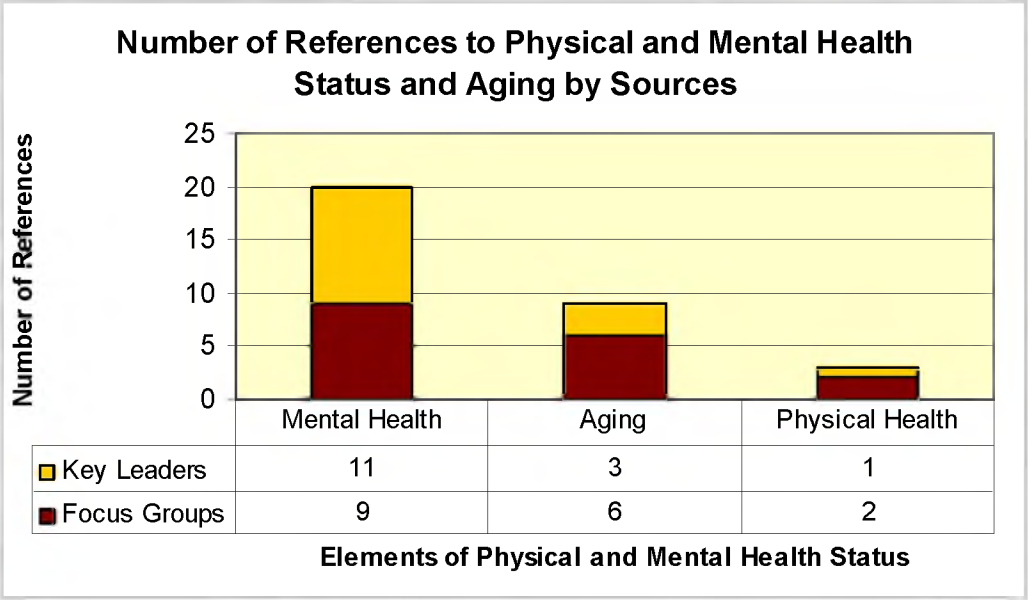
Focus group participants credited police Chief David Mara, "who isn't afraid to be criticized", with decreasing gang activity. Another participant spoke about how the YWCA provides support to women affected by domestic violence. Other participants were pleased with the self-defense courses offered to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

> *"We have sneakers handing from the wires which is a sign of drug and gang activity in the neighborhood."*

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

Physical and Mental Health Status

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



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

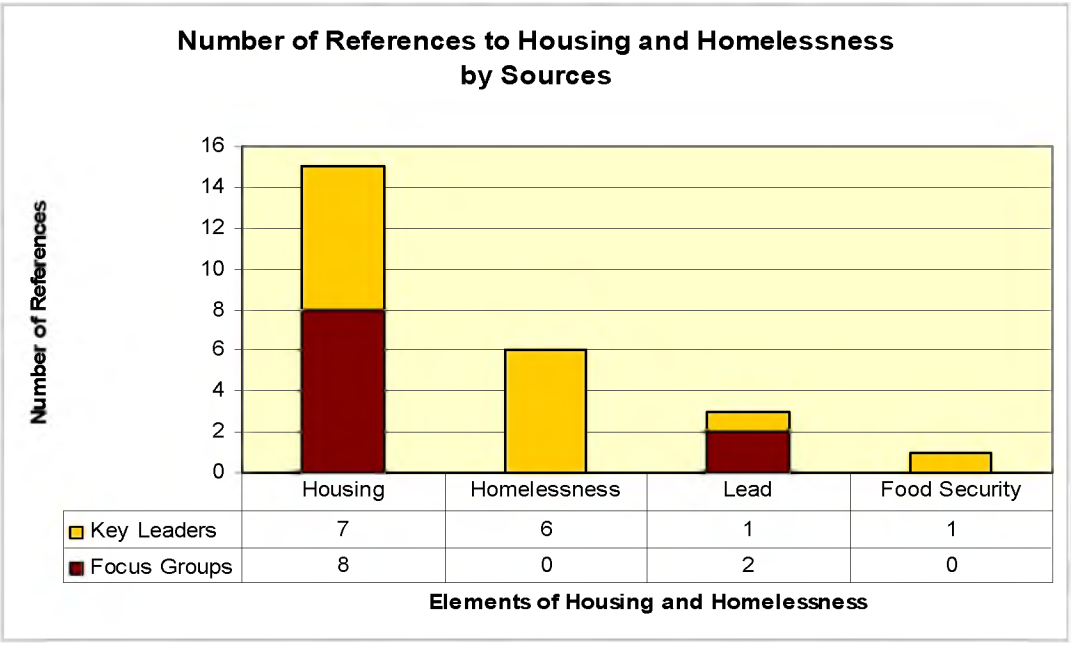
Focus group participants mentioned autism, diabetes and mental health in general. Much of the discussion around mental health issues was tied to access to care. Participants talked about insurance cuts related to mental health benefits and the costs of medication. They also talked about a lack of tolerance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

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

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

Housing and Homelessness

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



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

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

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

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

> *"People need to be able to have good housing and earn enough to pay for housing OR our housing just costs too much. Manchester is one of the most expensive places to live in the state."*
>
> *(Maureen Beauregard, Executive Director, Families in Transition)*

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

IX. WHERE WE GO FROM HERE?

In the opening pages of this report, the model for the Healthy Manchester 2015 Community Health Improvement Plan was described. The model presents four strategic imperatives that have guided this assessment and will continue to guide planning and action in a Community Health Improvement Process. Going forward, various organizations will be able to use the qualitative and quantitative data that was collected to help prioritize community needs under each strategic imperative and serve as baseline measurements for future community health improvement.

Major findings under each strategic imperative include the following list. Please see the individual chapters and data tables at the end of each Stage of Life section in Chapter IV.

HEALTHY PEOPLE IN EVERY STAGE OF LIFE

- **Healthy Start**
  - Many children in Manchester are born into circumstances that have an adverse affect on growth and development.
  - Hospitalization of young children in Manchester for acute Ambulatory Care Sensitive Conditions is significantly greater than in the rest of the state.
- **Healthy Youth**
  - Local teens report and display concerning tendencies and behaviors related to mental health.
  - Unsafe sexual activity among teens is resulting in negative outcomes such as pregnancy and sexually transmitted diseases.
  - More than one in ten first graders was obese last year.
- **Healthy Life**
  - Premature mortality is higher for adults in Manchester than in the rest of New Hampshire.
  - Health differs between younger adults and middle-age adults. It also differs among people of different incomes.
  - Manchester area adults have high rates of overweight, drug abuse hospitalization, Chlamydia, and some cancers.
  - Manchester adults have been visiting emergency departments at increasing rates for mental health concerns.

- **Healthy Aging**
  - The population of older adults in the area and across the state is growing.
  - Death from heart disease is more common in Manchester than in the surrounding area or the rest of the state.
  - Older adults tend to desire independence and, therefore, need connections to the community, to transportation, and to social supports and services.

ACCESSING QUALITY HEALTH CARE

- Access to health care and health insurance differs among people with different levels of income.
- Emergency department use is higher in Manchester than in the HSA or the rest of the state.
- Hospitalization for Ambulatory Care Sensitive Conditions is higher in Manchester than in the HSA or the rest of the state.

HEALTHY PEOPLE IN HEALTHY PLACES

- Residents and the health care and public health communities in Manchester find that some housing has a negative health impact, evidenced in particular by childhood blood lead levels.
- Health and illness are not distributed evenly across the City or HSA. In some geographic areas, residents experience more negative health outcomes and risk factors.
- Transportation is a major concern among residents and leaders.

PREPARING FOR EMERGING HEALTH THREATS

- Poverty is greater in Manchester than in the rest of state. Childhood poverty is growing. Unemployment rates are growing.
- In Manchester and the HSA, various poor health outcomes and risk factors are associated with income.
- Local service providers have seen increasing requests for assistance in the last year.
- Cultural diversity continues to grow in the City.
- While local groups are making strides in community emergency preparedness planning, many individuals do not feel prepared for emergencies.

The things that influence health in Manchester are varied, interconnected, and dynamic. Therefore, when local people want to take steps to improve community health and solve specific problems that have been identified, it would be good to do so in a way that takes into account the many different factors that are pushing and pulling health in different directions. For example, if teen births is

identified as a concern, groups interested in addressing the problem should take into account not only teen sexual activity, but also their educational circumstances, their social interactions, the policies that affect them, the places where they spend time, the outside-of-school opportunities they have available, their family circumstances, their connections to the community, and their overall mental and physical health. Community members will not be able to "fix" all of the relevant factors that contribute to issues such as teen pregnancy or adult Emergency Department utilization, but if we approach health issues with recognition of their multifaceted nature, we are more likely to identify effective long-lasting solutions and preventive actions.

NEXT STEPS

The next steps in the community health improvement process are to:

1.) Share the assessment findings with interested groups and organizations that have expertise related to the subjects or populations.
2.) Encourage discussion of findings.
3.) Prioritize findings based on need, urgency and capacity.
4.) Explore methods and approaches other communities have successfully implemented to address similar problems to those prioritized locally.
5.) Identify specific actions for health improvement that are adapted to the specific setting and needs of the target community in Manchester or the HSA.

BROAD RECOMMENDATIONS

Our broad recommendations for the community for moving forward following this community needs assessment, in light of our goal to develop a Community Health Improvement Plan, are to:

Strengthen the local infrastructure for assessing community health and well-being. The local data infrastructure would improve if the quality of health-related data gathered by various entities around the community improved and entities found better ways of sharing information and telling the community story to identify needs and assets. Also, knowledge of community needs would be enhanced by health data that are more descriptive regarding areas of potential inequity, such as race and ethnicity.

Continue to build relationships and collaborations. Communication and collaborative action among organizations, funders, and local government around identified health issues will increase access to data, make enhanced continuity of health care more achievable, and help the community address health using all available assets. Broad population health improvement will require cooperation; no one organization can be expected to do it alone.

Include community members in goal setting, planning, and activities. This report is one way of telling the story of the health of the members of this community. Community members need to be included in the prioritization, planning and implementation of improvement efforts whenever possible.

Set local goals. To some extent this report provides a baseline measure of health in Manchester. The current national Healthy People 2020 target-setting process will provide general

guidance. Using our baseline measures and considering national targets will enable local people to set ambitious but achievable goals that are locally appropriate for Manchester and the surrounding areas.

Consider targeting age groups or other high-risk groups rather than diseases, when planning health improvement programs. Many diseases or health-related concerns have overlapping causes and risk factors. Community health concerns can be more efficiently addressed if community groups work together and plan actions that address various factors in a risk group or factors that affect various risk groups at the same time.

This community needs assessment is an early step in a Manchester area Community Health Improvement Process, discussed above. The assessment was created through the active cooperation of numerous individuals and organizations. It is a living, on-going, inclusive process, intended to prompt action. Future input, including recommendations, critique, and ideas for action from already-involved partners as well as new partners are not only welcome, but essential.

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Greater Manchester Community Needs Assessment 2009

APPENDICES:
BELIEVE IN A HEALTHY COMMUNITY

DETAILED SUMMARY OF COMMUNITY INPUT AND ASSESSMENT METHODS

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APPENDIX ONE: DETAILED KEY LEADER AND FOCUS GROUP FINDINGS

I. HEALTHY COMMUNITY INDICATORS SUMMARY

During the focus group discussions and key leader interviews, participants were given a survey and asked to rate how responsive the community was to specific healthy community indicators. The rating scale was from 1 to 5 with 5 indicating that the community was doing an excellent job in addressing this particular health determinant. From the summary data, we learned that key leaders felt that the community as a whole was doing a good job at assuring that all children are immunized and in providing quality health care to its residents. Additionally, key leaders felt that the community could be doing a better job specifically in addressing issues of childhood obesity, healthy weight and nutrition; drug, alcohol, and tobacco use; responsible sexual behavior and mental health.

