"The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to the State than its public health; the State's paramount concern should be the health of its people."

- Franklin Delano Roosevelt

Introduction to the Public Health Report Cards

In 1997, the Institute of Medicine (IOM) broadly defined health as "a state of well-being and the capability to function in the face of changing circumstances." On the local level, health is a product of many factors, and many segments of the community have the potential to contribute to and share responsibility for its protection and improvement. For both individuals and populations, health depends not only on health care, but also on other factors including individual behavior, genetic makeup, exposure to health threats and social and economic conditions (IOM, 1997). The successful implementation of local initiatives to enhance community health calls for key leaders to be informed as to what these determinants of health are and how, by employing models that work, to best improve priority areas of health need among the City's most vulnerable constituents. Therefore, the purpose of this introduction is to (1.) provide readers of the Public Health Report Cards a better understanding of the characteristics of the individuals who live in Manchester and the many influences on health specific to the community and (2.) to describe the role that existing systems and agencies have in creating measurable change.

1. MANCHESTER IS AN URBAN COMMUNITY IN A PREDOMINATELY RURAL AND AFFLUENT STATE.

The City of Manchester is the largest community in the State and in northern New England with a total population of 107,006 residents (2000 U.S. Census). It is an old mill town, once home to the world's largest textile manufacturing complex along the Merrimack River, is densely populated and, as a designated refugee resettlement site, is considered the most racially and ethnically diverse area in New Hampshire. The City was originally founded mostly on the backs of immigrants, and prides itself today as being a cultural destination undergoing urban renewal and economic development; thus, the unofficial motto, based on a recent Chamber of Commerce contest, "*Where History Invites Opportunity*". Although segments of Manchester have enjoyed the prosperity that has come to New Hampshire for several years, creating a state sixth in per capita income and first in proportion of residents statewide employed in technology industries, many neighborhoods in the City have not benefited from this affluence. As a result, Manchester has become an ever-changing metropolis in a predominantly rural State, with public health challenges and complex disparities similar to those found in larger cities.

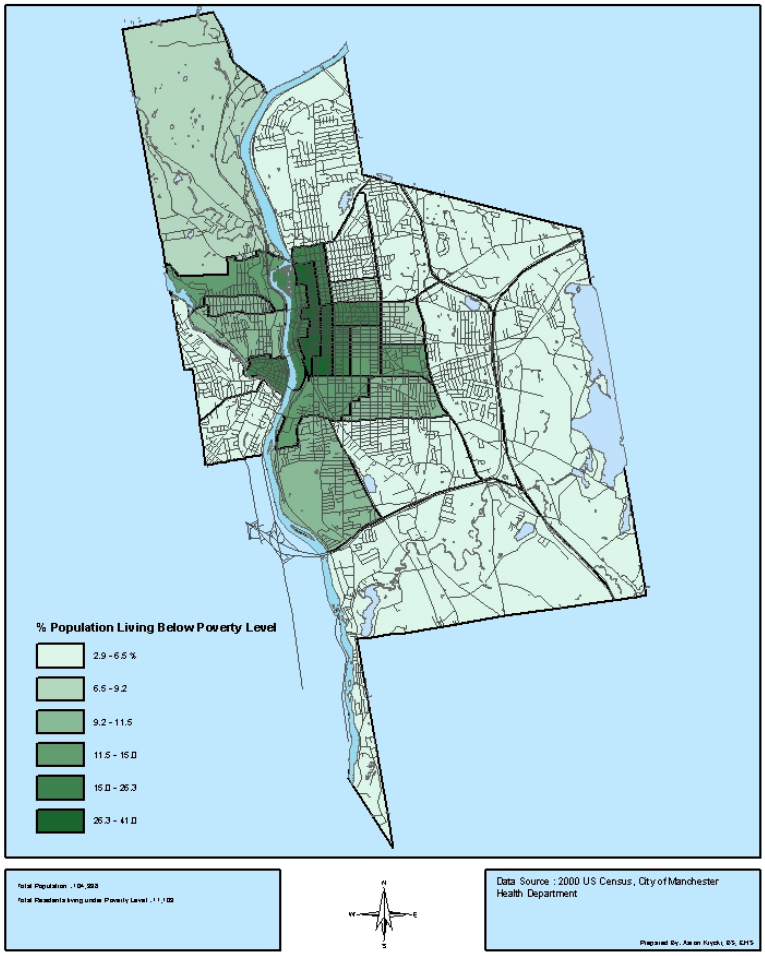
2. THERE ARE GREAT DIFFERENCES BY NEIGHBORHOOD AND SOCIOECONOMIC STATUS AMONG RESIDENTS.

