

2014

MANCHESTER NEIGHBORHOOD
HEALTH IMPROVEMENT STRATEGY



“**I**t is my hope that the changes we make together to improve the lives of our families and neighbors sets the stage for innovation and risk taking that results in the creation of a just and fair society. When we can say that ‘all’ of our children are learning, growing and succeeding, we will have fulfilled our promise to the residents of the City of Manchester: a promise to create communities of opportunity that allow all to participate, prosper, and ultimately reach their full potential.”

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I. Executive Summary

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DESIGNING A NEIGHBORHOOD HEALTH IMPROVEMENT STRATEGY FOR THE CITY OF MANCHESTER

BACKGROUND

In urban areas, serious health problems and unstable social conditions are often highly concentrated in a fairly small number of distressed neighborhoods. Nationally, effective place-based policies and interventions have been shown to mitigate toxic stress and improve these inequalities in health by concentrating strategically targeted efforts in areas where residents live, work, play, learn, heal, and preserve heritage. Properly designed neighborhood health improvement strategies intentionally integrate funding, intervention and accountability across systems to more effectively contribute to the collective impact on prosperity, equity, sustainability and livability of places. Manchester is in need of this type of overarching improvement strategy especially for its most impoverished neighborhoods.

Over 32,000 of Manchester's residents live at some level of poverty, which is as large as the entire population of one county in New Hampshire. Over half of these residents live within center city neighborhoods or what is also known as the City's Neighborhood Revitalization Strategy Area (NRSA), a designated area based on socioeconomic indicators.

The City's fastest growing population of "poor" (by age group) is children under the age of 18 years. Over half of Manchester's school children are enrolled in free or reduced meals. Approximately one in four children is living at or below the 100% of poverty threshold. Based on American Community Survey estimates, nearly 2,500 children under the age of 18 are considered "very poor" or living below 50% of the poverty threshold.

The City is currently positioned for the opportunity to create and implement such a strategy and embarks on this work in an effort to maximize the impact of funder dollars, increase resource sharing and partnership among multidisciplinary partners, and most importantly, improve the health of the community's most vulnerable residents. This is not only critical to the future of Manchester's families, but to the future overall health of the State of New Hampshire as well.

ACCOMPLISHMENTS TO DATE

The City of Manchester Health Department (MHD) is leading efforts to introduce neighborhood-based health improvement to underserved areas of the community. Accomplishments to date:

- The establishment of a **Leadership Team** including Manchester's Mayor, Police Chief, Superintendent, Public Health Director, residents, funders, and other community leaders to guide and facilitate the development of the Neighborhood Health Improvement Strategy (NHIS).
- The creation of a **Neighborhood Health Framework**, based on six domains shown in the research to produce health, to serve as the foundation of the NHIS: Educational Achievement, Economic Well-being, Supportive Living Environments, Access to Appropriate Care, Healthy Behaviors, and Social Connectedness and Safety.

I. Executive Summary

- Six **Community Forums** based on the Framework were held to gather input on local needs leading to the development of the NHIS for neighborhood-based investment in children and families. The NHIS provides a shared vision for the production of health within neighborhood populations and serves as an overarching guidance document for establishing the collective impact of community based health improvement efforts.
- Technical assistance from marketing and advertising firms to develop a **Communication Campaign** for Manchester’s children including NHIS brand strategy and a neighborhood-profile website.
- Investment in **Promise Scorecard**, a data collection tool now required of “Promise Neighborhood” sites nationally, needed to provide the performance-measurement infrastructure for integrating previously disconnected services into a centralized, robust and accountable neighborhood improvement system.
- **City-wide Summit** held featuring national experts to launch the plan and begin to formulate next steps in implementation of the NHIS.
- Ongoing implementation of the **Manchester Community Schools** project: Creating Healthier and Safer Neighborhoods in Manchester through the City’s Change to Multi-Use, Integrated and Resident-Engaging Community Schools at Beech Street, Bakersville and Gossler Park Elementary Schools.

PRIORITY RECOMMENDATIONS — MANCHESTER NEIGHBORHOOD HEALTH IMPROVEMENT STRATEGY

There are many worthwhile recommendations that were generated from the NHIS process. However, it would be highly challenging and resource intensive to attempt to implement ALL of these recommendations simultaneously. To establish a solid foundation in which to grow, the NHIS Leadership Team has identified the following as priority recommendations for action in launching the NHIS.

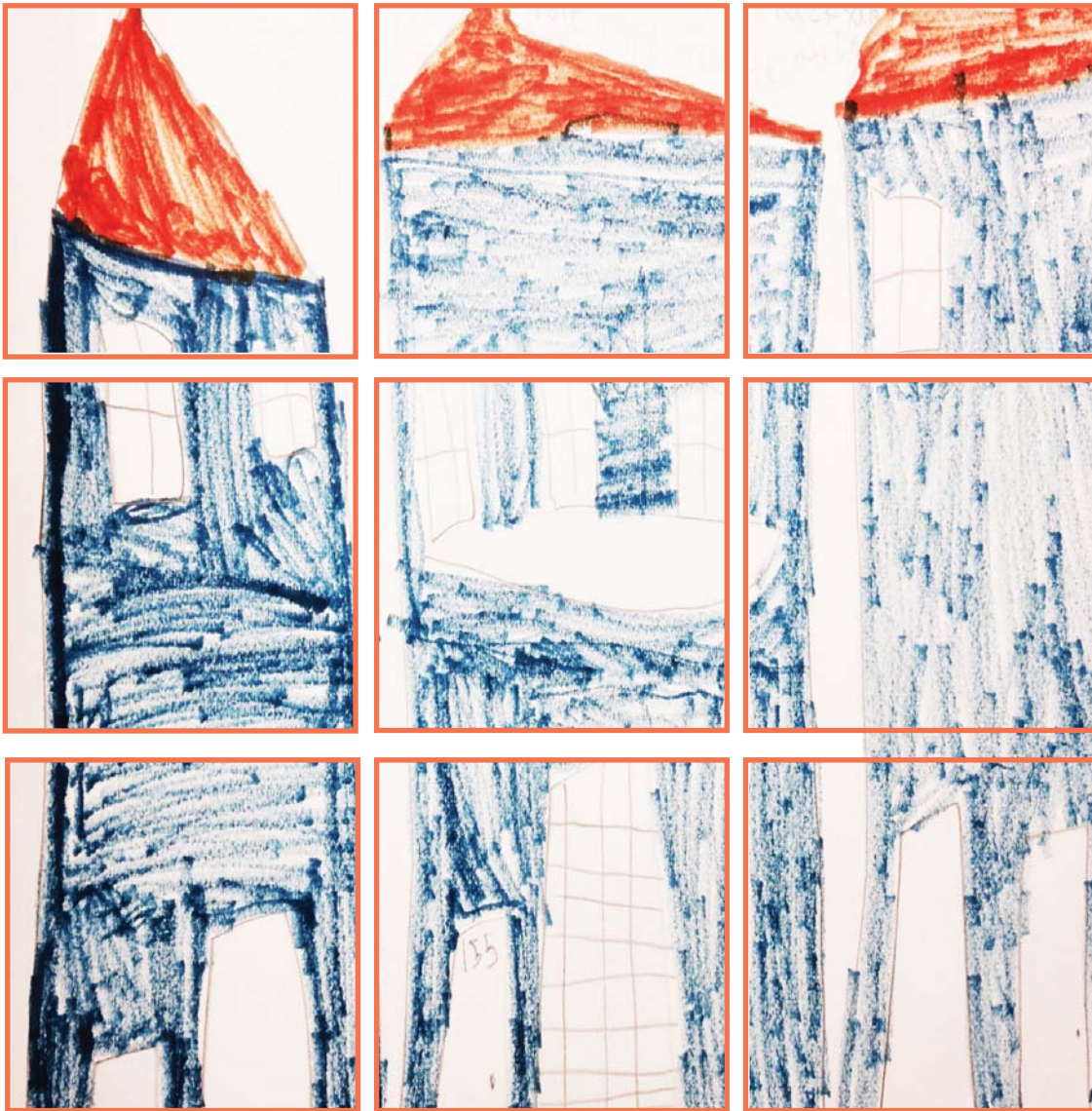
- Create resident leadership training opportunities for youth and families to be engaged and empowered to lead/participate in efforts to improve neighborhood safety and quality of life.
- Establish a coalition of key stakeholders to conduct an asset mapping and gap analysis of local resources essential for supporting economic self-sufficiency on the individual level as well as community economic development.
- Create a coordinated and sustainable “Healthy Homes” system comprised of multi-disciplinary partnerships and approaches that effectively and efficiently address living conditions which impact resident health, safety and well-being.
- Ensure that all children and families have the early developmental support that they need for a healthy start, including intensive programs that promote healthy child development, school readiness, and parental skill development.
- Strategically align and connect the health care delivery system with community and public health services to improve individual outcomes and overall neighborhood health through care coordination/case management in the elementary school environment.
- Strengthen the focus on behavioral and mental health care by co-locating providers in the elementary school environment.
- Provide intensive community services and programming for at-risk, elementary-aged youth and their families to prevent truancy and promote attendance.

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The priority recommendations were selected based on their ability to synergistically combine for greater impact. Overall, the NHIS Leadership Team believes that the Manchester community should first invest in building systems and mechanisms for empowerment aimed at improving family stability for younger children. Therefore, the beginning work of the NHIS has also been further prioritized for early childhood and elementary school aged children and their families.

NEXT STEPS - In collaboration with the NHIS Leadership Team, the MHD proposes to:

- Inventory existing funding sources that could be leveraged to support the priority recommendations.
- Research and inventory potential opportunities for Federal, State, and Local level funding sources to support the implementation of the priority recommendations.
- Create a written business plan that promotes collective action through a deeper-level of investment, such as the practices of collective impact and catalytic philanthropy, to support this large-scale, multi-sector initiative. The business plan should:
 - Incorporate ongoing support for existing initiatives that serve as a critical foundation for the priority recommendations, such as the Manchester Community Schools Project and Promise Scorecard.
 - Consider a phasing of funding to support the staggered implementation of the priority recommendations over several years; including ways to diversify funds to support blended resourcing for the long-term sustainability of systems changes, as well as for promoting shared accountability.
 - Identify innovative multi-sector partnerships and should look to leverage public-private opportunities for collaboration and resource development.