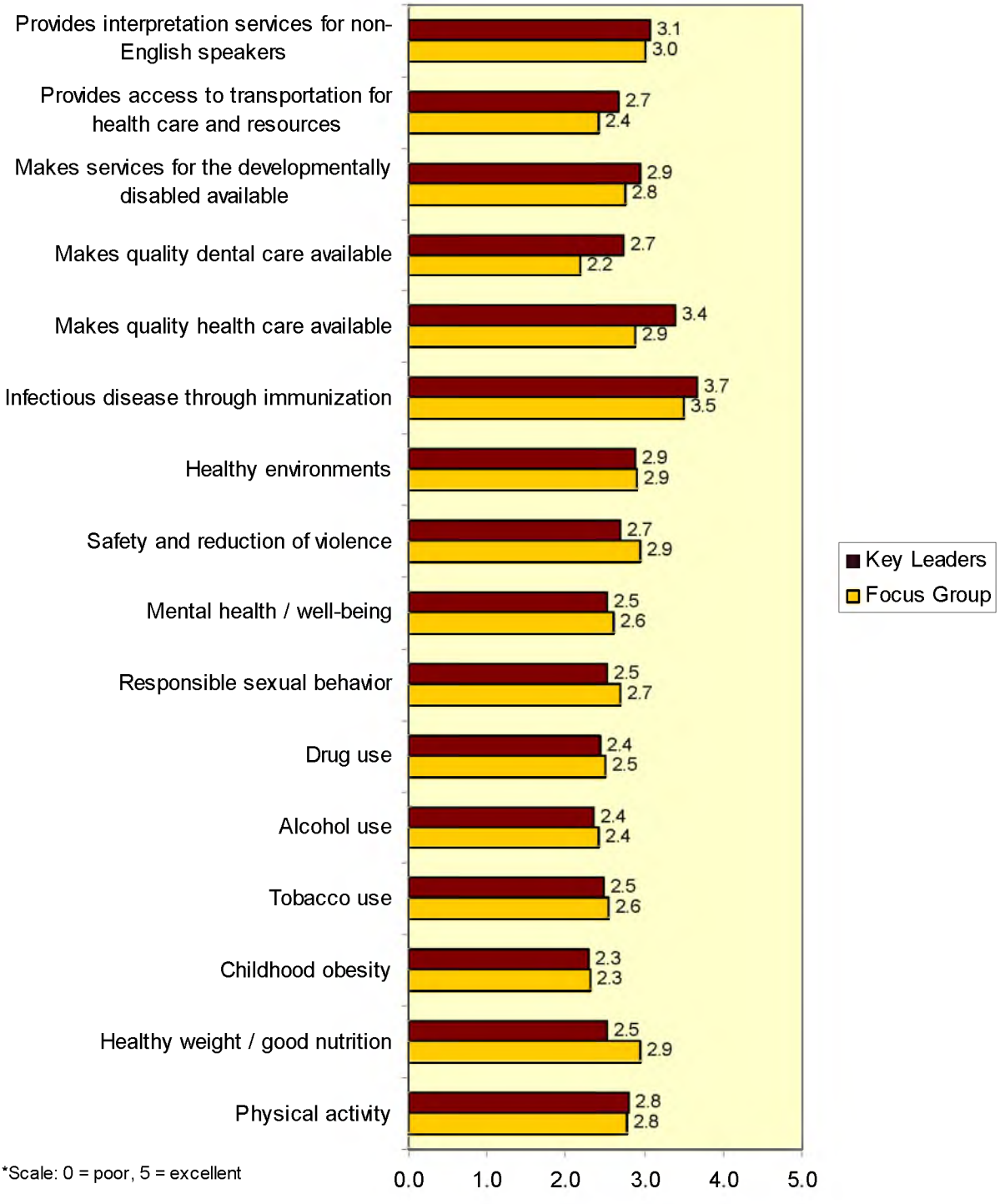
From the same survey administered at the focus groups, participants indicated that their community was responding best to issue related to infectious disease prevention, provision of interpretation services for non-English speakers, making quality heath care available and promoting healthy weight and good nutrition.

Important new areas where the focus group participants did not rate the community's response well were the availability of dental care, addressing issues around childhood obesity and alcohol use and providing access to transportation for health care. These areas of concern were consistent with the focus group discussions where the main concern for many participants included finding rides to their appointments, lack of dental care because of cost, and childhood obesity.

The community's response to making quality dental care available was the lowest rated indicator by the focus group participants. One participant made the comment that when someone has a medical emergency, they can go to the ED where they will be seen, regardless of income level or insurance status. This participant wondered why something like this was not available for dental care. She told a story about a friend who went to the dentist for a dental emergency, and partway through the procedure, was told that her insurance was not covered, and asked to pay hundreds of dollars out of pocket.

Lack of adequate transportation was another issue addressed by many of the focus group participants. One participant in particular had brought her infant by bus to the doctor for a vaccination, only to arrive and find out her appointment had changed. This mother was concerned because she did not know how she was going to find transportation to bring her back for the rescheduled appointment. The doctor's office offered a taxi voucher to the woman to make sure she could come back to have the baby immunized. Other participants have trouble scheduling appointments around the bus schedules, reported not having adequate access to the limited modes of public or charity transportation available in the city, such as ServiceLink, or Easter Seals.

Key Leader and Focus Group Perceptions
of Community Responsiveness to Healthy People 2010
Healthy Community Indicators



*Scale: 0 = poor, 5 = excellent

II. SUMMARY OF MAJOR AREAS OF NEED IDENTIFIED BY FOCUS GROUPS

West Side Residents

- Seven people identified job security and being able to afford their health insurance as a major issue that they worry about.
- Safety and the proper disposal and regular pick up of trash were identified as components that make a community a good place to live.
- Participants would tell the mayor to improve snow plowing, pick up the trash, increase/support neighborhood safety programs, and expand activities for youth.
- Participants said the schools need to do more to improve the eating habits of kids and to make children feel safe by dealing with bullying. Also, the City needs to make sure streets are safe to walk, and needs to offer activities for kids so they do not get into trouble.
- Four out of ten respondents said the Neighborhood Watch Program has had a positive impact on their community. One person said, "Community involvement is key to getting these things changed and to a better life for everyone."
- Six people said medical transportation was a problem, i.e. cabs are expensive, bus routes are inconvenient, and the program of the local hospital is expensive.
- Five respondents said the cost of care, co-payments or insurance impacts their ability or decision to seek healthcare.

East Side Residents

- There were nine participants in this focus group consisting of Neighborhood Watch group members and group captains.
- Transportation, the cost of healthcare and dental access were identified as the major concerns for the participants.
- All the participants agreed that neighbors helping neighbors is what makes a community a good place to live.
- Five participants said they would talk to the Mayor about the lack of dental services for adults without insurance. One person said, "If someone is really sick, you can call 911 and get treated. But, if you're in a lot of pain because of dental problems, there's no way to get care unless you can come up with the cash."
- Participants thought the schools were doing a better job in terms of healthy eating and active living. They also thought the city was offering more bike and walking trails and sponsoring fun runs.
- All participants agreed that the occurrence of crime is increasing, but thought the police department was doing its best, and had made improvements with gang and prostitution activity.
- In terms of a healthy environment, participants thought it was their responsibility to help keep the city clean. They did recommend better trash pick-up by the city.

- Overall the participants were satisfied with the many choices that Manchester offers for healthcare. They were concerned with access to dental care, mental health, and eye care. Additionally, they were concerned with the high cost of spend downs for Medicare and Medicaid.
- Many of the participants agreed that the emergency department (ED) is often misused by people who could be treated in an office visit, but they lack a doctor or insurance. They said they call their doctor first or the Ask-a-Nurse service before going to the ED.
- Three people talked about the need for the government to reform healthcare services.

Veterans or Family Members of People in the Military

- Three of the six participants talked about quality of care issues at the VA.
- Two people said that it is important to have a safe community with a good police force. Two talked about the need for good healthcare including rehab for drugs and alcohol.
- Two people were concerned about job security and insurance coverage.
- Two respondents want to talk with the Mayor about improving the police force, and safety in the community.
- Respondents said the city has improved its parks, school athletic fields, and the West Side soccer field.
- Two people said more needs to be done in the schools around drug and alcohol use.
- Regarding the environment, the group recommended improvements to trash removal, snow plowing, and the quality of water.
- Three respondents said the TriCare insurance coverage offered to active duty military members is inadequate. It only covers the member when on active duty.
- One member could not find a primary care physician and another could not find a substance abuse program in Manchester. Dental access was difficult for several participants.
- Two people said it should be easier to get help from the government. "We should not have to work this hard to get help."
- The long wait at emergency departments was cited as a concern.

Uninsured Residents

- The majority of the respondents (8 out of 10) said they were concerned with inadequate access to dental care. Eight participants also mentioned either job security or the economy as a major concern, and its impact on affordable health insurance.
- Five people said that caring neighbors and concerned citizens make the community a good place to live.
- Four people mentioned their frustration with the City and State when they applied for some sort of public assistance, but were not eligible. They believed they should be entitled to some assistance as U.S. citizens.

- Three people said there was no help to quit smoking and one said the methadone program is good.
- Every participant agreed that crime, especially events involving gun violence, has increased. Two people were disappointed with the police response. One thought the police chief is doing a good job. Respondents attribute the increase in crime to the economy and changes in youth attitudes. Respondents recommended more community watch programs and changes at the police department to better serve the communities.
- Three people said trash removal is an issue in Manchester, adding that the required bins are expensive and heavy.
- Several people brought up the fact that even services covered through the Manchester Community Health Center were very expensive for them, particularly if they were referred to outside specialists.
- Three people had concerns about the services available for medical transportation.

Teens

- Two out of six teens were concerned with getting financial assistance to help with living expenses.
- When asked what they believe make a community a good place to live, several participants mentioned safety, and another thought that no drugs made the community a good place to live.
- Three of the participants said they wanted to talk to the Mayor about some aspect of the benefits system, i.e. eligibility requirements, more programs.
- The teens are aware of programs related to good nutrition and weight management, but overall feel the programs and healthy food are too expensive. The participants feel that the schools could offer more healthy choices.
- All the teens talked about the school culture that accepts and promotes the use of drugs and promiscuity. Four of the participants said that teen pregnancy is very common and acceptable, and thought the schools could do a better job to prevent it.
- Four of the six teens smoked.
- All the teens said there are times when they do not feel safe in their community. Many of the teens walk around the city and have witnessed drug deals or domestic violence. They all mentioned that they thought part of the problem was an uncaring and unresponsive police force.
- Three teens said that trash pick-up was a problem. "Elm Street is nice, but they don't care about the other streets."
- Four of the six participants said they have good access to healthcare and are happy with their providers. They have health insurance. The other two just enrolled as patients at Child Health Services. They struggled with finding a provider and lack insurance.
- Four of the participants used the ED for care. One person said it was a long wait, and two others said they did not feel the staff was caring.

- All of the teens said that transportation was a major problem for them. They mainly walk to get around. The bus is too expensive.

Refugees from Somalia

- The chief concern in this group was the cost of housing. All the refugees struggled with the affordability of their apartments, and strived to get into subsidized housing.
- Another concern with this group was around lead paint exposure in their apartments. Several of their children are being treatment for lead exposure and it has affected their learning.
- All participants in this group said the Somali Development Center (SDC) helps them with a wide variety of services. The SDC helps them by scheduling appointments, picking up prescriptions, providing transportation, and assisting with shopping and cooking. If they need to go to the ED, the SDC will call ahead.
- In terms of health risk behaviors, the group said it was not a problem in their community as it is against their religious practice to smoke and use alcohol.
- They also said they do not have a problem with violence in their community.
- The cost of insurance and healthcare is a problem for the Somali refugees. Several participants in this group struggle with the cost of medical services. For the most part, their children are covered through Healthy Kids, but the focus group participants have no insurance. Many have lost their jobs and would like to receive Medicaid, but are not eligible. Those working cannot afford insurance. One person said, "Without Medicaid, you take over-the-counter drugs and do not go to the doctor."
- Access to dental care is a problem.
- Most of the participants go the Dartmouth Hitchcock-Manchester (DH-M) for their healthcare. One person said, "Dartmouth is the best clinic." The participants talked about the good treatment and services at DH-M.
- Several of the participants are very concerned with their benefits and what will happen after they run out.