The people of Manchester represent all walks of life, socioeconomic statuses, and religious and political affiliations. As with many urban communities across the country, Manchester also has its share of poverty and priority populations. From a public health planning perspective, the socioeconomic characteristics of a neighborhood may be the *greatest* determinant of disease status. Over 11,000 residents live below the poverty level in the City. A total of 27,715 residents, or nearly 26%, are considered "working poor" or living below 200% of poverty (2000 U.S. Census). This portion of the Manchester population may be considered a community all its own and is larger, if not as large, as 97% of all other cities and towns in the State. Geographically, these differences create a very densely populated and underserved center city area surrounded by a less populated and more affluent suburban circumference.

A Tale of Two Neighborhoods in Manchester

QUALITY OF LIFE INDICATOR	NEIGHBORHOOD A	NEIGHBORHOOD B
Total Population (Similar Age and Gender Distribution)	2456	3034
% H.S. Graduate or Higher	58.9%	94.6%
% Bachelor Degree or Higher	5.7%	48.7%
% Minority Residents	27.5%	2.4%
% Linguistically Isolated Households	11.8%	0.0%
% Households with No Vehicle	44.8%	4.5%
% Residents Who Own Their Own Home	9.2%	68.0%
% 65 and Older Living Alone	68.4%	33.3%
% of Families Headed by Single Mothers with Children	43.0%	3.0%
Per Capita Income	$12,482	$37,987
% Unemployed	21.2%	2.6%
% Residents Living Below Poverty Level	40.9%	4.6%
% Residents Below 200% Poverty Level	65.4%	7.4%

City Of Manchester, % Poverty Level - Population Distribution



In addition, Manchester's impoverished population is growing, particularly among the City's youngest residents. In 2000, nearly 13% of the City's 25,358 children aged 17 and younger were living below poverty level, an increase from 10% in 1990. This is a significant trend when compared to all other children in the State from the same age cohort, with 7% living below poverty in both 1990 and 2000 (2000 U.S. Census). For the 2003-2004 school year, almost 29% of Manchester's school children qualified for free and reduced lunch.

Nearly 54% of the City's housing units are occupied by renters. In 2004, the area's average Fair Market rent for a two-bedroom unit is $934 a month. However, the Housing Wage for Manchester's primary metropolitan statistical area was $17.96, which represents the amount a full time (40 hours per week) worker must earn per hour in order to rent a unit this size. Most notably, New Hampshire has the lowest minimum wage in the nation at $5.15 per hour. At times, these economic challenges, combined with other social and medical pressures, have pushed hundreds of Manchester residents into transitional living or homelessness. It is estimated that there are close to 1,700 individuals facing this plight at any given time throughout the City.

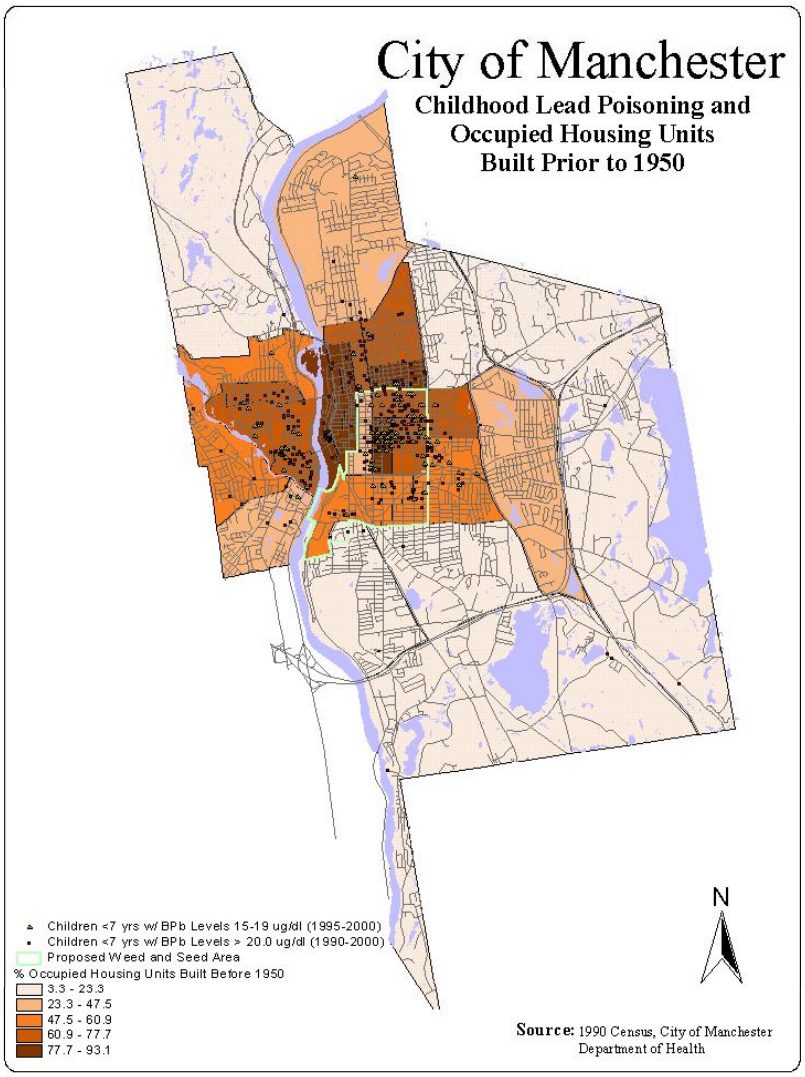
3. THE CITY IS EXPERIENCING EVER-CHANGING DEMOGRAPHICS.