II. Background

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BACKGROUND/STATEMENT OF NEED

In urban areas, serious health problems and unstable social conditions are often highly concentrated in a fairly small number of distressed neighborhoods. Nationally, effective place-based policies and interventions have been shown to mitigate toxic stress and improve these inequalities in health by concentrating strategically targeted improvement efforts in areas where residents live, work, play, learn, heal, and preserve heritage. Properly designed neighborhood health improvement strategies intentionally integrate funding, intervention and accountability across systems to more effectively contribute to the collective impact on prosperity, equity, sustainability and livability of places. Manchester is in need of this type of overarching improvement strategy especially for its most impoverished neighborhoods. The City is currently positioned for the opportunity to create and implement such a strategy and would embark on this work in an effort to maximize the impact of funder dollars, increase resource sharing and partnership among multidisciplinary partners and most importantly, improve the health of Manchester's most vulnerable residents. This is not only critical to the future of Manchester's families, but to the future health of the state of New Hampshire as well.

THE PROMISE AND OPPORTUNITY

Manchester is the largest community in New Hampshire and in northern New England. With an estimated total population of 109,565, Manchester represents over 8% of the state's estimated population of 1,316,470 residents. Manchester reigns as the state's "Queen City" (the largest city but not the state capital) and is rich in diversity and history, as evidenced by the unique architecture, museums, culture, and demographics of the region.

Known as New Hampshire's "Business Capital", the fortitude of Manchester is woven in the fabric of its heritage and innovation. One of its greatest strengths is its continued ability to mobilize, collaborate and leverage resources to respond to priority needs. The City's approach to problem-solving and decision making to improve the quality of life for all residents, especially the most vulnerable, has implications for generations to come. These community lessons may also guide other developing cities and towns across the country that have yet to face complex and multifaceted challenges related to health equity, either of the same volume or intensity.

GENERATIONS AT RISK

While Manchester is located in a predominately rural and affluent state, it is an economically diverse urban city with public health and academic achievement challenges similar to those found in larger cities across the United States. Illustrative examples of the challenges faced by Manchester families are listed below:

- Over 32,000 of its residents live at some level of poverty. Over half of these residents live within center city neighborhoods or what is also known as the City's Neighborhood Revitalization Strategy Area (NRSA), a designated area based on socioeconomic indicators that is prioritized for Community Development Block Grant Funding.

II. Background

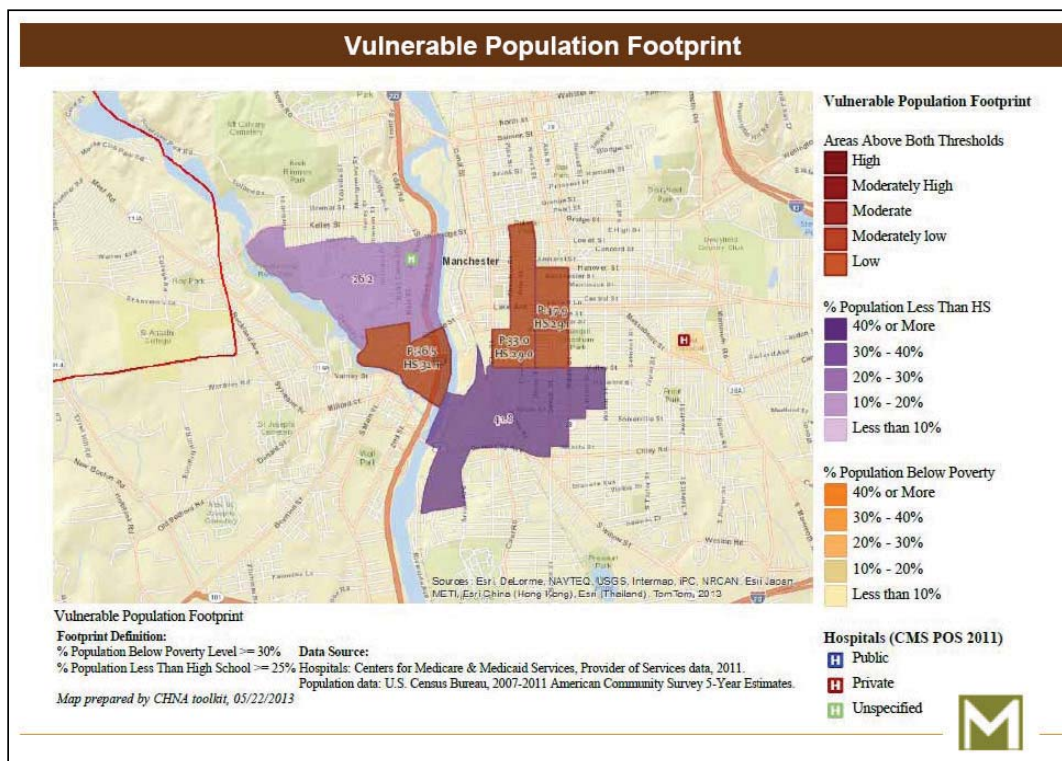
- The City's fastest growing population of "poor" (by age group) is children under the age of 18 years. Approximately one in four children in Manchester is living at or below the 100% of poverty threshold. Based on American Community Survey estimates, nearly 2500 children under the age of 18 are considered "very poor" or living below 50% of the poverty threshold. This translates to just over \$11,000 total annual household income for a family of four.¹
- More than half of the students in Manchester's public schools are enrolled in free/reduced meals (free/reduced meals are associated with childhood poverty and lack of access to health care). Nearly 90% of these students qualify for just the "free meals" portion of this benefit or are living below 130% of the poverty threshold (2013 data).²
- The Children's Alliance of New Hampshire and the Carsey Institute at the University of New Hampshire report that Manchester has neighborhoods that are at serious risk of food insecurity due to poverty alone.³
- Based on 2007 -2009 data (the most recent data available), over 40% of the babies born to Manchester mothers were out of wedlock. Two out of three low income children are living with one parent. In addition, nearly half of all births welcomed into the City were to mothers who have completed only a high school education or less.⁴
- Close to 150 teenage girls who reside in Manchester give birth annually producing a teen birth rate of 40.4 per 1000 births (among 15–19 year old females), which is more than double that of New Hampshire's rate and surpasses the national rate (2009 data).⁴
- The Manchester School District reports that Manchester had 2,852 "habitually truant" students in the 2012–2013 school year.²
- As of March 11, 2013, the Manchester School District identified 755 school children who have been homeless at least once during the academic year.²
- In the center city, nearly three out of every four housing units were built before 1950, compared to 26% throughout New Hampshire. An older housing stock increases the likelihood for substandard housing and exposure to environmental hazards, such as lead.¹
- Based on the 2011 Youth Risk Behavior Survey of Manchester High Schools, an estimated 300–400 students report attempting suicide at least once in the past year.⁵
- The Child Advocacy Center of Hillsborough County provided care to an average of 150 child victims of domestic and sexual abuse in Manchester per year (2010-2012). Research has shown that incidents of child sexual abuse are significantly underreported, estimating that nearly 90% of all cases go unreported.
- From 2010–2011, the United States Bureau of Justice Statistics reports that Manchester has the highest violent crime rate in New Hampshire at 496.4 incidents per 100,000 population.⁶
- From 2005–2007, the age cohort experiencing the highest rate of assault injuries resulting in a visit to the Emergency Room was Manchester's 15-24 year olds. In addition, Manchester's rate of assault injuries among these youth were more than double the rate throughout New Hampshire (1609 per 100,000 vs. 750 per 100,000, respectively).⁷

II. Background

Victim to these unstable living conditions and compromised neighborhood environments are the City's children and arguably, Manchester's future vitality. Many of the community's youngest residents are struggling to function and thrive, often in crisis situations. Children are especially vulnerable, as they are unable to defend or choose for themselves. If we believe that Manchester's future depends on our children, then the barometer for the health of our city should be the health status of our own children.

PRIORITY NEIGHBORHOODS

Eight neighborhoods in Manchester are considered to be "Federal Poverty Areas" as defined by having 20% or more of the resident population living below poverty. Based on 2007-2011 American Community Survey estimates, there are three neighborhoods or Census Tracts in which 40% or more of the population is living below 100% of poverty and more than 40% of residents have completed less than a high school education (see Vulnerable Population Footprint map below). In addition, five East Side center city census tracts have been designated by US Department of Health and Human Service's Health Resources and Services Administration Division as "Medically Underserved Areas," and four West Side center city census tracts have been designated as "Exceptional Medically Underserved Populations". These designated neighborhoods have been shown to have significantly higher rates of overall neighborhood deprivation and poor health outcomes such as higher rates of coronary heart disease mortality, violent crime, expectant mothers with late or no prenatal care, adolescent pregnancies, lead poisonings, childhood obesity, pedestrian accidents and fatalities, uncontrolled asthma, and substandard housing as compared with other neighborhoods throughout the City.





III. The Critical Connection

III. The Critical Connection:

NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

The Institute of Medicine defines health as “a state of wellbeing and the capability to function in the face of changing circumstances.”⁸ 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. For decades, research has primarily focused on defining the negative influence that individual-level poverty has on health status. More recently, researchers have begun to uncover a negative influence on health status among individuals, of any socioeconomic position, from merely residing in high deprivation neighborhoods alone.⁹

The impacts of living in high deprivation or poverty environments on health are far reaching and manifest themselves in the form of factors within the built/physical environment and social environment. Moreover, the health status of a person of low socioeconomic position is further compounded and magnified by his/her exposure to high deprivation neighborhood environments. This is especially true for children because of their vulnerabilities biologically, socially, and emotionally. Early exposure to high deprivation environments contributes to the development of adverse health outcomes across the course of a person’s life. “The Life Course Approach to Health” evolved from research documenting the important role early life events play in shaping an individual’s health trajectory.¹⁰ The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one’s lifetime. For example:

- Mothers living in poor neighborhoods have an excess risk of infant mortality compared to those living in the most affluent neighborhoods.¹¹
- Neighborhood factors like income, safety and social cohesion have been linked to cognitive and behavioral development in early childhood; in some cases in children as young as age two.¹²
- Children living in economically disadvantaged neighborhoods are six times more likely to be hospitalized for asthma than children in neighborhoods at the high end of the economic spectrum.¹³
- Rates of violent crime and teen births are far higher in poorest neighborhoods than in lower-poverty neighborhoods.¹⁴

“ You can predict the life expectancy
of a child by the ZIP code in which they
grow up...this is wrong ”

Housing and Urban Development Secretary
Shaun Donovan

III. The Critical Connection:

NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

- Results from the Panel Study of Income Dynamics¹⁵ show that sustained exposure to disadvantaged neighborhoods has a severe impact on high school graduation that is considerably larger than effects reported in prior research. The findings estimate that growing up in the most (compared to the least) disadvantaged quintile of neighborhoods reduces the probability of graduation from 95 to 87 percent for non-black children and from 96 to 76 percent for black children.
- According to research conducted by the University of Michigan, living in an economically disadvantaged community can increase the risk of heart disease by as much as 80%.¹⁶

Improving the health of neighborhoods and the children who are being raised within them calls upon both medical and ethical imperatives. The Manchester Neighborhood Health Improvement Strategy takes the first step to answer this call to action through the following overarching goals:

GOAL #1 PREVENT TOXIC STRESS & ADVERSE CHILDHOOD EXPERIENCES

Excerpted from

http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

The future of any society depends on its ability to foster the healthy development of the next generation. Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body (especially the brain), with damaging effects on learning, behavior, and health across the lifespan.

Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies prepare us to respond by increasing our heart rate, blood pressure, and stress hormones, such as cortisol. When a young child's stress response systems are activated within an environment of supportive relationships with adults, these physiological effects are buffered and brought back down to baseline. The result is the development of healthy stress response systems. However, if the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened systems and brain architecture, with lifelong repercussions.

It's important to distinguish among three kinds of responses to stress: positive, tolerable, and toxic. As described below, these three terms refer to the stress response systems' effects on the body, not to the stressful event or experience itself:

Positive stress response is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunization.

III. The Critical Connection: NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

THE TRUTH ABOUT ACEs

WHAT ARE THEY?

**ACEs are
ADVERSE
CHILDHOOD
EXPERIENCES**

HOW PREVALENT ARE ACEs?

The ACE study revealed the following estimates:*

Category	Sub-category	Percentage
ABUSE	Physical Abuse	28.3%
	Sexual Abuse	20.7%
	Emotional Abuse	10.6%
NEGLECT	Emotional Neglect	14.8%
	Physical Neglect	9.9%
HOUSEHOLD DYSFUNCTION	Household Substance Abuse	26.9%
	Parental Divorce	23.3%
	Household Mental Illness	19.4%
	Mother Treated Violently	12.7%
	Incarcerated Household Member	4.7%

percentage of study participants that experienced a specific ACE

Of 17,000 ACE study participants:

- 26% 1 ACE
- 16% 2 ACEs
- 9.5% 3 ACEs
- 12.4% 4+ ACEs
- 36% have experienced 0 ACEs
- 64% have at least 1 ACE

WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes

Possible Risk Outcomes:

BEHAVIOR				
Lack of physical activity	Smoking	Alcoholism	Drug use	Missed work
PHYSICAL & MENTAL HEALTH				
Severe obesity	Diabetes	Depression	Suicide attempts	STDs
Heart disease	Cancer	Stroke	COPD	Broken bones

rwjf.org/vulnerablepopulations

Robert Wood Johnson Foundation

*Source: <http://www.cdc.gov/aces/prevalence.htm>

III. The Critical Connection:

NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

GOAL #1 CONTINUED

Tolerable stress response activates the body's alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.

Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.

When toxic stress response occurs continually, or is triggered by multiple sources, it can have a cumulative toll on an individual's physical and mental health—for a lifetime. The more adverse experiences in childhood, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, and depression (see infographic below). Research also indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response.

III. The Critical Connection:

NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

GOAL #2 ATTAIN HEALTH EQUITY

Excerpted from

<http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm>

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health disparities or inequities, are types of unfair health differences closely linked with social, economic or environmental disadvantages that adversely affect groups of people. (Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention).

The social determinants of health are the aspects of the environment in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These aspects are shaped by a wider set of forces (e.g., economics, social policies, and politics). (Social Determinants of Health Key Concepts, World Health Organization).

Achieving health equity, eliminating disparities, and improving the health of all groups is an overarching goal for *Healthy People 2020* and a top priority for the Centers for Disease Control and Prevention (CDC). CDC’s Healthy Communities Program supports eliminating socioeconomic and racial/ethnic health disparities as an integral part of its chronic disease prevention and health promotion efforts. To improve health on the local, state, and national level, communities are encouraged to identify and address social determinants of health and improve these conditions through environmental changes.

III. The Critical Connection:

NEIGHBORHOODS MATTER IN THE DEVELOPMENT OF CHILDREN

GOAL #3 ACHIEVE ENVIRONMENTAL JUSTICE

Excerpted from <http://www.cdc.gov/healthyhomes/ej/definition.htm>

The environment is everything around you. It includes your home and the place where you work. The lake where you might swim or fish, the places where your food is grown or prepared, and even the places your drinking water travels through on its way to your home. The opportunity to live a healthy life often depends on living in a healthy environment. Everyone's environment should be free of unhealthy materials or hazards that can cause illness or even death.

The U.S. Environmental Protection Agency (EPA) defines environmental justice as “the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.”

Environmental justice has two major parts:

Fair treatment: no group of people should have to deal with an unequal share of the harmful environmental effects that happen because of policies or operations run by businesses or government.

Policies of, or operations run by, businesses or government can at times affect the environment and can make people sick. This often means that because of where one group of people lives or works, that group suffers an unequal portion of harmful environmental effects than other groups who live in other locations. Fair treatment means that everyone has equal protection from harmful environmental effects, and a fair chance to find a house, a job, and a school in a safe and healthy environment.

Meaningful involvement means that affected groups of people actually take part in the decision-making process. When government starts to address the problems that make an environment unhealthy, affected citizens need to participate in the process, and that citizen involvement has to be meaningful. This is an important step in addressing the health and housing inequalities among affected community members.

While environmental justice sometimes is viewed as addressing the disproportionate burden of environmental and/or public health impacts on minority or low-income communities, as described in the EPA definition, it also can include the disproportionate or inequitable sharing of benefits that improve the environment, health, and quality of life of communities.

Equitable distribution of benefits: Environmental justice is based on the principle that all people have a right to be protected from environmental pollution and to live in and enjoy a clean and healthful environment. This implies that Environmental Justice not only serves as a protection from harm, but should also promote the equitable distribution of environmental benefits,



IV. Describing Manchester's Neighborhood Health

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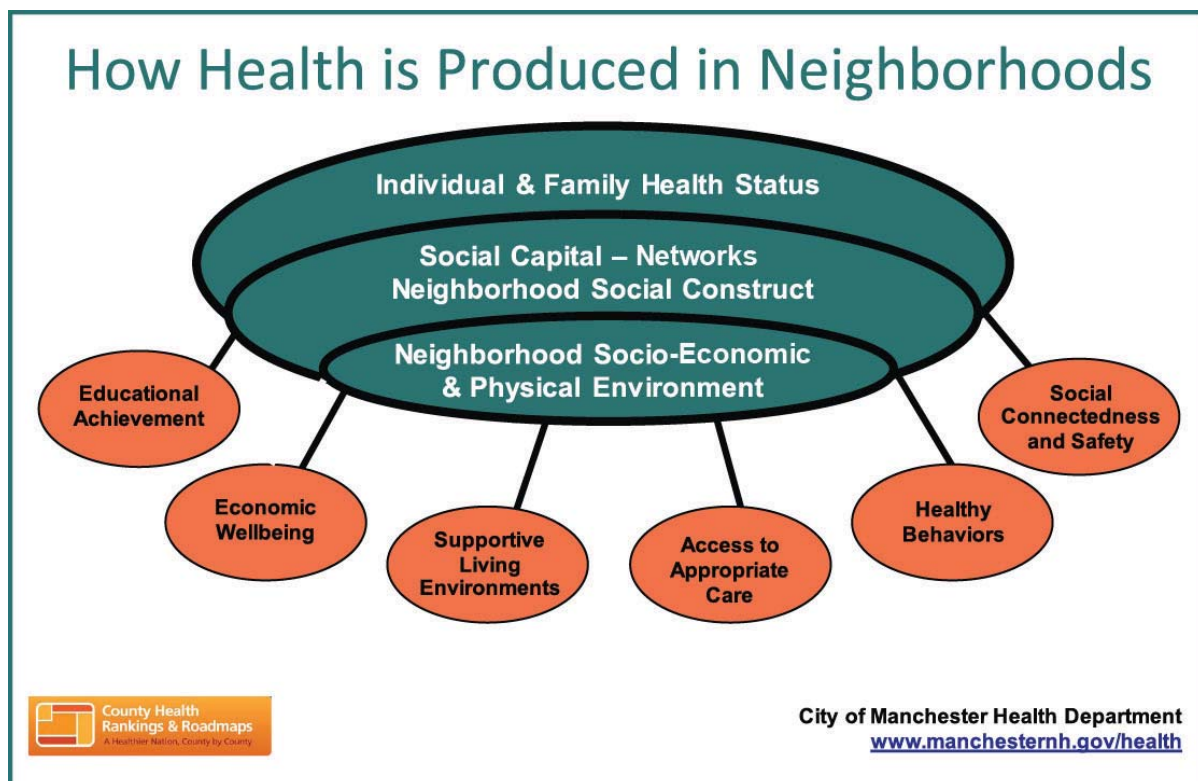
FRAMEWORK FOR NEIGHBORHOOD HEALTH

FRAMEWORK FOR NEIGHBORHOOD HEALTH

Manchester's Neighborhood Health Improvement Strategy (NHIS) applies a Framework for Neighborhood Health defined by six domains shown in the research to produce health sub-geographically throughout communities: educational achievement, economic wellbeing, supportive living environments, access to appropriate care, healthy behaviors and social connectedness and safety. The dynamic interaction of these domains influence the overall neighborhood socio-economic and physical environment as well as the social capital and social networks of a neighborhood, which in turn, impact individual and family health status.¹⁷

NHIS will use this Framework for Neighborhood Health as the basis for identifying priority recommendations for action and for organizing the community at large around improvement initiatives. The following pages include a description of the domain and its connection to health, as well as local data comparing Manchester's indicators to those of state and national trends. When available, key indicators are displayed through maps of the City at the census tract level.

NHIS Framework for Neighborhood Health



IV. Describing Manchester's Neighborhood Health

EDUCATIONAL ACHIEVEMENT

The Connection Between Education and Health

The relationship between educational achievement and improved health outcomes is well known. Better-educated individuals live longer, healthier lives than those with less education, and their children are more likely to thrive.

The County Health Rankings and Roadmaps report several ways that education affects health outcomes:¹⁸

- On average, education often results in higher incomes and more resources than a job that does not require education. Access to health care is a particularly important resource that often is linked to jobs requiring a higher level of educational achievement. However, when income and health care insurance are controlled for, the magnitude of education's affect on health outcomes remains substantive and statistically significant.
- Health literacy can help explain an individual's health behaviors and lifestyle choices. There is a striking difference between health literacy levels based on education. Only 3% of college graduates have below basic health literacy skills, while 15% of high school graduates and 49% of adults who have not completed high school have below basic health literacy skills. Adults with less than average health literacy are more likely to report their health status as poor.
- Not only does one's education level affect his or her health; education can have multi-generational implications that make it an important measure for the health of future generations. Evidence links maternal education with the health of her offspring. The education of parents affects their children's health directly through resources available to the children, and also indirectly through the quality of schools that the children attend.
- Education influences a variety of social and psychological factors. For example, more education improves an individual's self-perception of both his and her sense of personal control and social standing, which also predicts a better self-reported health status.