Pregnant Women and Mothers of Newborns

- There was agreement among participants that the cost of health insurance and job security were major concerns facing their families.
- The participants said good schools and affordable family-friendly activities make a community a good place to live.
- Participants in this group would tell the Mayor to improve the City's sidewalks with better plowing, better access to oral health care for those without coverage, and decrease in wait-time at the emergency departments. One person said the Urgent Care sites are a good resource, but her insurance does not cover a visit there.
- All the mothers agreed that there is more information and education today about nutrition and weight management than five years ago, adding it is expensive to eat well and the Farmer's Market is a good resource. They said exercise programs are expensive and the City could make more walking trails.

- Three of the five women mentioned the smoking ban in restaurants and other public places as a big change in the last five years.
- Four of the participants mentioned the community policing or the Neighborhood Watch programs as a change in their community regarding safety and violence stating they would like to see them maintained.
- In terms of a healthy environment, four participants said they have seen changes regarding water. The two participants from Londonderry mentioned the public water spigot is no longer available. Two women said more people are drinking bottled water and mentioned the concern about plastic and chemicals in this water.
- In terms of healthcare availability, it was important to this group to have appointments on weekends, early morning, or in the evening so they did not have to take their children out of school.
- Participants were able to get appointments when needed; however, they had to wait several months to schedule physician appointments or screenings. Two of the women without insurance had a hard time finding prenatal care.
- Two of the women used the midwifery practice for their prenatal care, delivery and follow up. They were extremely happy with the approach and service.
- Four of the women said they are concerned with errors with medical billing. One said, "If we weren't so diligent about checking and arguing our bills, we'd be paying a lot more, and I'm afraid everyone else is paying a lot more than they should be." Another woman said the hospital and insurance company "play off each other" when it comes to correcting the billing error.
- Regarding the use of the ED, the participants all tried to call their doctor's office before going. They would rather go to their doctor.
- The women were aware of various transportation services around the City to get to medical appointments.

People Representing Minorities

- The cost of health insurance and job security were the major concerns for these participants.
- The participants identified good schools, access to a grocery store, parks, and a bus system as components that make a community a good place to live.
- Three of the six participants would encourage the Mayor to become more involved and engaged in the community.
- In terms of physical activity, nutrition and weight, participants felt the City needs more grocery stores to offer affordable food, traffic calming measures, better sidewalks to promote walking, and more affordable exercise programs for youth.
- Regarding health risk behaviors, the participants said the schools need to do more around prevention and education. The minority families are dealing with a transition and their needs surround acquiring western attitudes. They need help assimilating this information. It was emphasized that the programs should be a model that involves the minority communities.

- Regarding safety and violence, the group feels the police chief is doing a good job. They added the City needs to maintain the Neighborhood Watch programs and provide programs to youth after school so they do not roam the streets. Participants said the police department needs to work on reaching out to the minority community to strengthen communication. Also, they said there seems to be a difference in the way the juvenile justice system treats minority youth versus other youth.
- In terms of the physical environment, the group said that many minorities like to stay in subsidized housing even as their incomes grows because the have established a sense of community. Also, much of the private housing stock in Manchester consists of older houses which have unabated lead paint and many are owned by absentee landlords who do not address maintainence problems in a timely manner.
- This group identified medical translation as an issue that trumps all other issues in terms of healthcare availability and access. They explained that many new immigrants are not seeking healthcare because they cannot speak English and cannot express what they need.
- Also, it was mentioned that many immigrants remain as patients of the the Manchester Community Health Center (MCHC) because MCHC offers culturally sensitive services and they feel comfortable there even though they have insurance and could be seen in a private practice. The majority of participants in this group expressed that the City departments need to come together and solve the issue of healthcare availability for all residents of Manchester.
- Several participants reinforced the need for better oral health care services saying that the hospital has a program to pull teeth for adults and that kids can now go to Small Smiles or Catholic Medical Center (CMC). Some immigrants travel back to their home country for dental care.
- Mental health services were also identified as a concern.

Individuals with a Mental Health Issue or Their Caregivers

- Six people identified the state of the economy and the impact it is having on their retirement, job security, and health insurance as their single biggest concern. Two people said they were most concerned about access to dental services.
- The majority of participants mentioned that good schools were important to make a community a good place to live. They also mentioned affordable housing, access to good healthcare services and good neighbors.
- The majority of participants (8 out of 10) would talk with the Mayor about affordable housing. They also mentioned the need to integrate mental health into health care, not cutting the bus service, establishing a mental health court, and access to oral health care services.
- In terms of healthy eating and active living, several participants thought the grocery stores were doing more, citing tours of the store, and nutritional counseling as examples. Also, they thought the schools were doing a better job by removing the soda machines. The participants suggested offering more walking and bike paths, and low-cost gym memberships. One participant suggested bringing the *In Shape* program

to Manchester. *In Shape* is a wellness program for people with mental illness which was developed in Keene.

- Regarding health risk behaviors, everyone agreed that the restaurant smoking ban has been a positive change. Conversely, several participants are concerned with the lack of substance abuse treatment programs especially for youth. Several participants thought the schools and community could do more in this area to educate students and parents.
- Regarding personal safety and violence, participants thought the Weed and Seed program was a good program and thought the YMCA did a good job supporting victims of domestic violence. This group was sensitive to the backlash towards sexual offenders saying many offenders are mentally ill. Many of the participants thought the issues with crime and violence stem from unsupervised youth and encouraged the city to offer more activities and after school programs.
- Several of the participants said they thought the City was doing a better job abating lead paint from apartments and the schools. Also, they thought the city had increased recycling and had improved on removing the snow although some thought there was room for improvement.
- In terms of health care availability, there were several concerns. Participants were concerned with the merger between CMC and DH-M because services may not be as convenient. Also, they were concerned with CMC closing the inpatient psychiatric unit, the increased caseloads at Greater Manchester Mental Health Center, and the lack of drug treatment and detox programs. Lastly, several people were very concerned with the availability of mental health services and medication for incarcerated people.
- When questioned about emergency department use, all the participants felt that people used the ED because they do not have a regular doctor, or they do not insurance. One person noted that her daughter used the ED because she could not organize herself to set and keep doctor appointments.
- In terms of health care access, many people mentioned the need for transportation services and a need for medical interpretation services.

Frail Elders

- All the participants identified the issue of transportation as a major issue. They do not want to be a burden to their families once they start to lose their independence. They were also concerned about their health status and growing older.
- The majority of the participants (6 out of 11) would talk with the Mayor about funding more programs like Easter Seals for elders.
- In terms of healthy eating and active living, a few in the group said they use Meals on Wheels, but it is expensive.
- Regarding violence and safety, most of the participants feel safe in their community. Most live in apartments that are secured. Two participants said the Weed and Seed program was positive.
- Two people want better trash pick-up.

- The majority of the participants feel they can get appointments easily when they need to. A few shared poor experiences with their doctors and nursing care at the hospital.
- All the participants felt like their health insurance covered them well. Two of the men had military pensions and said they had "very good coverage."
- The majority were not satisfied with dental care. They cannot afford care or find a provider who will take Medicare or Medicaid. Also, they identified eye care as a problem.
- A few of the participants had used the emergency room after being sent there by their doctors. Overall they were satisfied with the care.

Individuals with a Disability

- Participants identified financial security, major medical expenses, or their job security as a major concern for them.
- Participants said having access to services, transportation, and safety make the community a good place to live.
- The group would like to talk with the Mayor about traffic safety, access to oral health care services, and the high rates of autism in children born into families with relatives raised around the Jovine Drive area.
- In terms of healthy eating and active living, participants feel the city has improved the parks, bike paths and that the schools have made improvements.
- All the participants acknowledged the restaurant smoking ban as a positive measure.
- In terms of healthcare availability one participant said it is very difficult to get mental health services for her children so it is necessary to "take advantage of a crisis" to get needed services at that time. Also, two people said much needs to be done to improve access to substance abuse treatment and service. Overall, participants can get appointments for medical issues without problems.
- The caregivers in this group were very concerned with the Governor's proposed measures to balance the state budget and the impact that will have on people with disabilities.
- Everyone agreed that the City has become more violent. Neighborhoods that were once considered safe now have gang related insignia marking them. They suggested more Neighborhood Watch programs.
- The need for mental health parity was mentioned twice.

Individuals with a Chronic Illness

- The top concerns for this group were transportation, and the cost of healthcare.
- Participants from this group would tell the Mayor about the need for transportation, especially for people with a disability, and the need for information and referral services.
- Regarding healthy eating and active living, participants were aware of several improvements. They talked about the services available through the Elliot Wellness Center, Hannaford's grocery store, and the schools.

- Participants supported the smoking ban in restaurants.
- Regarding health risk behaviors, several of the participants thought this was a problem for youth because they were unsupervised, and that there needs to be more programs for youth and parenting classes.
- In terms of personal safety and violence, most of the participants said they feel safe in their community. Many live in private apartments with security.
- Two people said the O'Malley Building and the public housing on south Elm Street are run down and not secure.
- Regarding healthcare availability, one person new to Manchester has had a hard time finding a primary care physician who will take a new Medicare patient. Other participants said they thought the reimbursement rates for Medicare have impacted their care. The providers offer what is covered rather than what is needed. They also provide very short visits.
- A couple of participants said they have had a hard time finding medical specialists. The Senior Center is great in dealing with issues related to aging.
- Several people are going without routine dental care because of the cost. Even those with insurance have trouble paying for dental services. One person with diabetes recognizes the importance of regular cleanings, but cannot afford anything else. Another person said she traveled to the NH Technical Institute Concord and Tufts for cleanings. One person traveled north where appointments are cheaper. All participants would like to see more dental clinics.
- One woman would like to see more transparency in how the hospitals perform through quality measures.
- Of those who used the ED, they said they were satisfied with the quality of care, but they had to wait a long time while there.
- A couple of people said that health care and Medicare are very confusing. It is a struggle to understand everything and to make the best choice for coverage. They were aware of ServiceLink, but felt the community needed to do more to help families who are caregivers or dealing with their own health issues.

New Refugees from Bhutan and Bosnia

- The most pressing issue facing this group was related to Medicaid and insurance coverage. They would like to see this benefit extended to refugees beyond the initial eight months of arriving in this country. They said many immigrants work in low paying jobs where insurance is not provided.
- Participants are also concerned with job security.
- Most of the participants said job prospects make a community a good place to live.
- Participants would talk with the Mayor about extending Medicaid coverage, creating jobs, improving schools, increasing job training, and health care access. They would also talk about the expense of becoming a U.S. citizen.
- Participants said they think people are more aware about health eating and active living, but healthy food is expensive. They like the Farmer's Market, but it is expensive.

- In terms of health risk behaviors, participants said parents need to be stricter with the kids and kids need to be busy after school.
- Overall, participants feel safe in their community; however, it was acknowledged that crime increases during a bad economy.
- Regarding health environments, three participants believe drinking hot tap water is unhealthy. Two participants said they could benefit from some education on keeping their environment clean.
- In terms of health care availability, participants described problems of misunderstandings between them and their providers, i.e. missed appointments because they did not know where they were going, and insensitive providers.

APPENDIX TWO: ASSESSMENT METHODS

I. QUANTITATIVE METHODS

As the needs assessment process began, members of the Manchester Sustainable Access Project (MSAP) Data Sub-Committee reviewed the Healthy Manchester 2015 Strategic Imperatives Framework. This needs assessment's planning and organization were oriented around those Strategic Imperatives.