Manchester experiences a change in its racial and ethnic composition on an almost daily basis as it welcomes new Americans through refugee and immigrant resettlement. This growth has brought new cultures and interpretations of health to an existing diverse city fabric, with reports of over 90 different languages being spoken as primary languages in Manchester schools. Close to 1,300 school children participate in Limited English Proficiency classes every day throughout the school system (NHDOE).

Changes also occur in family structure. In 2000, one in five family households were headed by a female with no husband present (2000 U.S. Census). In 2002, over 36% of Manchester's babies were born to unwed mothers (NHDHHS). Unmarried mothers generally have lower incomes, lower education levels, and greater dependence on welfare assistance than do married mothers (CDC, 1999). Children born to unmarried mothers are at a greater risk of growing up in a single-parent household, experiencing instability in living arrangements, living in poverty, and displaying socioemotional problems (Aquilino, 1996). Also of concern are those individuals who might be more vulnerable to social isolation due to age or disability. In 2000, close to 5,000 Manchester residents aged 65 and older were living alone (2000 U.S. Census).

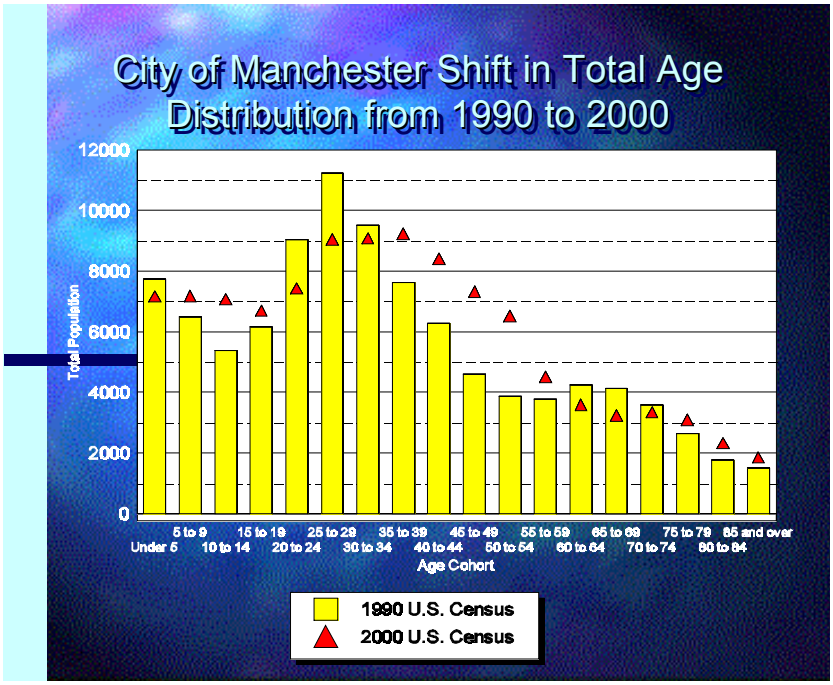
4. MANCHESTER'S PHYSICAL ENVIRONMENT CAN IMPACT THE PUBLIC'S HEALTH.

The physical environment is a common denominator for the health of all residents. Inadequate and dangerous physical environments in homes, schools, neighborhoods and workplaces, and risk factors such as air and water pollution, unsafe food, social isolation, high rates of unemployment, violence, and crime constitute some of the problems experienced by communities (IOM, 1997). In Manchester, 77% of the housing stock was built prior to 1980, with 44% of the housing units built prior to 1950; leaving an entire center city population at risk for lead poisoning exposure (2000 U.S. Census). In 2000, a two-year old child died from lead poisoning that was linked to a Manchester dwelling; the first documented case of its kind in this country in nearly a decade. The City was originally designed around a privy system and multi-dwelling three story "flats", creating modern-day center city neighborhoods with tight alleyways, one way streets, very few sidewalks and virtually no green space. Nearly 50% of the community's most violent crimes occur within the community's most densely populated areas. Research has shown that individuals who live in congested center city neighborhoods are more likely to experience asthma, heart disease and premature mortality. Like every other urban setting in this country, city leaders will be challenged in the coming years to develop healthy environments that are accessible to all.