How Does Manchester Compare?

Many of the community's youngest residents are struggling to function and thrive in often in crisis situations.

- In March of 2013, nearly 8000 or 53% of Manchester school children were enrolled in free and reduced meals. Of this total, 90% were enrolled in free meals which means that the total family income for these children were below 130% of the federal poverty guidelines.²
- Between 2007-2011, over 40% of Manchester's children under the age of 18 were living in single-parent households.¹
- As of March 11, 2013, 755 Manchester students who were homeless, representing more than 5% of the total student population.²
- The MSD reports that during the 2012-2013 school year, there were 2,852 "habitually truant" students. In addition, the MSD estimates that over 7,000 children of all ages are in need of some level of school attendance intervention.²
- In 2011, Manchester schools experienced over a 13% four-year cumulative dropout rate compared to less than 5% in the State of New Hampshire.²

Strengthening the community's social connectedness and neighborhood investment could serve as protective factors for the health and wellbeing of young people.

2011 COMMUNITY CONNECTEDNESS AMONG HIGH SCHOOL STUDENTS		
SOURCE: NH YRBSS	MANCHESTER	NH
Students who during an average week spend 1+ hours in clubs or organizations (non-sports) outside of school.	42.9%	42.8%
Students who agree or strongly agree that they feel like they matter to people in their community.	44.6%	47.7%
Students who performed any kind of community service as a volunteer in the last 30 days.	34.6%	41.1%

MANCHESTER SCHOOL DISTRICT - STUDENT FREE/REDUCED MEAL ENROLLMENT, HOMELESS COUNT AND TRUANCY DISTRIBUTION, 2013

MSD Public Schools	As of March 1, 2013					As of March 11, 2013		2012-2013 School Year		
	Free (F) Meal Enrollment	Reduced (R) Meal Enrollment	TOTAL Free and Reduced Enrollment	Total School Enrollment	F/R%**	Homeless Count ^a	Percent Homeless	Truancy Count ²	Total School Enrollment	Percent Habitually Truant
Title I Elementary Schools ¹	2758	212	2970	3858	77%	254	7%	791	3846	21%
Other Elementary Schools	976	145	1121	2978	38%	85	3%	254	2971	9%
Middle Schools	1507	194	1701	3048	56%	169	6%	409	3073	13%
High Schools	1882	269	2151	5170	42%	247	5%	1398	5252	27%
MSD Public Schools	As of March 1, 2013					As of March 11, 2013		2012-2013 School Year		
	Free (F) Meal Enrollment	Reduced (R) Meal Enrollment	TOTAL Free and Reduced Enrollment	Total School Enrollment	F/R%**	Homeless Count ^a	Percent Homeless	Truancy Count ²	Total School Enrollment	Percent Habitually Truant
Beech* ^{1 3}	533	28	561	579	97%	39	7%	133	571	23%
Wilson* ^{1 3}	378	26	404	442	91%	38	9%	103	434	24%
Gossler* ^{1 3}	319	19	338	402	84%	47	12%	96	410	23%
Bakersville* ¹	305	14	319	400	80%	19	5%	58	365	16%
McDonough* ^{1 3}	392	27	419	546	77%	43	8%	159	555	29%
Parkside ³	421	32	453	670	68%	51	8%	147	684	21%
Parker Varney* ^{1 3}	306	33	339	528	64%	16	3%	94	537	18%
Northwest ¹	367	39	406	656	62%	30	5%	119	667	18%
Hallsville ¹	158	26	184	305	60%	22	7%	29	307	9%
Southside ³	363	68	431	764	56%	42	5%	123	779	16%
McLaughlin	392	43	435	804	54%	48	6%	73	800	9%
MST HS	34	8	42	82	51%	1	1%	31	85	36%
West	506	71	577	1169	49%	55	5%	411	1192	34%
Hillside	331	51	382	810	47%	28	3%	66	810	8%
Jewett	179	31	210	460	46%	11	2%	82	441	19%
Weston	228	36	264	579	46%	24	4%	29	596	5%
Webster	193	11	204	462	44%	27	6%	21	462	5%
Central	762	76	838	2086	40%	79	4%	686	2126	32%
HGF	167	35	202	506	40%	16	3%	42	495	8%
Memorial	580	114	694	1833	38%	112	6%	270	1849	15%
Smyth	100	21	121	406	30%	6	1%	53	395	13%
Green Acres	109	11	120	565	21%	1	0%	27	582	5%
TOTAL	7123	820	7943	15054	53%	755	5%	2852	15142	19%

* CITY YEAR SCHOOL: City Year is currently serving six priority elementary schools. City Year Corps members support students with academic mentoring, after-school programming and connecting youth to their communities and schools through service learning and interactive programming.

** F/R%: Represents the total distribution of children enrolled in free and reduced meals per public school. To be eligible for free meal enrollment (F), the total annual household income per family must fall below 130% of the federal poverty guidelines (ie. for a family of four, this would equate to \$29,965.00 or less). To be eligible for reduced meal enrollment (R), the total annual household income per family must fall below 185% of the federal poverty guidelines (ie. for a family of four, this would equate to \$42,643.00 or less).

¹ TITLE I SCHOOL: Title I provides federal funding to public schools with high numbers or high percentages of poor children. The funding provides supplemental instruction for students who are economically disadvantaged or at risk for failing to meet state standards. Students are expected to show academic growth at a faster rate with the support of Title I instruction."

² TRUANCY is defined by 10 or more half days of unexcused absences during the academic calendar.

³ PRIORITY SCHOOL: This selection is the result of a new methodology approved in the state's Flexibility Waiver that allows the department to concentrate its support on certain Title I schools. Being a part of a Priority or Focus School cohort will provide additional resources and partnerships to these schools to support the students they serve. A priority school is one that accepts federal funds from Title I, Part A of the Elementary and Secondary Education Act, and that is among the lowest performing 5 percent of schools in the state based on the achievement of all students on the statewide assessment pursuant to RSA 193-C and which, when measuring the achievement of all students, has demonstrated a lack of progress on the statewide assessment over 3 years.

^a HOMELESS is defined as living in a shelter, living in a doubled-up residence, living unsheltered – e.g. car, park, campground, etc. or living in a hotel or motel. Homeless % was calculated using March 11, 2013 homeless counts and March 1, 2013 enrollment numbers.

SOURCE: Manchester School District, Manchester Health Department

IV. Describing Manchester's Neighborhood Health

ECONOMIC WELLBEING

The Connection Between Income and Health

Socioeconomic wellbeing has been shown to be one of the strongest predictors of health status. The evidence tells us that the relationship between income and health is based not just on how economic resources can affect our access to medical care, but also on how they enable us to live in safer homes and neighborhoods, buy healthier food, have more leisure time for physical activity, and experience less health-harming stress.¹⁸

Understanding the importance of the links between income, wealth and health can inform policies aiming to achieve better health for all residents while reducing variation in health status within neighborhoods.

The County Health Rankings and Roadmaps report several ways that education affects health outcomes:¹⁸

- Individuals need sufficient income so that they can obtain health insurance; pay for medical care; afford healthy food, safe housing, and access to other basic resources - at least until a certain income threshold is achieved. One study showed that if poverty were considered a cause of death in the US, it would rank among the top ten.
- While negative health effects resulting from poverty are present at all ages, children and families in poverty face greater risks. Children face greater morbidity and mortality due to greater risk of accidental injury, lack of health care access, and poor educational achievement. Early (or prenatal) poverty may result in developmental damage. Children's age-five IQ correlates more with family income than with maternal education, ethnicity, and living in a single female-headed household.
- Social and economic features of neighborhoods have been linked with mortality, general health status, disability, birth outcomes, chronic conditions, health behaviors and other risk factors for chronic disease, as well as mental health, injuries, violence and other important health indicators.

How Does Manchester Compare?

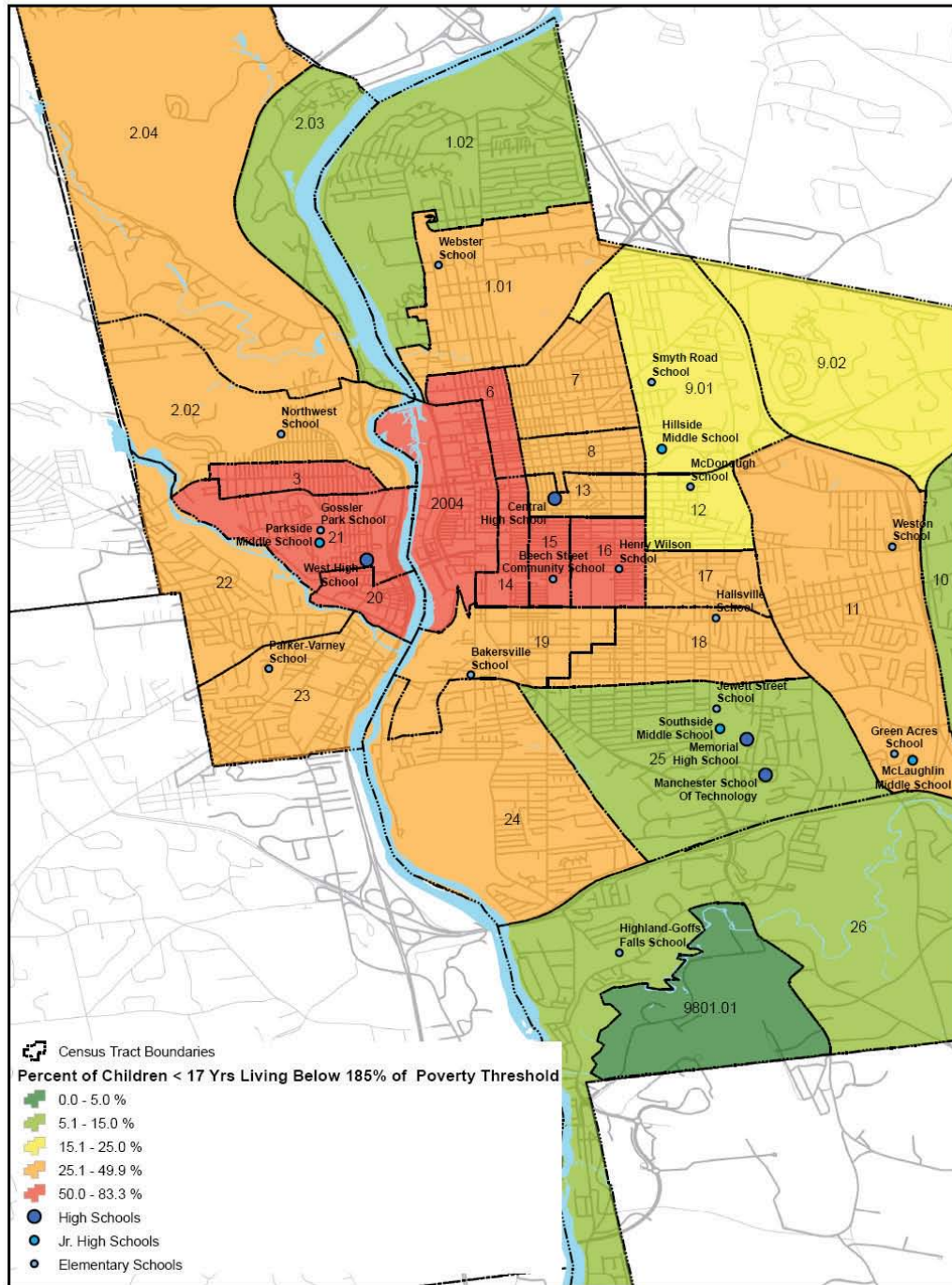
Since 1990, poverty among Manchester residents of all ages has increased gradually, while poverty among children under the age of 18 years has more than doubled. Over the last several decades, poor families have become more likely to live in neighborhoods with concentrated poverty and rich families became more likely to live in neighborhoods with concentrated wealth.¹⁹