The final list of indicators of public health and well-being used in this report was created by first developing extensive lists of recommended indicators for each of the Strategic Imperatives. The sources for the extensive lists are in the table below, with a majority from the first five sources. From that large list of indicators, the final indicators were selected based on whether each was useful, measurable, and feasible to collect, actionable, available over time, and understandable. Local experts with expertise relevant to specific indicators were consulted to help determine if the final list of indicators met those criteria. The indicators used in the report are science-based and recommended by reputable sources.

Data for the indicators was collected from existing local, state, and national sources. The majority of the quantitative data were obtained from the Census Bureau, the American Community Survey, the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBSS), and numerous state and local agencies. In particular, the New Hampshire Department of Health and Human Services (NH DHHS) Health Statistics and Data Management section provided extensive data and assistance. Also, the MSAP Data Sub-Committee members provided data from their organizations for the Access to Health Care chapter.

The large data request made to the Health Statistics and Data Management section of NH DHHS included behavioral, health outcome, and health care data. Where appropriate we requested that the data be provided for specific age groups, race/ethnicity, and income levels. NH DHHS provided extensive internally created and reviewed data tables.

One limitation of the data provided was that in instances in which the number of events reported was very small, NH DHHS either did not report the result, or reported the raw numbers in place of population rates. These circumstances applied to much of the health data related to the population of individuals of non-white races or ethnicities and explains why this report was rarely able to display local data for specific races or ethnicities.

Sources of Indicators of Public Health used in the 2009 Needs Assessment

Coded	Organization/Source	Resource
HP 2010	Healthy People 2010, US Dept of Health and Human Services	Healthy People 2010: Volumes I and II
IOM	Institute of Medicine	Improving the Health of the Community: A Role for Performance Monitoring
MAPP	National Association for County and City Health Officials	Mobilizing for Action through Planning and Partnerships
SUSA	Institute of Medicine	State of the USA
CHSI	DHHS	Community Health Status Indicators
CDC-NCHS	Centers for Disease Control and Prevention, National Center for Health Statistics	

MSAP	Manchester Sustainable Access Project	Manchester Sustainable Access Project's "*A Call to Action*" Report, 2008
RWJF	Robert Wood Johnson Foundation	State Health Access Profile
Elliot	Elliot Physician Network	Elliot Physician Network Quality Improvement, http://www.elliothospital.org/services/quality_EPN.html
WA	State of Washington public health indicators	
FQHC		Performance Monitoring for FQHCs
CDC-NCEH	Centers for Disease Control and Prevention, National Center for Environmental Health	Environmental Public Health Indicator Project
NACCHO	National Association for County and City Health Officials	2008-2009 Project Public Health Ready CRITERIA FOR LOCAL HEALTH DEPARTMENTS
AHRQ	U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality	Emergency Preparedness Resource Inventory: A Tool for Local, Regional, and State Planners
CDC	Centers for Disease Control and Prevention	Data Needs and Uses for Older Adult Health Surveillance: Perspectives From State Health Agencies
CDC	CDC Healthy Aging	The State of Aging and Health in America 2007 Report
CDC	Centers for Disease Control and Prevention	21 Critical Health Objectives for Adolescents and Young Adults
NH 2010	Healthy New Hampshire 2010	
Dashboard	New Hampshire Citizen's Health Initiative	New Hampshire's Healthcare Dashboard 2008
MCHB	HRSA- Maternal and Child Health Bureau	Promising Practices in MCH Needs Assessment: A Guide Based on a National Study
ERS/USDA	Economic Research Service/ United States Department of Agriculture	Food Security Measures
Bright Futures	American Academy of Pediatrics	Bright Futures

II. FOCUS GROUP & KEY LEADER INTERVIEW METHODS

Overview: Focus Group and Key Leader Interview Methodology

Through a contract developed by the City of Manchester Health Department (Health Department), the Data Sub-Committee of the Manchester Sustainable Access Project (Data Committee) hired the Community Health Institute/JSI (CHI) on January 1, 2009 to implement focus groups and key leader interviews in the Manchester Health Service Area. These participant interviews were conducted to meet the Manchester charitable trusts' mandate to complete a community health assessment. The Data Committee determined that focus group participants and key leaders would provide richness and nuance and to validate the quantitative data provided by the state and Manchester Health Department that provided the major framework for their assessment.

The Data Committee determined that all data and information collected during the 2009 community health assessment process would be used to inform the strategic imperatives of the Healthy Manchester Leadership Council and Department of Health. Thus, the development of these focus groups were directed by the strategic imperatives summarized below:

Manchester City 2009-2010 Strategic Imperatives

1.) Healthy people in every stage of life
2.) Healthy people in healthy places
3.) People prepared for emerging health threats
4.) People accessing quality health care

CHI collaborated with the Data Committee to develop the scope of the focus group and key leader interview questions and methods of data collection. During each focus group and key leader interview we captured both qualitative and quantitative data. Quantitative data were collected through administration of a paper-pencil survey instrument at the beginning of each interview, followed by a facilitated focus group discussion or key leader interview.

Focus Group Interview Methods and Sample Development

Together, the Data Committee and CHI staff identified and recruited community-based organizations (CBO) that provide services to clients from the Greater Manchester Health Service area (Manchester and its seven surrounding towns of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, and New Boston) to participate in the identification and recruitment of focus group participants.

A total of ten CBO's were identified as "Lead CBO" due to their ability to access participants and willingness and capacity to do so within the allotted timeframe. A lead CBO was

assigned to be the key coordinating body for recruitment for each focus group. Each lead CBO took responsibility for:

a. working with other community organizations to recruit appropriate participants based on the profile population assigned,
b. hosting the focus group,
c. helping participants get to the focus group, and
d. providing free space and snacks during the focus group meeting(s).

An effort was made by each CBO to recruit participants from within and outside of their own service system as long as they resided within Manchester and its surrounding towns. Each participant received a $25 gift card incentive to a local store as a way of thanking them for their participation (total cost of $2,765).

CHI provided the training documents to each lead CBO: Recruiting Agency Fact Sheet, Focus Group Profiles, Participant Fact Sheet (included later in this section). Each focus group was scheduled for two hours.

CHI developed profiles of the populations to be included in the focus group process based on input from the Data Committee. Thirteen focus group populations of interest were identified:

1.) Individuals with mental health needs
2.) Individuals living on the East Side of the city
3.) Caregivers of young children
4.) Pregnant women or those with newborns
5.) New refugees
6.) Individuals living on the West Side of the city
7.) Individuals with (or caring for someone with) a chronic illness
8.) Frail elders
9.) Teenagers
10.) Individuals who are uninsured
11.) Minority populations
12.) Individuals or family members of those who are currently serving in the military or who are veterans
13.) Individuals living with (or caring for someone with) a disability

A total of 115 individuals from thirteen communities participated in the 13 focus groups. A total of 109 participants completed a survey prior to the focus group discussion resulting in a 94.7% survey participation rate.

Focus Group Sample – Demographic Description

The following tables provide descriptive information for each of the 13 focus groups, summarized by age, city, gender and insurance status for the focus group participants who completed a survey. These descriptives below are illustrated for each of the thirteen focus group target populations.

Participants by Age					
Focus Group Population:	Age				
	0-17	18-64	65+	Unknown	Total
Have mental health issues	0	8	4	1	13
Live on East Side	0	9	1	0	10
Caregivers of young children	0	6	0	0	6
Pregnant women or new mothers	0	4	0	0	4
New refugees	0	9	0	0	9
Live on West Side	0	10	0	0	10
Have/caring for person with chronic Illness	0	1	9	0	10
Frail Elders	0	0	11	0	11
Teenagers	3	3	0	0	6
Individuals who are uninsured	0	11	0	0	11
Minority populations	0	7	1	0	8
Military or Veteran	0	6	0	0	6
Have/caring for person with disabilities	0	5	0	0	5
Total	**3**	**79**	**26**	**1**	**109**

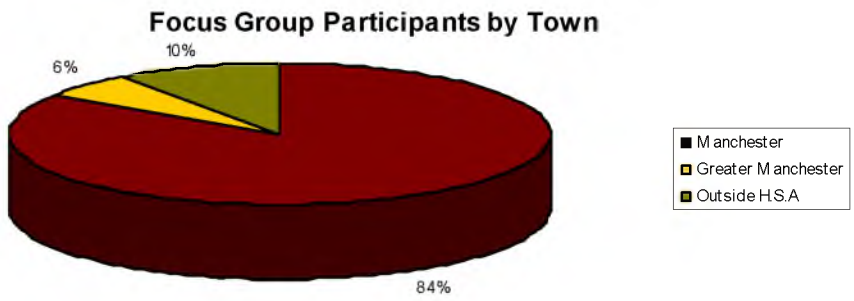
Participants by City			
Focus Group Population:	City		
	Manchester	Greater Manchester	Total
Have mental health issues	9	4	13
Live on East Side	10	0	10
Caregivers of young children	2	4	6
Pregnant women or new mothers	2	2	4
New refugees	8	1	9
Live on West Side	10	0	10
Have/caring for person with chronic Illness	6	4	10
Frail Elders	11	0	11
Teenagers	6	0	6
Individuals who are uninsured	10	1	11
Minority populations	8	0	8
Military or Veteran	6	0	6
Have/caring for person with disabilities	4	1	5
Total	**92**	**17**	**109**

Participants by Gender			
Focus Group Population:	Gender		
	Female	Male	Total
Have mental health issues	9	4	13
Live on East Side	9	1	10
Caregivers of young children	6	0	6
Pregnant women or new mothers	4	0	4
New refugees	4	5	9
Live on West Side	6	4	10
Have/caring for person with chronic Illness	8	2	10
Frail Elders	8	3	11
Teenagers	5	1	6
Individuals who are uninsured	6	5	11
Minority populations	8	0	8
Military or Veteran	2	4	6
Have/caring for person with disabilities	4	1	5
Total	**79**	**30**	**109**

Participants by Insurance Status				
Focus Group Population:	Insurance Status			
	Has Insurance	Does Not Have Insurance	Unknown	Total
Have mental health issues	11	2	0	13
Live on East Side	9	1	0	10
Caregivers of young children	6	0	0	6
Pregnant women or new mothers	4	0	0	4
New refugees	6	3	0	9
Live on West Side	7	3	0	10
Have/caring for person with chronic Illness	10	0	0	10
Frail Elders	9	2	0	11
Teenagers	4	2	0	6
Individuals who are uninsured	2	9	0	11
Minority populations	7	1	0	8
Military or Veteran	6	0	0	6
Have/caring for person with disabilities	3	0	2	5
Total	**84**	**23**	**2**	**109**

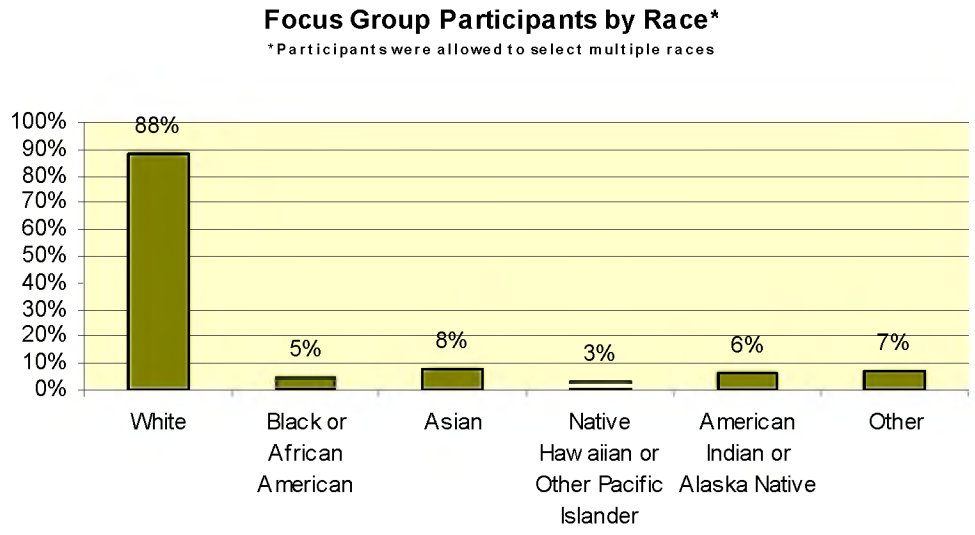
Focus Group Participant Description

A total of 115 people participated in the focus groups, with 109 completing the quantitative survey. Eighty-four percent of the participants live in Manchester, 6% live in Greater Manchester (seven communities in the Manchester Health Service Area [HSA] selected by the MSAP Data Committee), and 10% live outside the HSA.