5. RESIDENTS ARE GETTING OLDER AND LIVING LONGER.

The community is getting older, and with advancements in technology, drug therapies and chronic disease management, it is anticipated that the total number of Manchester residents age 65 years and older will nearly double by the year 2020, to represent over 20% of the City's population (up from 11.4% in 2000). The first "baby boomers" are now turning 55 years old, beginning a new era of need for long term care, senior housing, home visiting programs and retirement communities. As this population ages, the City and its partnering agencies will need to take on a more prominent role in caring and planning for these residents.



6. THE SHIFT FROM INFECTIOUS TO CHRONIC DISEASE.

With the community living longer, more residents are living with chronic diseases. In 1885, the leading causes of death in the City were Diarrhea, Enteritis, Tuberculosis, Pneumonia and other Infectious Diseases (1885 Manchester BOH Report). In 2000 and beyond, Manchester residents now face leading causes of death such as Heart Disease, Cancer, Chronic Lower Respiratory Disease, Cerebrovascular Disease and Diabetes (NHDHHS). Modifiable risk behaviors like the lack of exercise and poor diets, tobacco, alcohol and illicit drug use, and unsafe sexual behavior are estimated to account for more than half of all premature deaths (McGinnis and Foege, 1993). Although chronic diseases are among the most prevalent and costly health problems, they are also among the most preventable (CDC, 2005). Effective measures exist today to prevent or delay much of the chronic disease burden and curtail its devastating consequences (CDC, 2005). Promoting healthy behavior choices, through education and through community policies and practices, and ensuring good access to health care and screening services, are essential measures to reducing the burden of chronic diseases.

7. THE POPULATION, ESPECIALLY CHILDREN, IS MORE SEDENTARY THAN EVER BEFORE.

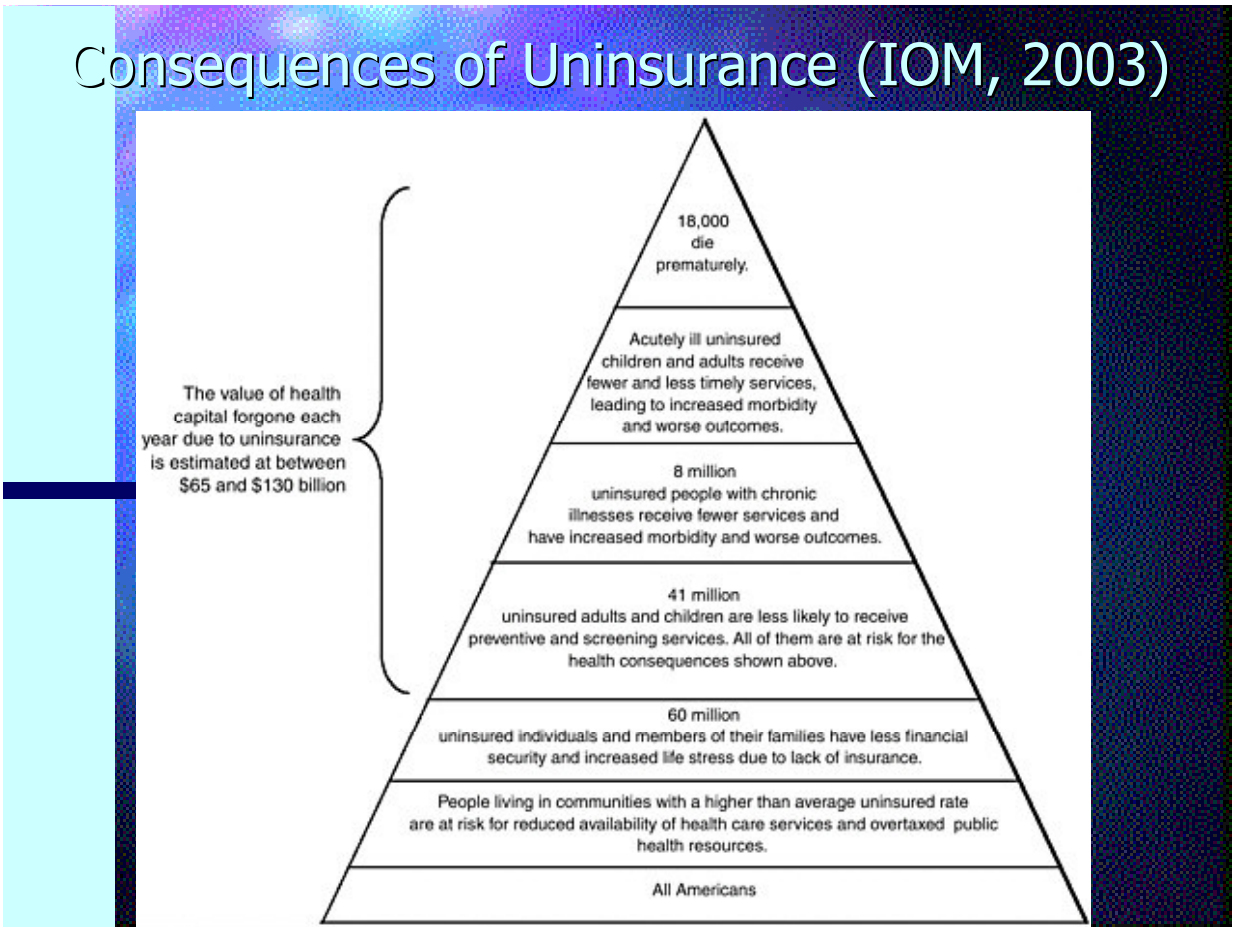
It is well known that regular physical activity that is performed on most days of the week reduces the risk of developing or dying from some of the leading causes of illness and death in the United States (CDC, 2005). Despite common knowledge that exercise is healthful, more than 57% of Manchester's adults are not regularly active, and nearly 17% of adult residents are not active at all (2001 NH BRFSS). Close to 16% of the City's high school students did not exercise on any day for 20 minutes during the past 7 days and 28% report watching TV an average of 3 hours or more on an average school day (2001 NH YRBSS). Of even greater concern is the increasing numbers of overweight first graders screened in Manchester schools. In 2002, almost 40% of these students were considered at risk for being overweight, with close to one in five surpassing the body mass index for obesity. Physical activity and unhealthy weight have been deemed the next leading cause of death in this country, second to tobacco use, and will have long term ramifications throughout generations without intervention.