- In 2012, the Carsey Institute reported that while New Hampshire holds the lowest child poverty levels in the nation, Manchester's rates are now nearly as high as those in Boston (27%) and New York City (28%).²⁰
- In March of 2013, nearly 8,000 or 53% of Manchester school children were enrolled in free and reduced meals. Of this total, 90% were enrolled in free meals which means that the total family income for these children were below 130% of the federal poverty guidelines.²
- Manchester over represents New Hampshire in measures of individual economic disadvantage. Close to 7,000 residents live in neighborhoods in which at least 20% of its constituents are living below poverty. Poor health outcomes, such as coronary heart disease mortality, occur at rates 1.5–2.0 times greater in these high deprivation neighborhoods.¹

2007-2011 INCOME AND WEALTH INDICATORS		
SOURCE: ACS,* US CENSUS	MANCHESTER	NH
Unemployment Rate Among Residents Age 16 and Older	7.5%	6.3%
Median Household Income	\$53,278	\$64,664
Total Residents Living Below Poverty Threshold	13.8%	8.0%
Related Children Under 5 Years	24.9%	12.5%
Children Under 18 Years	22.4%	9.9%
Adults Age 65 and Older	8.5%	6.6%
Proportion of Housing Units that are Renter Occupied	50.1%	27.5%
Percentage of Households Without a Motor Vehicle	9.1%	5.0%

ACS: American Community Survey

City of Manchester Children Aged 17 Years and Younger Living Below 185% of Poverty Threshold 2006-2010



Data Source : US Census, City of Manchester Health Department

Prepared By: Aaron Krycki, MPH, REHS | May 2012

IV. Describing Manchester's Neighborhood Health

SUPPORTIVE LIVING ENVIRONMENTS

The Connection Between Environment and Health

Place matters. Years of research have shown that the physical structure and environment of a home represents only one dimension of potential health risks. Socially mediated factors, such as exposure to violence in home, and economic conditions are also considered healthy homes related concerns. Moreover, as the definition of Environmental Justice implies, it is equally important to ensure residents have access to basic resources where they live, learn, work and play such as healthy, affordable foods, safe places for recreation, and other neighborhood assets, such as faith-based organizations and community health centers. In other words, health is shaped by many factors and is much more complex than individual behavior and access to medical care alone.

The County Health Rankings and Roadmaps reports that 50% of our health status is produced by social, economic and physical environment factors and provides several examples illustrating how supportive living environments affect health outcomes:¹⁸

- Literature indicates that the number of calories consumed daily has increased over the past several decades. Among children, fast food restaurants are the second highest energy provider, second only to grocery stores. Environments with a large proportion of fast food restaurants have been associated with higher obesity and diabetes levels.
- Similarly, access to places for recreation is associated with higher rates of physical activity and lower rates of obesity. The evidence for the effectiveness of improving access to recreational facilities is so strong that the Centers for Disease Control and Prevention (CDC) recommend it as one of the 24 environmental and policy-level strategies to reduce obesity.
- Childhood lead poisoning, injuries, respiratory diseases such as asthma, and quality of life issues have been linked to the more than 6 million substandard housing units nationwide. In its "Healthy People" national goals, the US DHHS calls for a 52% reduction in the number of substandard occupied housing units throughout the United States.

How Does Manchester Compare?

Variations in health outcomes and living environments occur at a sub-geographic or neighborhood level in Manchester, and often over represent New Hampshire's distribution of need.

In addition:

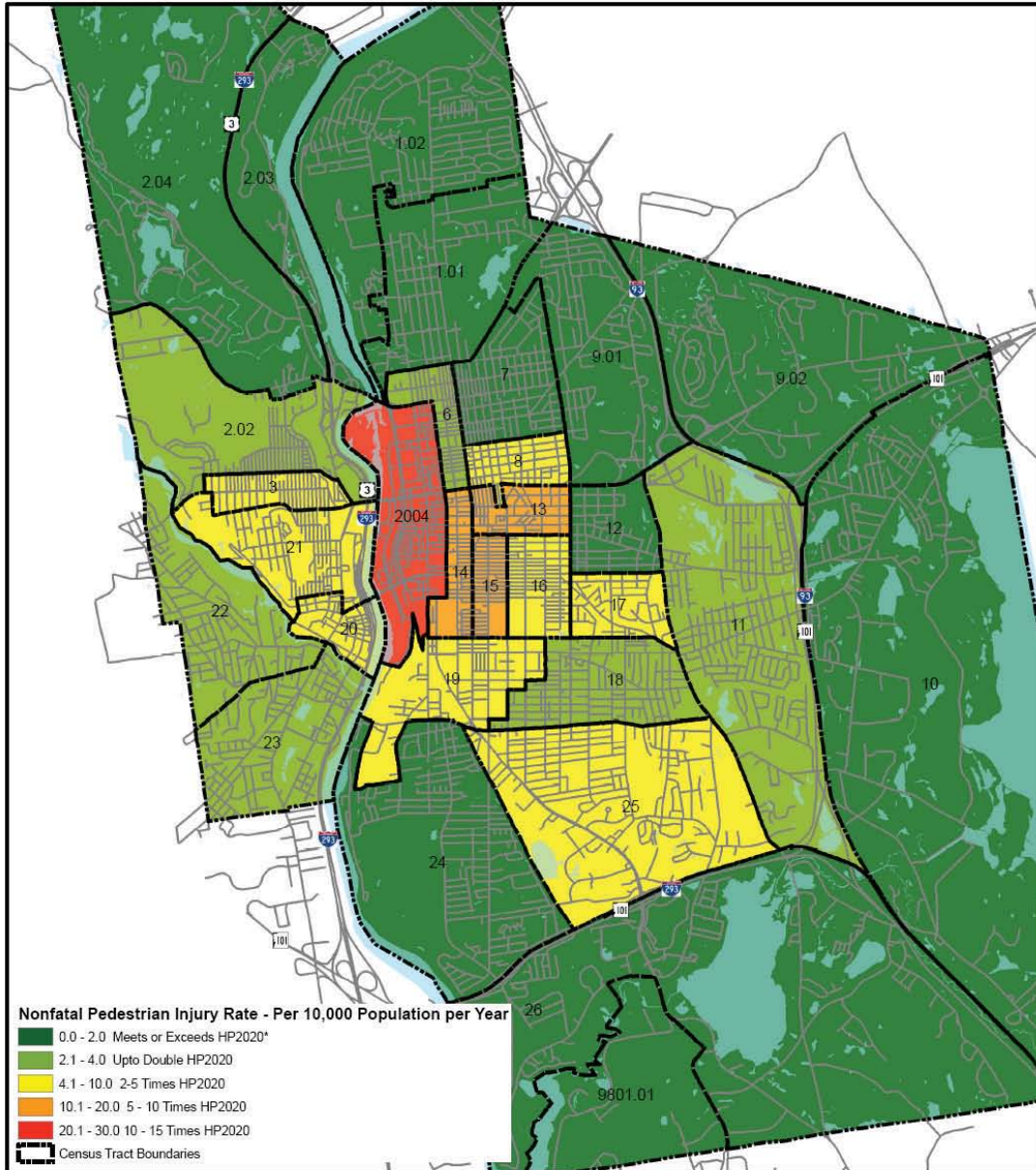
- From 2007-2011, there were 45,130 occupied housing units in Manchester. Half of these housing units were renter occupied, compared to 27% throughout New Hampshire.¹
- Of the 49,250 total housing units available in the City for this same time period:¹
 - Over 8% were vacant, of which 6% were rental properties.
 - Nearly 50% were gas heated, 35% by fuel oil or kerosene.
 - Close to 400 units lacked complete plumbing facilities with nearly 500 units lacking complete kitchen facilities.
- In the center city, nearly three out of every four housing units were built before 1950, compared to 26% throughout New Hampshire.¹
- Since 2000, more than 20,000 Manchester children under the age of six have been screened for blood lead and close to 750 of these children have been identified as having an elevated blood lead level (> 10 ug/dl).²¹

POTENTIALLY PREVENTABLE HOSPITAL DISCHARGES**	TOTAL CITY	CITY & HEALTH SERVICE AREA	TOTAL NH
Unintentional Injury ED Visits and Observation Stays, 2005-07	11805.5*	9978.0*	11048.5
Asthma ED Visits and Observation Stays, 2005-07	689.9*	513.2	499.7
Diabetes Related Inpatient Discharges, 2006-08	1798.8*	1516.8*	1433.4

*Denotes a statistically significant difference between the City of Manchester, its Health Service Area and New Hampshire.