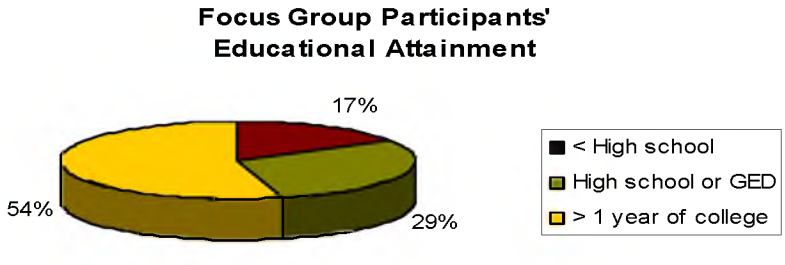


Seventy-three percent of participants were female, and 27% were male. The average age of participants was 52. The youngest participant was 14 years old, and the oldest participant was 92 years old. The majority of participants (73%) were between the ages of 18 and 64. Twenty four percent of participants were 65 years and older.

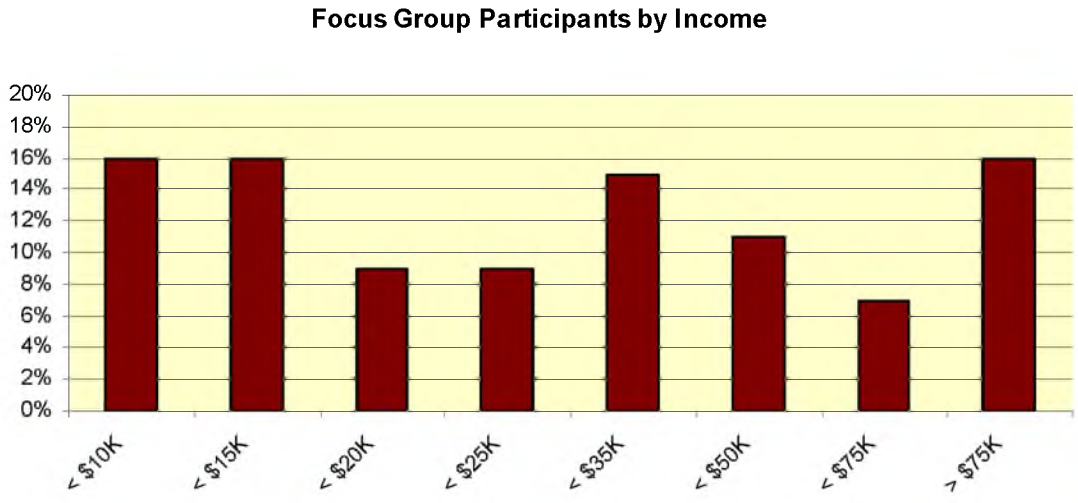
Eighty-eight percent of the focus group participants identified their race as white, 8% identified themselves as Asian, 6% as American Indian or Alaska Native, 5% as black or African American, and 3% as Native Hawaiian or Other Pacific Islander. Seven percent of the participants identified themselves as Hispanic or Latino. Participants were asked to check as many races as applied.



Seventeen percent of the focus group participants did not complete high school. Twenty-nine percent of the participants had their high school diploma or equivalent, 31% have completed some college, and 23% have completed four or more years of college.

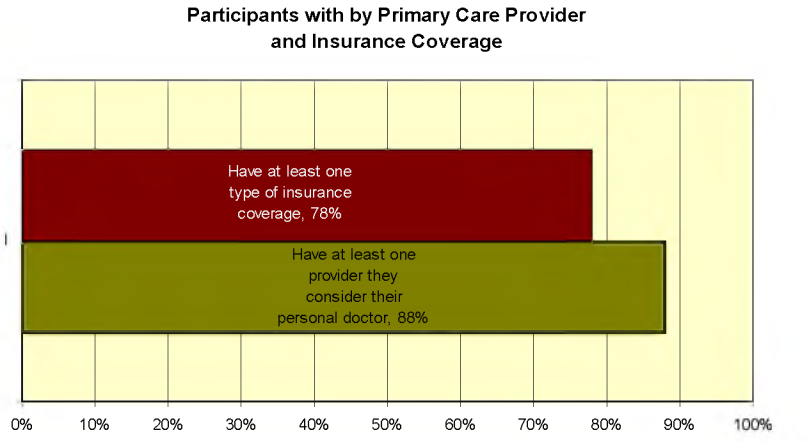


Fifty-one percent of the focus group participants have an annual household income (from all sources) of less than $25,000, with 16% having less than a $10,000 annual household income. Sixteen percent of participants have an annual household income of over $75,000. Of all the participants, only 47% are currently employed for wages (through an employer, or self). Fourteen percent have been out of work for at least a year, 10% are unable to work, and 23% are retired. Six percent are either homemakers or students.



Almost half of the focus group participants reported being limited in any activity by an impairment or health problem (46%). This high number is not surprising considering that the focus groups were made up of members of vulnerable populations from the community, included disabled residents, and chronically ill residents.

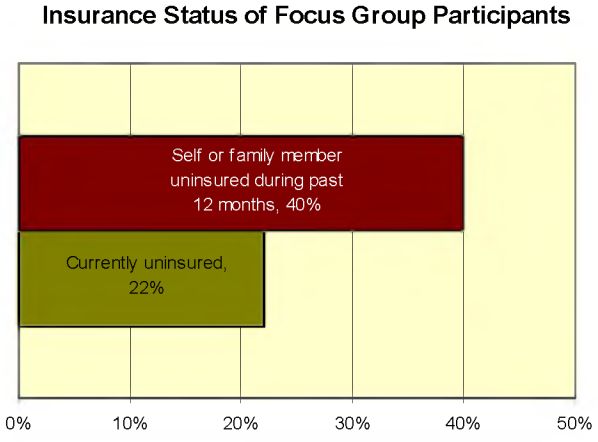
Eighty-eight percent of the focus group participants reported having at least one health care provider that they consider their personal doctor. This number is consistent with state BRFSS data from 2005-2007, where 89% of Manchester residents reported having one provider that they consider their personal doctor.[1] Seventy-eight percent reported having at least one kind of health insurance.



This rate of insurance is significantly lower than that of the Manchester residents sampled in the 2005-2007 BRFSS surveys, in which 88% reported that they had insurance.[1] With the increasing unemployment rate and rising costs of health care coverage, it is not surprising that this rate of insured residents has decreased.

Among focus group participants, there is a significant correlation between income level and insurance coverage (p = .009). Focus group participants with higher levels of income have a higher rate of insurance coverage. This correlation is consistent with national data. The National Health Interview Survey data from 1997-2001 showed a trend of higher uninsurance rate as the poverty level of Americans increased: Twenty-eight percent of surveyed Americans under the age of 65 considered "poor", 27% who were considered "near poor", and only 9% of those considered "not poor" were uninsured.[2]

The most common reason why people did not have insurance was that it is too expensive (44%). Eighteen percent of participants who reported having no insurance (or a family member with no insurance) during the past twelve months reported that the reason was that their job didn't offer any benefits, and another 18% reported that the reason was that they were unemployed.



There was also a significant correlation between family insurance status and race. Statistical analysis shows that within the focus group participants, those who identified themselves as white had a higher rate of family insurance status (p = .007), and those who identified

themselves as black or African American had a lower rate of insurance status ($p = .011$). Again, this correlation is consistent with national data. The National Health Interview Survey data from 2001 shows that white persons under the age of 65 had an uninsurance rate of 13.5%, while black person in the same age category experienced an uninsurance rate of 22.8%.[2]

Key Leader Interview Methods and Sample Development

Between March and May of 2009, the Community Health Institute (CHI) staff interviewed twenty-six key leaders from the Manchester Area who had been identified by their peers as being leaders who understood well the current and emerging issues of the city of Manchester and its surrounding towns. Six key leaders interviewed were specifically chosen to add insight on the issues of Manchester's surrounding towns. Four leaders were interviewed specifically for their unique perspective as business leaders in the city. Over all, key leaders represented city and town government, the education system, the health delivery system, business, non-profit social organizations, and police.

Key leaders were identified by the Data Committee based on their diverse knowledge of the community. Fourteen key leaders who work in Manchester based organizations were initially identified from the leader list from the 2004 Manchester Community Health Assessment. Before the interview was administered, all key leaders received a letter of introduction, a summary of the topics to be covered in the open-ended interview and the quantitative survey instrument.

Finally, one interview was also completed with four prominent business leaders over a working lunch arranged by the City of Manchester Department of Health. Due to time constraints of the business leaders, it was impossible to interview these persons separately. These leaders represented and provided input to the assessment from the perspective of both small and large business owners. For purposes of our analyses, 20 interviews were conducted although 24 persons were interviewed.

A standard script and protocol was used for conducting the interviews. Whenever possible, the interviews were conducted in-person (out of the 21 interviews, only five were conducted by phone). The key leader interviews were developed to obtain insight regarding leaderships' vision for an ideal city, greatest needs facing the Manchester Health Service Area population today, and emerging issues of concern for the future. Additionally, specific questions were asked to capture more detailed information specific to the community's ability to address CDC's healthy community leading health indicators: physical activity, weight and nutrition; health risk behaviors; personal safety and violence; healthy environments; and health care availability and access. Finally, through administration of a final open-ended wrap up question we invited these key leaders an opportunity to speak about any other issues that they were facing regarding the city's needs for health care/system improvement.

A standard paper pencil survey instrument was also completed by each key leader in an effort to summarize quantitatively his/her perspective on the Centers for Disease Control (CDC) leading health indicators of community health (healthy weight and nutrition, drug, alcohol, and tobacco usage, and health care availability). The survey ended with a question asking how the health of the community compares to five years ago, and a question which asked leaders how they would rate the health of the community today.

The key leaders were aware of the community health assessment process and many of them have participated in similar interviews in the past, thus they seemed to be very comfortable and actively participated in this process. Although we attempted to modify all questions and survey data to reflect the position and perspective of the key leaders, some of the leaders found the focus of the health indicator questions confusing because they did not live in the city of Manchester or in the Health Service Area. In the Key Leaders Interview section we summarize the major themes of the interviews by question category.