8. THE CITY IS FACING NEW AND EMERGING HEALTH THREATS.

While some diseases have been effectively controlled with the help of modern technology, new diseases such as SARS and West Nile Virus infection are constantly appearing. Others, such as Malaria, Tuberculosis, and Bacterial Pneumonias, are now appearing in forms that are resistant to drug treatments (CDC, 2005). Naturally occurring events, such as an Influenza Pandemic due to genetic mutations, continue to pose a threat to communities. In addition, since the Fall of 2001, the threat of bioterrorism has challenged local regions across the country to develop public health preparedness and response plans. The City of Manchester Department of Health continually partners with key health care and emergency response leaders in the Greater Manchester area to proactively prepare the City for these new and emerging public health threats. This challenge is exasperated by the City's growing and ever changing vulnerable populations.

9. THE NUMBER OF UNINSURED RESIDENTS IS GROWING.

Nearly 15% of New Hampshire's uninsured residents live within the greater Manchester area. The Institute of Medicine has shown that health insurance coverage is associated with better health outcomes for children and adults. It is also associated with having a regular source of care and with the greater and more appropriate use of health services (IOM, 2003). In 2003, over 16% of Manchester's first graders had no health insurance and almost 14% did not belong to a medical home. For some community residents, barriers to accessing routine quality health care will be present, such as heath care providers who do not accept public insurance (i.e. Medicaid or sliding fee scales), the lack of open clinic hours, the need for interpretation services, the lack of transportation and child care services and the inability to pay for co-pays and prescription drugs. Many of these families will resort to using hospital emergency rooms for their primary care, placing additional costs on already overtaxed local health care services. To attain the vision of a healthy community, leaders from all facets including public health, health care, business and urban planning must strategically and collectively redefine the current health care delivery system in order to keep pace with the burgeoning and unmet needs.



10. MANCHESTER IS A COMMUNITY AT RISK AND A COMMUNITY WITH PROMISE.

As the population continues to grow, the urban issues, which define the City, will become more complex and magnified in severity. As of 2001, 80% of Manchester high school students report using tobacco, alcohol, marijuana or other drugs at some point in their lifetime (2001 NH YRBSS). One in four high school students report being in a physical fight at least once in the past year with 4% reporting having been injured as a result. In addition, over 10% of teenagers report being a victim of sexual assault. In 2003, there were 61 crimes of rape in the community, an increase of 39% over the preceding year (2005, MPD). Nearly 2,500 unduplicated calls for service for domestic violence occur locally every year. The City's ability to deploy violence prevention initiatives and make available quality mental health services will be paramount to making the community a safe place to live, work and play in the years to come.

WHO WILL KEEP THE COMMUNITY HEALTHY?

Around the country, State Public Health Systems (SPHS) are set up with varying degrees of infrastructures, yet many share the same common mission: to assure and protect the health and safety of its residents. All SPHS have a central state run office or division within the government to carryout its mission. Many SPHS break down the state in regions and have some type of governmental county or district health departments. Some states then have city health departments within those counties or districts.