**Rates are per 100,000 population.

Nonfatal Pedestrian Injury Rates on Public Roads by Census Tract, City of Manchester, 2008 - 2012 YTD



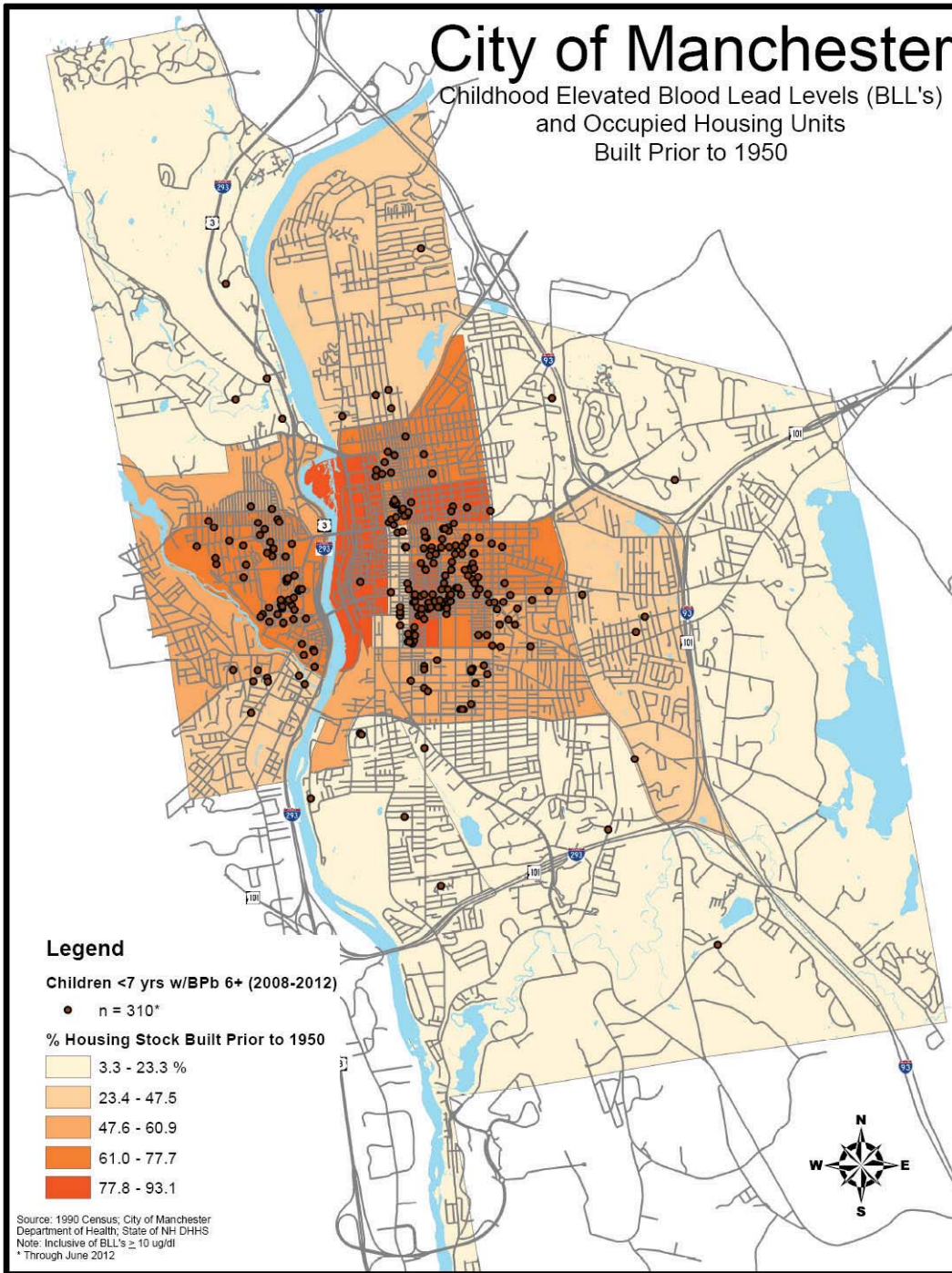
* Healthy People 2020 Objective: Reduce nonfatal pedestrian injuries on public roads to no greater than 2.0 injuries per 10,000 population.



Prepared By: Manchester Health Department
 Aaron Krycki, MPH, REHS - Sr. Public Health Specialist
 Data Sources:
 City of Manchester Police Department
 State of NH Department of Safety

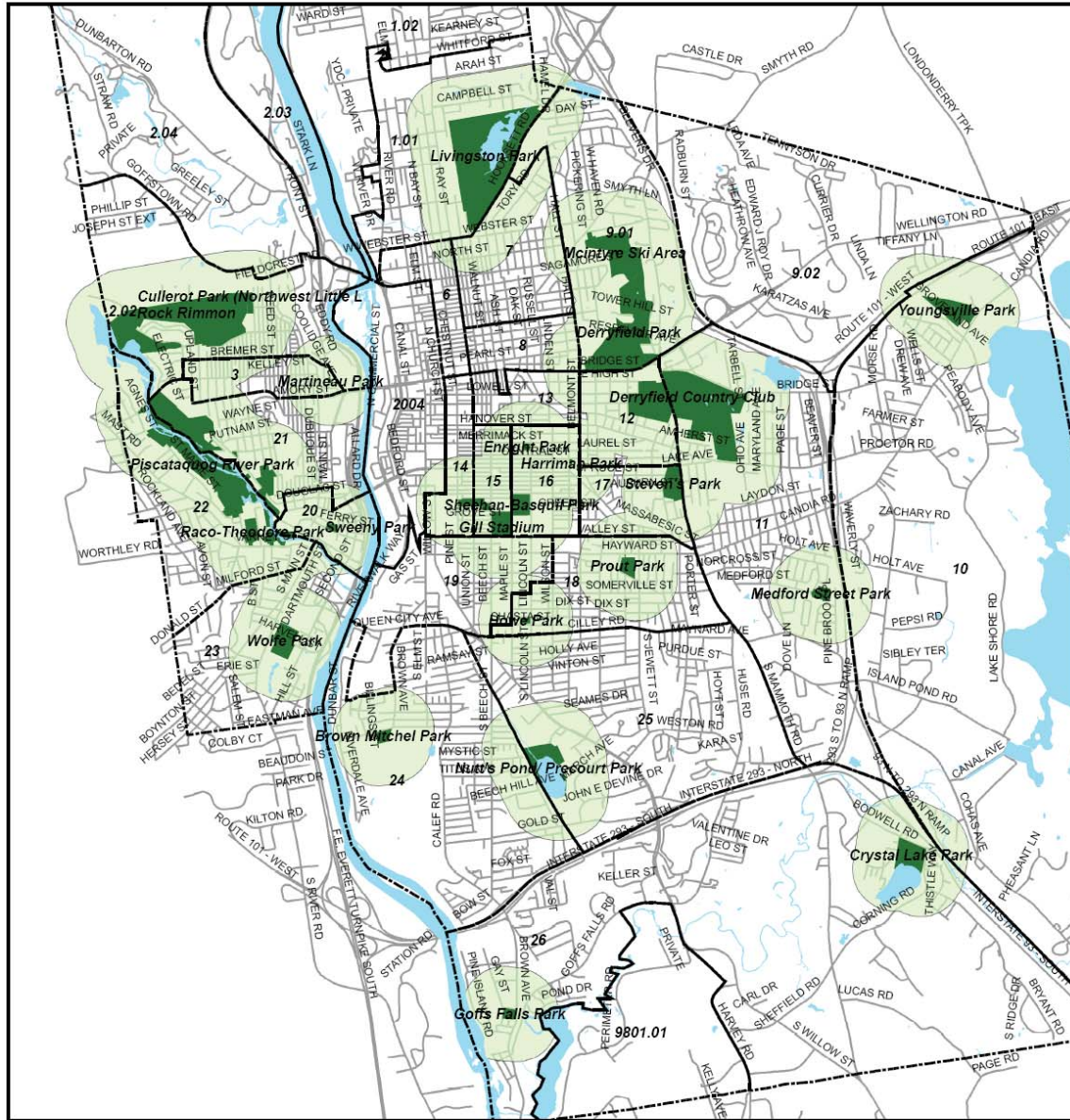
City of Manchester

Childhood Elevated Blood Lead Levels (BLL's)
and Occupied Housing Units
Built Prior to 1950



Prepared by: Aaron Krycki, MPH, REHS, HHS

City of Manchester Proximity of Public Recreational Parks by Census Tract



- Recreational Park
- Area within 1/4 mile of Recreational Park
- Census Tract Boundary



Data Source : 2010 US Census, City of Manchester

Prepared By: Aaron Krycki, MPH, REHS

IV. Describing Manchester's Neighborhood Health

ACCESS TO APPROPRIATE CARE

The Connection Between Access to Care and Health

Quality healthcare is the right care, for the right person, at the right time. The Institute of Medicine (IOM) further defines the quality of healthcare as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The IOM lists six characteristics of quality healthcare: safe, timely, effective, efficient, equitable, and patient-centered.

While having health insurance is a crucial step toward accessing needed primary care, health care specialists, and emergency treatment, health insurance by itself does not ensure access. It is also necessary to have comprehensive coverage, providers that accept the individual's health insurance, relatively close proximity of providers to patients, and primary care providers in the community.¹⁸

The County Health Rankings and Roadmaps Initiative reports several ways that access to timely and appropriate care affects health outcomes:¹⁸

- The uninsured are less likely to receive preventive and diagnostic health care services, are more often diagnosed at a later disease stage, and on average receive less treatment for their condition compared to insured individuals.
- The uninsured population has a 25% higher mortality rate than the insured population.
- Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. One analysis found that each increase of one primary care physician per 10,000 population is associated with a reduction in the average mortality by 5.3%.
- While there have been modest improvements in the overall quality of care provided in recent years, significant disparities have stayed the same or worsened for African-American, Asian, and low-income populations.

How Does Manchester Compare?

While Manchester represents just over 8% of New Hampshire's total population, the City is home to nearly 11% of the state's uninsured and 14% of its Medicaid enrollees.

In addition:

- Close to 15,000 Manchester residents are without health insurance coverage (2009-2011).¹
- Over the past decade, Manchester's Medicaid enrollment has grown from just over 13,500 residents to nearly 22,000. Of these, just under 13,000 Medicaid enrollees are children age 18 and younger.²²

Socioeconomic factors can influence Manchester residents' ability to access care at the appropriate time.

ACCESS TO CARE INDICATORS AMONG RESIDENTS AGE 18 AND OLDER, 2011	MANCHESTER		TOTAL NH
	ANNUAL HOUSEHOLD INCOME <\$25,000	TOTAL CITY	
No Check Up Within the Past Year	41.7%*	33.9%	29.4%
Could Not See a Doctor Due to Cost	46.0%*	22.3%*	14.9%
Do Not Have Health Care Coverage	40.3%*	19.9%*	13.7%

SOURCE: NH BRFS

* Denotes a statistically significant difference between the City of Manchester and New Hampshire.