Key Leader	Title	Agency	Interviewer	Date
Tim Soucy	Director	Manchester City Health Department	Dotty Bazos and Katie Robert	3/11/2009
Frank Guinta	Mayor	City of Manchester	Dotty Bazos	3/20/2009
Karen Burkush	Assistant Superintendent	Office of the Superintendent of Schools	Dotty Bazos	3/23/2009
David Mara	Chief of Police	Manchester Police Department	Dotty Bazos	3/24/2009
Tom Blonski	CEO	Catholic Charities	Dotty Bazos	3/24/2009
Maureen Beauregard	CEO	Families in Transition	Dotty Bazos	3/30/2009
Doug Dean	CEO	Elliot Hospital	Lea Ayers LaFave	4/8/2009
Alyson Pitman Giles	CEO	Catholic Medical Center	Lea Ayers LaFave	4/9/2009
Ed George	President	Manchester Community Health Center	Lea Ayers LaFave	4/9/2009
Patrick Tufts	President/CEO	United Way	Martha Bradley	4/9/2009
Fred Rusczek	Executive Director	Child Health Services	Lea Ayers LaFave	4/14/2009
Dr. Steve Paris	Medical Director	Dartmouth-Hitchcock Manchester	Martha Bradley	4/14/2009
Peter Janelle	President/CEO	Greater Manchester Mental Health Center	Martha Bradley	4/14/2009
Phone Interviews:				
George Edwards	High School Principal	Town of Bedford	Dotty Bazos	5/28/2009
Carrie Rouleau-Cote	Health Officer	Town of Auburn	Katie Robert	4/16/2009
Colleen Guardia	Deputy Health Officer	Town of Deerfield	Katie Robert	4/14/2009
Richard O'Brien	Fire Chief	Town of Goffstown	Katie Robert	4/16/2009
Peter Rowell	Health Officer	Town of Hooksett	Katie Robert	5/7/2009
Shannon Silver	Health Inspector	Town of New Boston	Katie Robert	4/29/2009
Business Leaders Lunch Meeting:				
Cathy Champagne	Owner	Jutras Signs	Dotty Bazos and Katie Robert	5/5/2009
Jeff Eisenberg	President	Manchester Monarchs		
Ron Dupont	Owner	Red Oak Property Management		
Michael Amthor	HR Manager	Sylvania		

Interview and Survey Question Development

The focus group and key leader interview scripts for the qualitative interviews were developed to capture similar information from both samples – focus groups and key leaders.

First, by asking three open-ended questions, we captured information on high level issues summarizing participants' perceptions of current and emerging issues of the area's population health and health services needs:

1.) Vision for an ideal city,
2.) Perception of greatest needs facing the Manchester Health Service Area population today, and
3.) Perception of emerging issues of concern.

Second, using fifteen specific questions we captured more detailed information regarding the participants' perception of the community's ability to address Healthy People 2010 Community Health Indicators Report [3]: physical activity, weight and nutrition; health risk behaviors; personal safety and violence; healthy environments; and health care availability and access. These leading health indicator questions were also asked in the 2004 Manchester Community Health Assessment.

Third, through administration of a final open-ended wrap up question, we invited participants an opportunity to speak about any other issues that they face regarding their needs for health care/system improvement.

Quantitative data were also collected through a survey instrument developed by the CHI health assessment team. Two surveys were designed and administered to the two sample populations – focus groups and key leaders – before any discussion took place.

The final focus group and key leader survey instruments are similar but were modified to accommodate the perspectives from which these data were collected; i.e., those who receive services, versus those who provide services (see the Focus Group and Key Leader Quantitative Survey Instruments section). The Data Committee reviewed and approved the final scripts and survey questions and proposed methodology before administration of the assessment began.

The focus group survey instrument consisted of twenty-three questions administered to each participant as a paper and pencil survey at the beginning of each focus group. These questions captured participant demographic, health status, and health care access information (including questions on emergency department usage) as well as participant perceptions of leading health indicators of community health. In addition, the survey included standardized questions from the 2009 BRFSS in order to provide more detailed demographic and descriptive data of these persons.[4]

The key leader survey instrument consisted of eighteen questions also administered as a paper-pencil survey instrument. Data collected from these surveys summarized leader perceptions of the Healthy People 2010 Community Health Indicators Report.

Both survey instruments concluded with questions asking about the participants' perception of how the health of the community compares to five years ago, and how he/she would rate the health of the community today.

Qualitative Data Analyses Methods

For each focus group, a note taker documented the major themes and points of each group interview. All focus group interviews were tape recorded. Notes from each interview were summarized and reviewed by the focus group leader and note taker for completeness. Tapes of the interviews were reviewed to fill in any missing data, thus resulting in a complete summary of each focus group meeting. Summary notes were written using a standard protocol so that they could be analyzed using NVIVO 8 statistical software program.

Key leader input was captured during each interview by an interviewer who took notes during the scheduled meeting. All interviews were completed as one-on-one meetings with the exception of the business leaders interview in which four leaders participated at one time (for analyses, n=1). Fifteen interviews were conducted in-person and five were conducted by phone. Interview notes were summarized and entered into a computer word document immediately after each interview session. These notes were captured in a consistent format and analyzed for key themes using NVIVO 8 statistical software. In an effort to limit interview bias as much as possible, CHI assigned (whenever possible) interviewers to key leaders whom they had not worked with in any close capacity during the past year.

Quantitative Data Analyses Methods

The quantitative survey data were collected at the beginning of each focus group and key leader interview were key-punched into two separate SPSS databases for descriptive analysis of the data.

It is important to note that focus group participants were not selected based on a random sample of the Manchester and surrounding communities' populations, but instead were created to capture the needs of vulnerable populations within the community. Participants were recruited by health care providers, of whom the focus group participants were likely patients. If a participant did not respond to a question he/she was excluded from the analysis of that question. When all focus group participants responded to a question the total number of respondents was 109.

Seventeen key leaders completed surveys (70% response rate) which were also were completed and analyzed. If a participant did not respond to a question he/she was excluded from the analysis of that question.

FOCUS GROUP LOGISTICS

Recruiting Agencies and Focus Group Totals

Recruiting Organization	Focus Group	Date	Participants
Mental Health Center of Greater Manchester	Individuals with Mental Health Issues	February 19th	14
Elliot Health System	Individuals Dealing with Chronic Health Condition(s)	March 10th	9
Easter Seals	Individuals who are Elders	March 12th	11
Child Health Services	Individuals who are Teens	March 12th	6
NH Minority Health Coalition	Individuals who are Racial and Ethnic Minorities	March 16th	8
Manchester Community Health Center	Individuals with no or limited access to care through insurance	March 16th	11
Manchester Health Department	Individuals who are East Side residents	March 19th	9
Easter Seals	Individuals who are Military Veterans, Active Duty Members or Family Members	March 23rd	6
Easter Seals	Individuals who are Disabled	March 25th	6
Dartmouth-Hitchcock Manchester	Individuals who are caregivers of young children 2 yrs to 12 yrs	March 4th	6
Catholic Medical Center	Pregnant Women or Women with Newborns	March 4th	5
Catholic Medical Center	Individuals who are new refugees - Bosnian/Bhutanese	March 5th	8
Catholic Medical Center	Individuals who are new refugees - Somali	March 5th	6
Manchester Health Department	Individuals who are West Side residents	March 9th	10

Focus Group Recruiting Agency Task List

Agency's Responsibilities	Due Date
Assign a staff person to coordinate the logistics of recruiting focus group participants and act as the liaison with Community Health Institute (CHI).	
Review the profile for the group(s) you were assigned. *Please note that you are recruiting people who fit a particular profile from the community not just from the people you serve. You can work with other groups/ agency to recruit people who fit the profile that you were assigned.*	
The lead agency should meet or hold conference calls with coordinating agencies to define tasks. Lead agency to assign participant recruitment numbers to each coordinating agency.	
Schedule a date for the focus group. Call Shasta at 603-573-3312 to coordinate a date.	
Reserve a meeting room for 10-12 people. The room should allow for conversation and discussion.	
Recruit 10-12 people to participate in the focus group. You will need to identify and invite at least 20 people to get 10-12. (Refer to script & Participant Fact Sheet.)	
Follow your agency's protocol for collecting data, if applicable.	
Call Shasta 3 days before the focus group to report final participant numbers. This will help to determine the number of gift cards to purchase.	
Assist individual(s) with their personal logistics such as child care, transportation and translation.	
Send each participant a copy of the focus group the *Participant Fact Sheet.*	
Prepare list of participants for facilitator.	
Provide light refreshments at the focus group.	

Community Health Institute Task List

Community Health Institute's Responsibilities	Due Date
Provide each agency technical assistance to identify and recruit focus group participants.	On-going
Provide each agency instructions on who to recruit and assignments.	Completed
Design strategy and scripts for qualitative data collection.	Completed
Facilitate focus groups.	TBD
Document and transcribe focus groups.	On-going
Write summary report of focus groups.	April 2009
Buy $25 gift card for focus group participants to a store recommended by recruiter.	TBD

Focus Group Participant Fact Sheet

This fact sheet was distributed by the CBOs to the focus group participants prior to the scheduled discussion.

Thank you for agreeing to be part of the Manchester Sustainable Access Project's Community Benefits Assessment. The Manchester Sustainable Access Project is conducting 13 focus groups in Manchester to help us understand what health care services people need in the Manchester area. We would like to hear about your experience getting and receiving health care for you or a family member in the Manchester area.

This fact sheet gives answers to frequently asked questions as well as more information about the upcoming focus group you will be involved in.

Common Questions about Focus Groups:

What is a focus group?
A focus group is a structured discussion with a leader. We will ask the group specific questions and each person will have a chance to share his or her experience getting health care services in Manchester.

How is the information used?
You will not be identified in any of the reports that are written. Your comments and experiences may be shared in the reports, but your identity will be kept private. The report will be a summary of common themes that we hear in the groups.

Why are you doing a focus group?
State law requires that any agency receiving grant funding of more than $100,000 must conduct an assessment for their community every three years to determine the extent to which the community benefits from their services. The Community Health Institute has been hired by the Manchester Sustainable Access Project through funding from Catholic Medical Center, Elliot Health System and Dartmouth Hitchcock Medical Center to provide these focus groups.

What should I bring?
You do not need to bring anything to this focus group meeting. Just come and share your honest thoughts during the discussion.

How long is the focus group meeting?
The focus group will last for 1 ½ - 2 hours.

Can I bring my children?
You cannot bring your children. If you need help with childcare, please let us know before the meeting.

Will I get paid to attend the group?
You will get a gift card for $25.oo to a local store at the end of the focus group meeting.

Who do I call with questions?
Insert recruiter's name and contact information.

Will there be food?
Yes, we will serve light refreshments.

Is there help with transportation?
Yes, please let us know of your need for transportation assistance.

Is there help with translation?
Yes, please let us know of your need for translation assistance.

Focus Group Details:

Date:	*Fill in date of focus group*
Location:	*Fill in location of focus group*
Time:	*Fill in time of focus group*
Contact Person:	*Provide recruiter contact information*
Directions:	*Give directions to focus group location*
If you need help with childcare, transportation or translation, please call:	*Provide recruiter contact information*

Focus Group Script

This script was followed by the focus group facilitator, a CHI team member, during each focus group.

Thank you for taking the time to meet with us today.

Before we begin we'd like you to complete this survey. It is an anonymous survey so DO NOT write your name on it. Once you are finished, hold on to the survey because you may want to refer back to it during our discussion. I will collect the surveys at the end of our discussion.

To capture your feedback, we will record the conversation using both a digital recorder and hand written notes. This is done so that we can be sure that the information you provide is captured correctly. Are there any objections to recording the discussion?

Introduction & Ground Rules:

- Hello and welcome to our discussion, or focus group, today. Thank you for taking the time to participate. I will keep the meeting to 2 hours so that we finish by_____. You should also feel free to get up and stretch, go to the bathroom, or help yourself to refreshments.
- My name is XX. I will act as the moderator for today's discussion. This is my co-worker XX. She is here to take notes of the discussion and *keep track of time*. You can also get her attention if you need her assistance for any reason during the group. We are both with the Community Health Institute, which is located in Bow, NH. CHI is a public health consulting agency.
- We are taping this session so we can remember the important points of our discussion when we write the report. This is done so that we can be sure that the information you provide is captured correctly. No names or identifying information will be transcribed from the tape or used in any report. ***Is it okay that we tape this group?***
- Every few years your community charitable trusts are asked to reach out to community members to find out how they can help improve the health and well-being of the community. Information from this focus group will be used by local organizations; including both hospitals and Dartmouth- Hitchcock to develop action plans to meet your needs.
- My role is to make sure that we stay focused on the topic, that all the questions are touched on as fully as possible within the time frame and that everyone gets a chance to participate and express his or her opinion. We are here to learn about your experience. I know you all have a lot of information and personal experience to offer, but I may have to jump in to keep us on track and time.
- As participants, your role is to give your ideas, and share your experiences related to my questions and to the comments made by other members of the group. I will ask general questions, and ask for your opinions and ideas. Please remember that there

are **no right or wrong answers.** Everything you tell us is important. It is important that you speak loudly and clearly, and that one person speaks at a time.

