# 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.



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