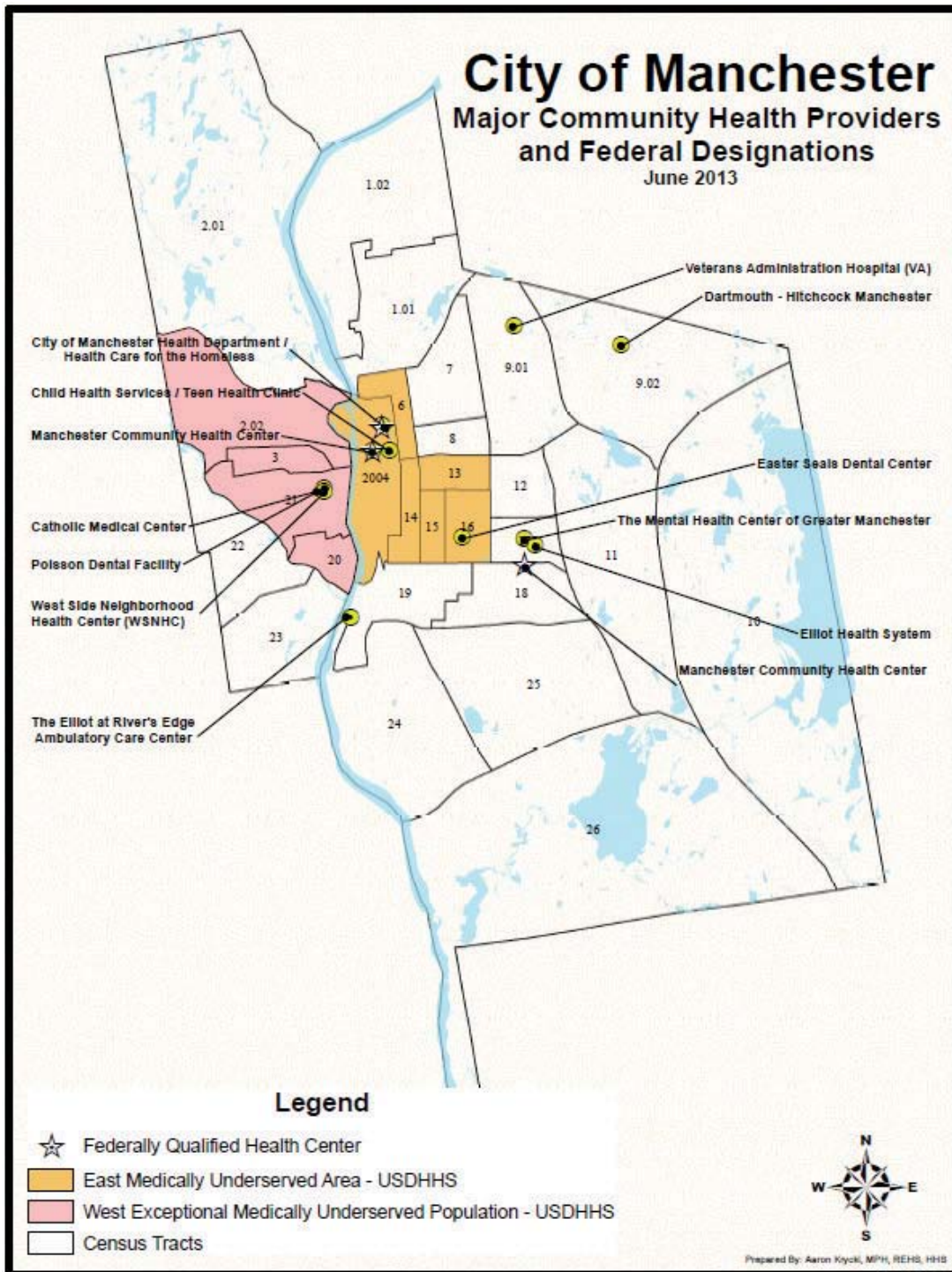
POTENTIALLY PREVENTABLE HOSPITAL DISCHARGES**, 2003-2007	TOTAL CITY	City & Health Service Area	TOTAL NH
Mental Health Conditions ED Visits/Observation Stays	202.1*	141.2*	136.9
Substance Abuse-Related ED Visits	110.8*	80.5*	68.3
Acute Ambulatory Care Sensitive Conditions	90.7*	78.0*	69.7
Chronic Ambulatory Care Sensitive Conditions	79.8*	66.9*	60.5

SOURCE: NH HealthWRQS, NHDHHS

*Denotes a statistically significant difference between the City of Manchester, its Health Service Area and New Hampshire.

**Rates are per 10,000 population.

City of Manchester Major Community Health Providers and Federal Designations June 2013



IV. Describing Manchester's Neighborhood Health

HEALTHY BEHAVIORS

The Connection Between Behavior and Health

The County Health Rankings and Roadmaps (CHR) Initiative reports that our behaviors contribute to 30% of the factors which define our health status:¹⁸

- Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity.
- The relationship between tobacco use, particularly cigarette smoking, and adverse health outcomes is well known. Because smoking cessation can lead to immediate health benefits at any age, smoking prevalence is an important measure to include when assessing/ planning interventions at a neighborhood level.
- Consuming a healthy amount of calories and healthier foods is important to maintaining health, and decreasing risk of chronic diseases, e.g., diabetes, hypertension, cancers; and overweight and obesity.
- Sexually transmitted infections (STI's) are associated with significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, pelvic inflammatory disease, involuntary infertility, and premature death.
- Approximately 80,000 deaths are attributed annually to excessive drinking. It is the third leading lifestyle-related cause of death for people in the US each year. Binge/heavy drinkers account for the most episodes of alcohol-impaired driving.
- The Center on Media and Child Health young people spend more time using media—TV, movies, music, computers, Internet, cell phones, magazines, and video games—than engaging in any other single activity except sleep². These pervasive, persuasive influences have been linked to both negative health outcomes (e.g., smoking, obesity, sexual risk behaviors, eating disorders and poor body image, anxiety, and violence) and to positive outcomes (e.g., civil participation, positive social behavior, tolerance, school readiness, knowledge acquisition, and positive self-image).

How Does Manchester Compare?

Manchester's risk behavior profile varies by school and by neighborhood, as well as compared to statewide:

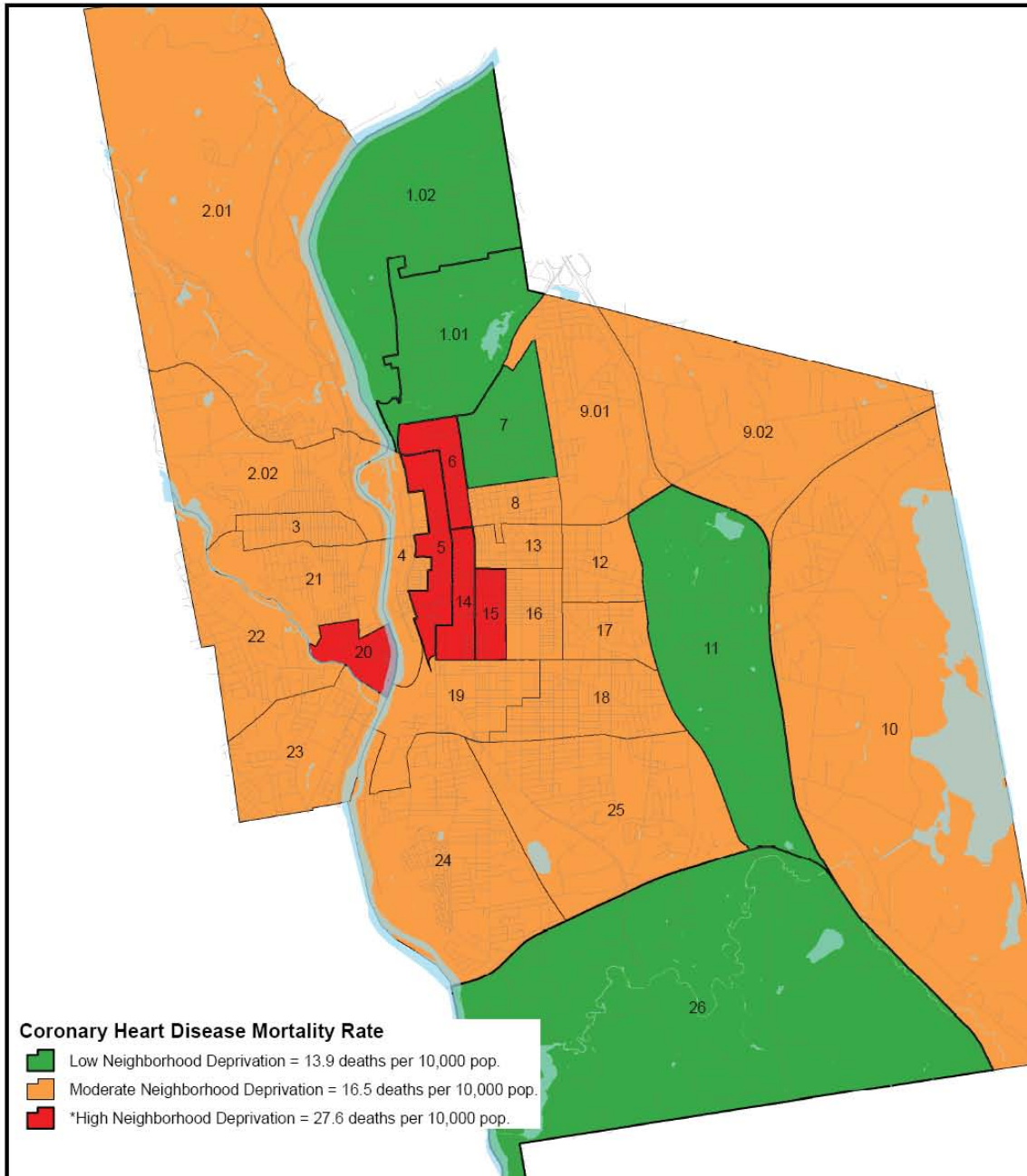
- During the 2011-12 school year, 22% of the City's elementary school children screened at Title One schools were overweight (with a BMI greater than the 85% percentile) compared to 19% screened at all other elementary schools.²³
- In 2011, over 13% of Manchester high school students were considered obese (based on self-reported height and weight). Nearly one in four students reported binge drinking or having five or more drinks of alcohol in a row, within a couple of hours, on one or more of the past 30 days.⁵
- From 2007-11, while Manchester represented just over 8% of New Hampshire's population, the City experienced 18% (2135/11756 cases) of the Chlamydia cases reported to NHDHHS at a rate double that of the state.²⁴
- From 2006-2008, Manchester's teen birth rate was 40.4 per 1,000 women aged 15-19 years, significantly higher than the state rate at 18.5 per 1,000 women aged 15-19 years. These rates historically have been shown to be elevated among center city neighborhoods.⁴
- In 2009, 26% of the City's high school students reported video or computer usage for something that is not school work for three or more hours on an average school day.⁵

RISK BEHAVIOR AMONG RESIDENTS AGE 18 AND OLDER, 2011	MANCHESTER		TOTAL NH
	ANNUAL HOUSEHOLD INCOME <\$25,000	TOTAL CITY	
Current Smoker	35.2%*	26.9%*	19.6%
No Exercise in the Past 30 Days	29.6%	26.0%	22.4%
Obese (BMI >=30)	34.9%	34.1%	26.6%
Binge Drinker	N/A	15.1%	18.9%

SOURCE: NH BRFSS

* Denotes a statistically significant difference between the City of Manchester and New Hampshire.