- Finally, what we discuss in this group remains private. We will not share what you said with others. Your remarks will be incorporated into a summary report (with other peoples' remarks) where we capture major themes and patterns. We will not link what you say with who you are. We ask all of you all as members of this discussion to honor the privacy by not sharing what is said with others outside this group.

First, we would like to start by asking you a few general questions about you and your community.

What is the single most important issue facing you and your family?

- If reluctant, broaden scope of question by asking biggest concern among families in your community right now?

What do you believe makes a community the best place to live?

- List three things that could contribute to an ideal community.
- What does your ideal community look like?

If you could talk to the Mayor about one new or emerging health and safety issue in your community, what would it be?

Now we would like to ask you some questions about some of the things we asked about on the survey.

(Facilitator, refocus discussion to the leading indicators of health)

***Physical Activity, Weight and Nutrition* - Regular physical activities, healthy weight, good nutrition, childhood obesity**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?
- What do you think your community could do better about____?

***Health Risk Behaviors* – These are behaviors that could impact your health such as tobacco, drug and alcohol use, sexual behavior**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

- What do you think your community could do better about _____?

Personal Safety and Violence **- Safety, violence, family violence**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were not available five years ago?

What do you think your community could do better about _____?

Healthy Environments **- Physical environment, lead paint, air and water quality**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

Health Care Availability **– Regular or routine care and appointments, lab work or diagnostic services, medical care (including prevention services like immunizations, mammograms, colorectal screening, mental health and dental care services and other specialty services such as the use of the emergency room)**

After all we have talked about today; we now want to talk about health care availability. We would like to spend the next ½ hour looking at the issues you face with cost, quality and access of health care.

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

Prompts:

- Have you seen a change in getting a doctor's appointment? Cost? Quality?
- Can you get appointments that work for you? Has anything changed in you getting an appointment?
- What is better or worse in the last 5 years?

What do you think your community could do better about _____?

Additional Questions

- We know a lot of people in Manchester use the ER for regular medical care and we are trying to find out why?

Think about the last time you or a family went to the ER (or someone you know). Did you try to see or talk to your primary care doctor first?

What made you decide to use the ER instead of going through a doctor's office?

Prompts:

- Was it a life threatening emergency?
- The doctor or the answering service takes to long to return a call?
- Went in an ambulance?
- Do not have a doctor?
- After hours…did not think to call?
- Did do not know the number
- Instructed to go to the ER by doctor?

Health Care Access - Transportation, interpretation services

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

We have just one more question to ask before we wrap things up.

Are there other concerns about the health care system or your own health care that you feel are being overlooked?

- Beyond that we already discussed, are there specific things you need that are not available or easy to get in your community.

KEY LEADER INTERVIEWS

Key Leader Interview Schedule

Key Leader	Title	Agency	Interviewer	Date
Tim Soucy	Director	Manchester City Health Department	Dotty Bazos and Katie Robert	3/11/2009
Frank Guinta	Mayor	City of Manchester	Dotty Bazos	3/20/2009
Karen Burkush	Assistant Superintendent	Office of the Superintendent of Schools	Dotty Bazos	3/23/2009
David Mara	Chief of Police	Manchester Police Department	Dotty Bazos	3/24/2009
Tom Blonski	CEO	Catholic Charities	Dotty Bazos	3/24/2009
Maureen Beauregard	CEO	Families in Transition	Dotty Bazos	3/30/2009
Doug Dean	CEO	Elliot Hospital	Lea Ayers LaFave	4/8/2009
Alyson Pitman Giles	CEO	Catholic Medical Center	Lea Ayers LaFave	4/9/2009
Ed George	President	Manchester Community Health Center	Lea Ayers LaFave	4/9/2009
Patrick Tufts	President/CEO	United Way	Martha Bradley	4/9/2009
Fred Rusczek	Executive Director	Child Health Services	Lea Ayers LaFave	4/14/2009
Dr. Steve Paris	Medical Director	Dartmouth-Hitchcock Manchester	Martha Bradley	4/14/2009
Peter Janelle	President/CEO	Greater Manchester Mental Health Center	Martha Bradley	4/14/2009
Business Leaders				
Cathy Champagne	Owner	Jutras Signs	Dotty Bazos and Katie Robert	5/5/2009
Jeff Eisenberg	President	Manchester Monarchs	Dotty Bazos and Katie Robert	5/5/2009
Ron Dupont	Owner	Red Oak Property Management	Dotty Bazos and Katie Robert	5/5/2009
Michael Amthor	HR Manager	Sylvania	Dotty Bazos and Katie Robert	5/5/2009
Surrounding Town Leaders				
Carrie Rouleau-Cote*	Health Officer	Town of Auburn	Katie Robert	4/16/2009
George Edwards	High School Principal	Town of Bedford	Dotty Bazos	5/28/2009
Colleen Guardia*	Deputy Health Officer	Town of Deerfield	Katie Robert	4/14/2009
Richard O'Brien*	Fire Chief	Town of Goffstown	Katie Robert	4/16/2009
Peter Rowell*	Health Officer	Town of Hooksett	Katie Robert	5/7/2009
Shannon Silver*	Health Inspector	Town of New Boston	Katie Robert	4/29/2009

*** Denotes phone interview**

Sample Key Leader Informational Letter

This letter was sent to the key leaders prior to their scheduled interview, along with a copy of the questions the interviewer would be asking.

Dear XX,

The Community Health Institute has been asked by the Data Committee of the *Manchester Sustainable Access Project* (MSAP) to help complete the 2009 Manchester Community Health Assessment. Every few years, as part of the Community Benefits Law, community charitable trusts are asked to reach out to key informants to learn about health concerns in the local area. In Manchester, several charitable trusts have joined together under the umbrella of MSAP to jointly develop this assessment. As part of this effort, Lea or I will interview fifteen key leaders from the Manchester area to obtain their input on the health of the population of Manchester and its surrounding towns.

Thank you for agreeing to participate in this important effort. In preparation for our interview I am sending you the following: (a) a paper survey which you can complete before the interview, and (b) the interview questions that we will focus on. You may refer to the paper survey during our discussion and then I shall take it with me and include your scores in the survey database.

The survey questions ask you to rate how well you think your community addresses indicators identified by Healthy People 2010 as being important to community health. A similar survey was used in the Manchester 2004 community assessment. Thus, these data may help us better understand the Manchester area and how it is changing overtime. In our interview we will address these 2010 indicators in more depth and then talk specifically about issues of health care access.

As a reminder, please note that your remarks and survey responses will be incorporated into a summary report (with other peoples' remarks) where we capture major themes and patterns. Thus, what we discuss during this interview will not be linked back to you or to your position. The interview will take about one hour.

Thank you in advance for your time and support of this effort.

Sincerely,

Community Health Institute Staff

Sample Business Leader Solicitation Letter

This invitation was sent to business leaders, requesting their participation in the group interview.

Dear XX,

The Manchester Health Department would like to invite you to join us in a discussion on the health and health care needs of the Manchester community. This focus group meeting of leaders from both small and large local businesses will be held either on May 5th or May 6th from 11:30 a.m.-1:00 p.m., depending on participant availability. Katie Robert, from the Community Health Institute (573-3331), will follow-up with you to confirm your interest and availability to attend this important luncheon.

The Manchester Health Department is currently working with the Manchester Sustainable Access Project (MSAP) data committee to complete a Community Health Assessment of Manchester and its surrounding towns. MSAP is an initiative of the Healthy Manchester Leadership Council, and brings Manchester's health care providers together to work to decrease economic barriers and expand access to primary care services in Manchester.

This Community Health Assessment (CHA) must be completed every five years according to state law, and is used to assist charitable trusts in completing their Community Benefits Report, due annually to the Office of Charitable Trusts. This year, several charitable trusts in Manchester have joined under the umbrella of MSAP to fund this assessment which includes an analysis of public health and health care data by the Manchester Health Department and interviews with community residents and leaders, including business leaders.

A healthy workforce is an integral part of a healthy community. Thus, we are very interested in your perspective as business leaders on health and health care as we complete this assessment. With the rising cost of health care and a declining economy we understand that employers are faced with very difficult decisions every day, which will affect the ability of Manchester residents to meet their health and health care needs.

I have included a summary of the questions we will discuss at the meeting and Katie Robert will call you shortly to confirm your interest and ability to attend the luncheon.

Sincerely,

Timothy M. Soucy, MPH

Public Health Director

Key Leader Interview Script

This script was followed by the key leader interviewers during each key leader interview.

My name is _____ and I work at the Community Health Institute. I have been asked by the Data Committee of the MSAP project to help them with their community health assessment. Every few years your community charitable trusts are asked to reach out to community members and key informants to find out how they can help improve the health and well-being of the community. Information from this focus group will be used by local organizations; including both hospitals and Dartmouth- Hitchcock to develop action plans to meet your needs.

As part of this assessment I am interviewing 15 key leaders from the Manchester area to obtain their input on the health of the population of Manchester and the surrounding towns.

Thank you for taking the time to meet with me today. I will keep this interview to one hour so we will finish by _____.

The interview has two parts – a quick written survey that I will ask you to complete and then a discussion.

The survey is focused on community health indicators. A similar survey was used in the 2004 community assessment, thus these data may help us better understand the Manchester area and how it is changing overtime.

One you complete the survey you may refer to it during our discussion and then I shall take it with me and include it your scores in the database.

I just want to remind you that everything we discuss here will remain private. We will not share what you said with others. Your remarks will be incorporated into a summary report (with other peoples' remarks) where we capture major themes and patterns. We will not link what you say with who you are.

First I would like to start by asking you a few general questions about your community.

What is the single most important issue facing your community?

- If reluctant, broaden scope of question by asking biggest concern among families in your community right now?

What do you believe makes a community the best place to live?

- List three things that could contribute to an ideal community
- What does your ideal community look like?

If you could talk to the Mayor about one new or emerging health and safety issue in your community, what would it be?

Now I want to talk to you about some of the leading health indicators that were the focus of the survey:

Physical Activity, Weight and Nutrition **- Regular physical activities, healthy weight, good nutrition, childhood obesity**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about_____?

Health Risk Behaviors **– These are behaviors that could impact your health such as tobacco, drug and alcohol use, sexual behavior**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

Personal Safety and Violence **- Safety, violence, family violence**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were not available five years ago?

What do you think your community could do better about _____?

Healthy Environments **- Physical environment, lead paint, air and water quality**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

Now I would like to shift gears and would like you to talk about the health care system in the community particularly about healthcare quality, access and cost.

Health Care Availability **– Regular or routine care and appointments, lab work or diagnostic services, medical care (including prevention services like immunizations, mammograms, colorectal screening, mental health and dental care services and other specialty services such as the use of the emergency room)**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

Health Care Access **- Transportation, interpretation services**

When you think about _____, have you seen anything new or different being done in your community in the past five years?

- Are there any new or different services or resources available to you or your family that were or were not available five years ago?

What do you think your community could do better about _____?

I have just one more question to ask before we wrap things up.

Are there other concerns about the health care system or your own health care that you feel we have not yet talked about that you would like to discuss?

- Beyond that we already discussed, are there specific things you need that are not available or easy to get in your community?

Focus Group and Key Leader Quantitative Survey Instruments

Focus Group Quantitative Survey

Thank you for taking the time to meet with us today. We are conducting a community needs assessment to learn more about health concerns in Manchester and the surrounding area. This survey includes questions about you and your health, the area in which you live and the health care you may need.

Do not write your name on this survey. The information you give us is confidential and will only be used in combination with other participants' answers. You can skip any questions you do not feel comfortable answering.

Once you are finished completing the survey please hold on to it until you are asked to hand it in to the facilitator.

First, we would like to ask you some questions about yourself.