In New Hampshire, there is a central governmental state office within the Department of Health and Human Services called the Division of Public Health Services (NH DPHS). The NH DPHS mission is to "assure the health and well being of communities and populations in NH by protecting and promoting the physical, mental and environmental health of its citizens and by preventing disease, injury and disability". Since the beginning of the century, NH State RSA 128, indicates that each town shall have a health officer appointed to enforce public health laws and regulations and investigate sanitary public health threats. Two cities, Nashua and Manchester, have built upon this statute and created governmental city health departments.

The City of Manchester Department of Health

The Manchester Health Department (MHD) has a congruent mission to the NH DPHS: to improve the health of individuals, families, and the community through disease prevention, health promotion and protection from environmental threats. The vision of the MHD is "to be a healthy community where the public can enjoy a high quality of health in a clean environment, enjoy protection from public health threats and can access high quality of health care". Since the Department's formation in 1885, MHD has diligently worked to adhere to its mission and has met the changing public health needs of its population with great vigor. The MHD is served by a 5 member Board of Health. The Board provides professional advice to the Department, acts as a hearing body for regulatory matters pertaining to permits and licenses, and represents the public interest in Department policy matters. The composition of the board includes a physician, a dentist, a nurse, and representatives of labor and the public at large.

The Manchester Health Department has a history of commitment towards the community health improvement process. Community health improvement efforts are based on a commitment of shared responsibility and an ethic of shared accountability. This ensures that health improvement efforts are strategic, coordinated, unduplicated,

and employ an effective use of community assets and resources. In Manchester, the community health improvement process is carried out through the Healthy Manchester Leadership Council (HMLC). HMLC is a partnership of key health and social services organizations with the MHD providing local health data analysis, guidance on evidence-based public health interventions and best practices and as needed, acting as a fiscal agent on HMLC grant initiatives. Over the last decade, HMLC has initiated many health improvement efforts, of which, two of the most notable achievements include the implementation of comprehensive school education in Manchester city schools and the passing of the referendum for community water fluoridation.

Public Health Practitioner Quality

To ensure the core government public health functions (Assessment, Policy Development and Assurance) are being met by the MHD, much effort has been made to recruit and retain a highly qualified staff. Many employees of the MHD have health and science-related bachelors degrees, masters in public health, nursing and medical degrees. Additionally, the New Hampshire Institute for Local Public Health Practice at Manchester was created in 2003 to provide additional training to MHD staff and other local public health practitioners in the state. Courses provided by the Institute develop skills, knowledge and abilities public health practitioners need to have the competencies required to respond to public health threats and emergencies, and to lead their respective communities in addressing public health issues. The Institute aims to build a competent workforce by providing core coursework grounded in the application of principles and foundations of public health practice.

First graduating class of the NH Institute for Local Public Health Practice

Manchester Health Department Divisions

The MHD is divided into four divisions: Division of Community Health, Division of Environmental Health, Division of Public Health Assessment and Planning and the Division of School and Youth Health. Across the divisions, many programs take place to improve and protect the health of the community. Community Health is led by the MHD Medical Director (physician) and is made up of nurses, community health educators, and dental hygienists. This Community Health Division provides communicable disease control, immunization clinics, sexually transmitted disease clinics, HIV counseling and testing, Hepatitis B screening and vaccination, community education, lead poisoning case management, Tuberculosis screening, head lice checks, refugee health case management for new arrivals and oral health services for children preschool through grade twelve. In addition, community health has two mobile vans providing neighborhoods and schools with much needed oral health and public health services.