1. **What is your current zip code?**	_____ (5-digit zip code)
2. **In what town do you currently live?**	_____ (town)
3. **What is your gender?**	❑ Female ❑ Male ❑Other
4. **What is your age?**	_____ years old
5. **Are you Hispanic or Latino?**	❑ Yes ❑ No
6. **Which one or more of the following would you say is your race?** **(Check all that apply)**	❑ White ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ American Indian or Alaska Native ❑ Other
7. **What is the highest grade or year of school you completed?** **(Check one)**	❑ Never attended school or only attended kindergarten ❑ Grades 1 through 8 *(Elementary)* ❑ Grades 9 through 11 *(Some high school)* ❑ Grade 12 or GED (High school graduate) ❑ College 1 year to 3 years (Some college or technical school) ❑ College 4 years or more *(College graduate)*

8. **Is your annual household income from all sources…?** **(Check one)**	❑ Less than $10,000 ❑ Less than $15,000 ($10,000 to less than $15,000) ❑ Less than $20,000 ($15,000 to less than $20,000) ❑ Less than $25,000 ($20,000 to less than $25,000) ❑ Less than $35,000 ($25,000 to less than $35,000) ❑ Less than $50,000 ($35,000 to less than $50,000) ❑ Less than $75,000 ($50,000 to less than $75,000) ❑ $75,000 or more
9. **Are you currently…?** **(Check one)**	❑ Employed for wages ❑ Self-employed ❑ Out of work for more than 1 year ❑ Out of work for less than 1 year ❑ A Homemaker ❑ A Student ❑ Retired ❑ Unable to work
10. **How would you rate *your health* in general now?**	❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
11. **Are you limited in any way in ANY activities because of an impairment or health problem?**	❑ Yes ❑ No
12. **Do you have one person you think of as your personal doctor or health care provider?**	❑ Yes, only one ❑ More than one ❑ No
13. **Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?**	❑ Yes, only one ❑ More than one ❑ No

14. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?	❑ Yes, only one ❑ More than one ❑ No
15. In the past 12 months, have you or a family member been uninsured?	❑ Yes ❑ No
16. If yes, what is the *main* reason you didn't have or currently don't have health insurance? **(Check one)** **17.**	❑ It is too expensive ❑ Your job doesn't offer benefits ❑ You are or were between jobs or unemployed ❑ You were refused coverage because of a pre-existing condition ❑ You don't know how to get coverage ❑ You don't need insurance ❑ Some other reason (Please specify: _____ _____)

18. During the past 12 months, what problems, if any, have you experienced getting health care in the area? **(Check all that apply)**	❑ No problems getting health care ❑ Difficult to get transportation ❑ Difficult to get someone to take care of children ❑ Lack of services that are at a convenient time ❑ Long time to be seen at clinic or doctor's office/waiting time ❑ Can't get off from work ❑ No insurance ❑ Do not understand medical directions ❑ Different culture ❑ Lack of sensitivity among health care providers ❑ Lack of sensitivity among staff ❑ Difficulties in making appointments ❑ Language barrier with physician ❑ No translator ❑ Don't know where to get health care ❑ Lack of trust in the health care system ❑ Can't afford medications ❑ Can't afford to visit clinic/doctor ❑ Could not find a doctor accepting new patients ❑ Some other reason (Please specify: _____ _____)
19. How many times have you or someone in your household been to a hospital emergency room in the past year?	_____ times in past year
20. Think about the last time you or a family member went to a hospital emergency room. Before you went, did you consider seeing a doctor in his or her office for that problem?	❑ Yes ❑ No
21.	

22. Please rate how well you think your community does the following?	Excellent	Very Good	Good	Fair	Poor	Don't know
a. Promotes regular physical activity	❑	❑	❑	❑	❑	❑
b. Promotes healthy weight and good nutrition	❑	❑	❑	❑	❑	❑
c. Prevents childhood obesity	❑	❑	❑	❑	❑	❑
d. Prevents and reduces tobacco use	❑	❑	❑	❑	❑	❑
e. Prevents and reduces alcohol use	❑	❑	❑	❑	❑	❑
f. Prevents and reduces drug use	❑	❑	❑	❑	❑	❑
g. Promotes responsible sexual behavior	❑	❑	❑	❑	❑	❑
h. Promotes mental health and well-being	❑	❑	❑	❑	❑	❑
i. Promotes safety and reduce violence	❑	❑	❑	❑	❑	❑
j. Promotes healthy environments	❑	❑	❑	❑	❑	❑
k. Prevents infectious disease through immunization for all age groups	❑	❑	❑	❑	❑	❑
l. Makes available quality health care	❑	❑	❑	❑	❑	❑
m. Makes available quality dental care	❑	❑	❑	❑	❑	❑
n. Makes available services for the developmentally disabled	❑	❑	❑	❑	❑	❑
o. Provides access to transportation for health care and	❑	❑	❑	❑	❑	❑

resources throughout the community						
p. Provides interpretation services for non-English speakers	❑	❑	❑	❑	❑	❑

23. In your opinion, how would you rate the health of *your community* in general now?	❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
24. Do you feel that the health of *your community* is better, about the same, or worse than 5 years ago?	❑ Better ❑ About the same ❑ Worse ❑ Did not live in Manchester area 5 years ago

KEY LEADER QUANTITATIVE SURVEY

Thank you for taking the time to meet with me today. I am conducting a community needs assessment to learn more about health concerns in Manchester and the surrounding area. This quick survey focuses on how you rate indicators identified by HP2010 as being important to community health. In our interview we will address these indicators in more depth.

Do not write your name on this survey. The information you give us is confidential and will only be used in combination with other participants' answers. You can skip any questions you do not feel comfortable answering.

1. Please rate how well you think your community does the following?	Excellent	Very Good	Good	Fair	Poor	Don't know
a. Promotes regular physical activity	❑	❑	❑	❑	❑	❑
b. Promotes healthy weight and good nutrition	❑	❑	❑	❑	❑	❑
c. Prevents childhood obesity	❑	❑	❑	❑	❑	❑
d. Prevents and reduces tobacco use	❑	❑	❑	❑	❑	❑
e. Prevents and reduces alcohol use	❑	❑	❑	❑	❑	❑
f. Prevents and reduces drug use	❑	❑	❑	❑	❑	❑
g. Promotes responsible sexual behavior	❑	❑	❑	❑	❑	❑
h. Promotes mental health and well-being	❑	❑	❑	❑	❑	❑
i. Promotes safety and reduce violence	❑	❑	❑	❑	❑	❑
j. Promotes healthy environments	❑	❑	❑	❑	❑	❑
k. Prevents infectious disease through immunization for all age groups	❑	❑	❑	❑	❑	❑
l. Makes available quality health care	❑	❑	❑	❑	❑	❑
m. Makes available quality dental care	❑	❑	❑	❑	❑	❑
n. Makes available services for the	❑	❑	❑	❑	❑	❑

	developmentally disabled						
o.	**Provides access to transportation for health care and resources throughout the community**	❑	❑	❑	❑	❑	❑
p.	**Provides interpretation services for non-English speakers**	❑	❑	❑	❑	❑	❑

2.	**In your opinion, how would you rate the health of *your community* in general now?**	❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
3.		
4.	**Do you feel that the health of *your community* is better, about the same, or worse than 5 years ago?**	❑ Better ❑ About the same ❑ Worse ❑ Did not work in Manchester area 5 years ago

APPENDIX THREE: HEALTHY MANCHESTER LEADERSHIP COUNCIL MEMBERSHIP

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APPENDIX FOUR: MANCHESTER AREA HEALTH CARE PROVIDER 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 the home of the Poisson Dental Facility, a Healthcare for the Homeless Project, the Parish Nurse Program, and the new Westside Neighborhood Health Center.

Catholic Medical Center is also home to the nationally recognized New England Heart Institute (NEHI), 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. Other community hospitals in the NEHI Network of hospitals include Monadnock, Huggins, Androsscogin Valley, Speare Memorial, and St. Joseph's.

SERVICE AREA

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

TOTAL DISCHARGES

Unduplicated patients 2006-2008 = 32,811

Child Health Services
1245 Elm Street
Manchester, NH 03101
(603) 668-6629
Special Medical Programs
(603) 606-5456
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 programs focused on meeting the special health care needs of children and youth. Supported by Special Medical Services, New Hampshire's Title V Program, 1,400 children and adolescents receive services through our Child Development and Neuromotor Clinics, and our 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 Pediatric primary care service area includes Auburn, Bedford, Candia, Goffstown, Hooksett, Manchester and New Boston.

TOTAL UNIQUE PATIENTS

Unduplicated 2008 = 1,769 patients (includes both Child Health Services and Teen Health Clinic)

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

Dartmouth-Hitchcock
Notre Dame Pavillion
at Catholic Medical Center
87 McGregor St.
Manchester, NH 03102

MISSION

We advance health through research, education, clinical practice and community partnerships, providing each person the best care, in the right place, at the right time, every time.

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 125 physicians and associate providers. Dartmouth-Hitchcock Manchester's primary and specialty care departments offer a full range of healthcare services for the entire family, including onsite laboratory and radiology services. Local and traveling 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, in Manchester, providing world-class care close to home.

As part of an integrated system of healthcare that includes the state's leading teaching and specialty hospital, New Hampshire's only children's hospital and a nationally designated cancer center, patients have access to a collaborative group of medical professionals that are researching new treatments, providing patient-centered care, and delivering excellence in all specialties. Dartmouth-Hitchcock Manchester 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 patients 2006-2008 = 103,437
Patient visits 2006-2008= 703,185

555 Auburn Street
Manchester, NH 03103
(603) 623-8863
(800) 870-8728
www.eastersealsnh.org

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, veteran's services, senior services, and transportation. At the core of the Easter Seals organization is a common passion for caring shared by its 1,374 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 2008, we provided more than $4 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

2008 individuals and families served: 28,883

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 September 2008, a new Cancer Center in Londonderry opened in collaboration with Dana Farber Cancer Institute.

Elliot Physician Network offers primary care services throughout 22 physician practices in the Greater Manchester area.

AWARDS

2009 Healthcare Business of the Year
Most Wired Hospital
Press Ganey Summit Award – given to Elliot 1-Day Surgery Center
Community Value Index
Breast Imaging Center of Excellence

SERVICE AREA

Elliot Hospital's primary service area includes Auburn, Bedford, Candia, Chester, Deerfield, Derry, Francestown, Goffstown, Hooksett, Londonderry, Manchester , New Boston, and Raymond.

SUMMARY STATISTICS

Total Inpatient Discharges 2008 = 12,587
Ambulatory Surgery = 4,186
Emergency Room = 52,503
Observation = 3,704

MANCHESTER community HEALTH CENTER

145 Hollis 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 direct service 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. MCHC also offers transportation assistance and discounted pharmacy assistance.

AWARDS

Citizens Bank – NH Community Champion Fall 2004
Pfizer Sharing the Care – Recognition for serving more than 2,600 patients
NH Immunization Program – Recognition for achieving 90% coverage for selected vaccine series
NH HealthyKids – Recognition for Medicaid enrollment rate

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 2006-2008 = 9,401 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 provider of outpatient mental health services in New Hampshire. The Center has grown over the last 49 years into one of the nation's most respected mental health centers, providing service to over 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 VII (Greater Manchester). As such, it provides a broad range of services to 3,300 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 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 are clearly in need of 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 a high quality, comprehensive, evidence-based system of mental services that enables our clients to restore the quality of there lives and serves to promote wellness.

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 2006-2008 = 21,392 patients

ENDNOTES

1. New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management. *Behavioral Risk Factor Surveillance System.* Concord: New Hampshire Department of Health and Human Services; 2005-2007.

2. Centers for Disease Control and Prevention. National Health Interview Survey. http://www.cdc.gov/nchs/nhis.htm.

3. United States Department of Health and Human Services. *Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010.* Washington, DC 2001.

4. New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management. *Behavioral Risk Factor Surveillance System.* Concord 2009.