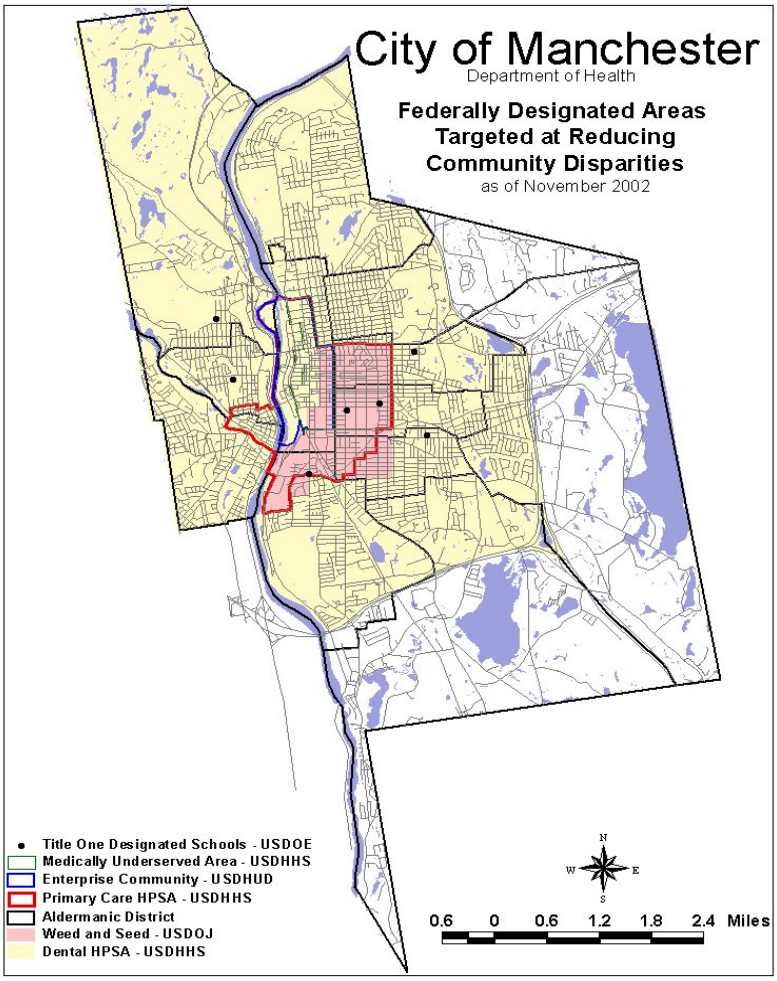
The Division of Environmental Health is supported by a team of Environmental Health Specialists who perform inspections and investigations and enforce environmental health laws and ordinances in the areas of food protection, hazard or nuisance concerns, sewage and septic systems, water quality, indoor and outdoor air quality and other environmental health matters. The Division of School and Youth Health is led by a pediatrician and is supported by school nurses in each of the 22 public schools in the city, serving children in preschool through grade twelve. School Health Services maintains health records on each student and provides health screening programs, health education inside and out of the classroom, health counseling, first aid and illness care. The Division of Public Health Assessment and Planning provides on-going health/environmental assessment of the community and uses the data to identify community health problems, establish effective solutions and evaluate the effectiveness of those interventions. Specific health issues are highlighted in annual public health report cards or reviewed through in-depth reports.

The Local Healthcare Delivery System

The greater Manchester healthcare delivery system is a combination of public and private health institutions providing population-based public health services, social services, primary, secondary and tertiary care. Manchester is the home to two full service hospitals open to the public and one Veterans Administration Medical Center. The Elliot Heath System has a 296-bed hospital, hosts a regional cancer center and has one of three Neonatal Intensive Care units in New Hampshire. The Elliot is the designated trauma center for the greater Manchester area with a Level II Trauma Center. The Catholic Medical Center (CMC) is a 330-bed facility and hosts the New England Heart Institute and the Poisson Dental Facility. The Manchester VA Medical Center is a 25-bed hospital that was a full service hospital at one time but currently has a stronger focus on long-term care and end-of-life care for veterans.

There are several other key healthcare centers that serve the community at large and vulnerable populations. Child Health Services (CHS) provides comprehensive medical care, social support services and nutritional consultation to children and youth in the greater Manchester area who are from low-income families. CHS also has a Child Development Clinic that focuses on behavioral and developmental problems in early childhood. The Teen Health Clinic (THC) provides primary health care, nutrition, and social support services and health education to medically underserved adolescents in the Manchester area. The Manchester Community Health Center (MCHC) is a federally-qualified community health center providing family-oriented primary care services in the greater Manchester area for those who lack access to quality health care, are under-insured or uninsured. The Mental Health Center of Greater Manchester is a non-profit charitable organization that provides an array of psychiatric and substance abuse services. Dartmouth Hitchcock (DH) Manchester has primary, secondary and tertiary healthcare services available and is backed by the resources of Dartmouth-Hitchcock Medical Center (DMHC) and the Children's Hospital at Dartmouth (ChaD) in Lebanon. The direct link to DMHC and ChaD allows for specialty services not otherwise available in the Manchester area. DH Manchester also serves as a resource to other health centers in the area such as MCHC and CHS. Each of these institutions is considered a health care charitable trust (Elliot Health System, CMC, DH Manchester, CHS, THC, MCHC, and the Mental Health Center of Greater Manchester). "Health care charitable trust" means a charitable trust organized to provide health care services including, but not limited to, hospitals, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services, or a charitable trust operating as a health insurer or health maintenance organization with fund balances greater than $100,000.

The capacity of the Manchester healthcare delivery system is limited by the number and type of facilities able to serve its population and by the numbers of providers willing to serve low-income populations. In 2000, Manchester's ratio of primary care providers to underserved populations was 1:5,840. Nine census tracts in the center city are federally designated as Health Professional Shortage Areas (HPSA) with an additional six also designated as Dental Health Professional Shortage Areas (DPSA). The entire City has been under consideration for designation as a Mental Health Professional Shortage Area (MPSA) but failed to meet the shortage ratio threshold. These shortage area



designations offer school loan forgiveness incentives to practitioners who are willing to work in these areas. Within the HPSA, two center city Census tracts are designated as a medically underserved area (MUA), which is a requirement for the establishment of a federally qualified community health center.

In addition, the center city was once federally designated as an U.S. Department of Housing and Urban Development Enterprise Community to stimulate community revitalization and economic growth. Eight out of the City's fourteen public elementary schools are recognized as Title One Schools by the U.S. Department of Education, along with one preschool, two middle schools and four nonpublic schools. Title One Schools receive this designation when 40% or more of the student population qualifies for free or reduced lunch. The center city core on the East Side of Manchester has been designated an U.S. Department of Justice Weed and Seed area to reduce and prevent the high rates of crime.

Social and Enabling Services

The Greater Manchester area is home to over 150 health and social service organizations, which provide enabling services. These services, often non-reimbursable by healthcare, are employed by comprehensive community health providers to systematically reduce access barriers to primary care. Information and referral networks, such as Southern NH Service's Info-Bank, Catholic Medical Center's Ask-A-Nurse, Elliot-On-Call and the Heritage United Way maintain a local inventory of these resources. Without this level of care giving and support, many residents throughout the community would not be able to regularly access care or would be left to navigate through existing systems with great difficulty.

PERFORMANCE MEASUREMENT AND LOCAL ACCOUNTABILITY

Changes in public policy, in public and private sector roles in health and health care, and in public expectations are presenting opportunities and challenges for communities in addressing both the overall health status of the population and more specific health issues (IOM, 1997). While many entities in the community share the responsibility for maintaining and improving the health of community members, responsibility shared can easily become responsibility ignored or abandoned. There is a need to account for performance and outcomes within organizations (ie. local health department or a local hospital through charitable trust reporting), but there must also be a way to monitor performance and outcomes for the community as a whole. Looking at the results of many separate efforts will not provide a comprehensive community picture, and those separate efforts cannot, by themselves, ensure that health improvement achieves its goals (IOM, 1997). The City of Manchester Department of Health works with key leaders using a community health improvement process to prioritize and address unmet needs, to maximize the utilization of resources and possibly additional resources from outside funding resulting from improved community knowledge of problems and objective data, and to benchmark the success of these efforts designed to measurably improve the health and quality of life for Manchester citizens. The Public Health Reports Cards serve as a tool to assess activities in many sectors, to promote collaboration and accountability in working toward better health for the City's constituents and to further the local health department's ability to accomplish its mission.

WHAT DOES A HEALTHY COMMUNITY LOOK LIKE?

Institute of Medicine, 2003

- A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and policies support health, and where essential public health services, including quality health care, are available.
- In a healthy community, communication and collaboration among various sectors of the community and the contributions of ethnically, socially, and economically diverse community members are valued.
- In addition, the broad array of determinants of health is considered and addressed, and individuals make informed, positive choices in the context of health-protective and supportive environments, policies and systems.

HOW TO USE THE PUBLIC HEALTH REPORT CARDS

The Public Health Report Cards were first published by the City of Manchester Department of Health in 1997 and were used by policy makers and planners to prioritize the City's public health needs. In 2005, the Department's Public Health Assessment and Planning team, its Supervisory Group and members of the Healthy Manchester Leadership Council present this updated version to stimulate a broad community response around the issues which afford the greatest opportunities for prevention and intervention initiatives. There are several components of the Public Health Report Cards which readers should take into consideration:

- **INTRODUCTION TO THE PUBLIC HEALTH REPORT CARDS**
  This document should provide a better appreciation for the characteristics of the individuals who live in Manchester and the many influences on health specific to the community. Not everyone experiences health or access to health care in the same way; therefore, thought should be given to solutions designed uniquely for the needs of Manchester residents for each issue highlighted on the Public Health Report Cards.

- **PUBLIC HEALTH REPORT CARDS**
  Every Public Health Report Card will display public health data through the use of charts and tables. Readers should take into consideration not only the number of residents who are directly affected by these conditions, but the potential number of residents who are at future risk of developing poor health outcomes. Every bar graphs represents a story, a name, a face of a neighbor or a loved one. The narrative is designed to describe the public health and economic implications that occur when these community issues are not adequately addressed. Recommendations for action are also provided on the community and the individual level. These evidence-based public health and medical care practices are drawn from the most credible, widely demonstrated and evaluated scientific studies conducted on improving community health. Finally, contact information is made available for organized efforts or organizations, which are working diligently to address these unresolved areas.

- **EVALUATION FORM**
  It is the goal of the authors of the Public Health Report Cards to provide the most useful information available for local health improvement efforts. Please help us to best fulfill your needs by filling out this brief survey and returning it to the Manchester Department of Health.

For more information on the Public Health Report Cards or the references used throughout this Introduction, please contact the Public Health Assessment and Planning team at the City of Manchester Department of Health by calling (603) 624-6466. We look forward to hearing from you.