Coronary Heart Disease Mortality and Neighborhood Deprivation in Manchester, NH, 1995-2005



Interpretation Notes:
 Coronary Heart Disease Mortality is 2.0 times greater in high deprivation neighborhoods than low deprivation neighborhoods.
 * statistically significant difference



Data Source : CHD Mortality Rates 1995- 2005, 2000 US Census, City of Manchester Health Department

Prepared By: Aaron Krycki, BS, REHS
 Jamie Hoebeke, MPH, CHES

IV. Describing Manchester's Neighborhood Health

SOCIAL CONNECTEDNESS & NEIGHBORHOOD SAFETY

The Connection Between Safety and Health

The County Health Rankings and Roadmaps reports that the health impacts of community safety are far-reaching, from the obvious impact of violence on the victim to the symptoms of post-traumatic stress disorder (PTSD) and psychological distress felt by those who are routinely exposed to unsafe communities.¹⁸ Community safety impacts various other health factors and outcomes as well, including birth weight, diet and exercise, and family and social support. In addition:

- Violence against others is a major public health problem in the U.S., accounting for the loss of 18,000 lives each year. Among Americans between the ages of 15 and 24, homicide was the second leading cause of death in 2010. Many violent crimes, however, do not result in death. In 2011, throughout the United States, an estimated 681,000 unique children were determined to be victims of abuse or neglect.
- Exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders. It also may lead people to engage in smoking in an effort to reduce or cope with stress. Exposure to violent neighborhoods has been associated with increased substance abuse and sexual risk-taking behaviors as well as risky driving practices.
- Neighborhoods with high violence are thought to encourage isolation and therefore inhibit the social support needed to cope with stressful events. This exposure to chronic stress contributes to the increased prevalence of certain illnesses, such as upper respiratory illness and asthma, in neighborhoods with high levels of violence.
- Understanding how many individuals in a community are socially isolated also provides a more complete perspective on a community's health. One study found that the risk associated with social isolation (or lack of family or social support) for adverse health outcomes is similar in magnitude to the risk of cigarette smoking.

How Does Manchester Compare?

The NH Center for Public Policy reports that Manchester's violent crime rate has more than doubled over the past decade. In addition, other indicators are beginning to show the City's social vulnerability:

- From 2010-11, the City of Manchester Part I Violent Crime Rate was 496.4 per 100,000 population, compared to that of the County Health Rankings National Benchmark of 73.0 per 100,000 population or less.¹⁸
- From 2005-2007, the rate of assault injury emergency department visits and observation stays for Manchester was twice that of the State of New Hampshire, with the highest rate for these visits occurring among 15 to 24 year olds.⁷
- In Manchester, family households take a variety of forms. From 2007-2011, 42% of all households with their own children were headed by a single householder. During this time period, nearly 43% of residents age 65 and older in the City lived alone. In 2011, close to 70% of householders lived in their homes for ten years or less.¹
- From 2007-2011, 27% of workers who resided in Manchester traveled 30 minutes or more to work each day. Bettertogether.org reports that each 10 minutes of additional commuting time cuts all forms of social capital by 10% – 10% less church-going, 10% fewer club meetings, 10% fewer evenings with friends, etc.¹

INDICATORS OF SOCIAL VULNERABILITY AND VIOLENCE	TOTAL CITY	CITY & HEALTH SERVICE AREA	TOTAL NH
Adults Reporting Mental Health Not Good 14 to 30 Days, 2011	20.1%*	15.4%	12.3%
Mental Health Condition Inpatient Discharges, 2006-08**	541.1*	451.8	441.6
Assault Injury ED Visits and Observation Stays, 2005-07**	520.7*	363.9*	263.5

SOURCE: NH HealthWRQS, NHDHHS

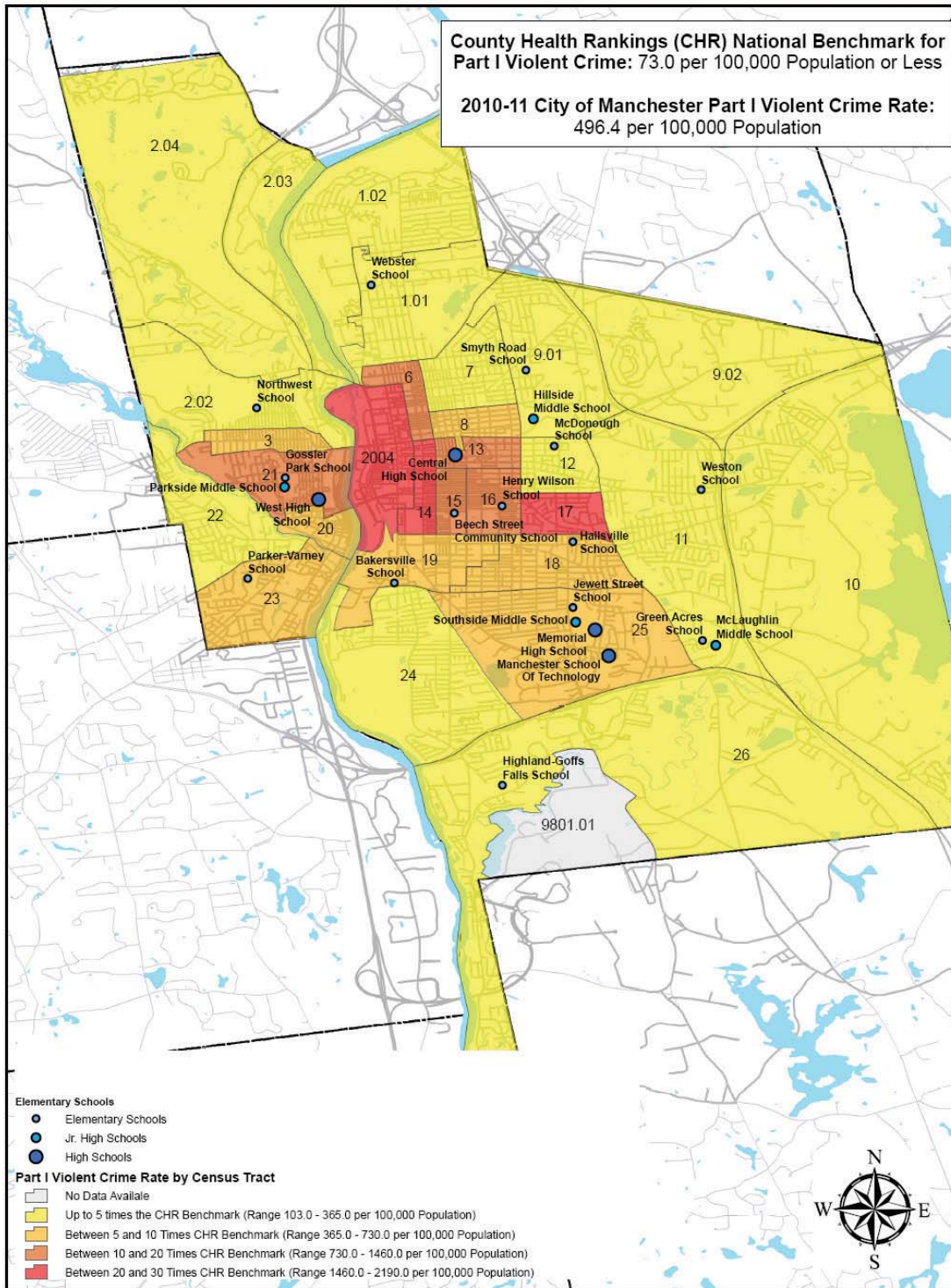
*Denotes a statistically significant difference between the City of Manchester, its Health Service Area and New Hampshire.

**Rates are per 100,000 population.

City of Manchester Part I Violent Crime Rate per 100,000 Population by Census Tract 2010-11

County Health Rankings (CHR) National Benchmark for Part I Violent Crime: 73.0 per 100,000 Population or Less

2010-11 City of Manchester Part I Violent Crime Rate: 496.4 per 100,000 Population



Data Source : US Census, City of Manchester Health Department, City of Manchester Police Department
County Health Rankings & Roadmaps—A Healthier Nation, County by County, 2012 National Benchmarks

Prepared By: Aaron Krycki, MPH, REHS : March 6, 2013



V. Resident Perspective on Neighborhood Health

V. Resident Perspective on Neighborhood Health

RESIDENT SURVEYS

SURVEY DESIGN AND IMPLEMENTATION

In August 2013, the Manchester Health Department (MHD) began surveying residents of the three school catchment areas designated for the Manchester Community Schools Project (MCSP): Beech, Bakersville and Gossler Park, as described more on page 58. These surveys are one of many efforts that help to ensure that residents play a key role in this project. They are also a means by which residents can share their perspectives with their everyday experiences, attitudes toward and concerns about the neighborhoods in which they live to inform community-level planning. Their input is critical to not only identifying local barriers to wellbeing, but solutions that more effectively target the root causes of concern.

Despite their geographic proximity to one another, the three school catchment areas for the MCSP vary demographically and economically, as well as in terms of available neighborhood assets/resources. Efforts to improve the health and wellbeing of residents must therefore reflect the needs of residents while capitalizing on the strengths of each neighborhood. Such interventions may include increasing access to a variety of services—such as healthcare, employment, and education and job training—as well as finding ways to improve a number of factors related to health and wellbeing, including increasing supportive living environments—both in terms of neighborhood design and home environments—and fostering interpersonal ties among residents and reducing social isolation.

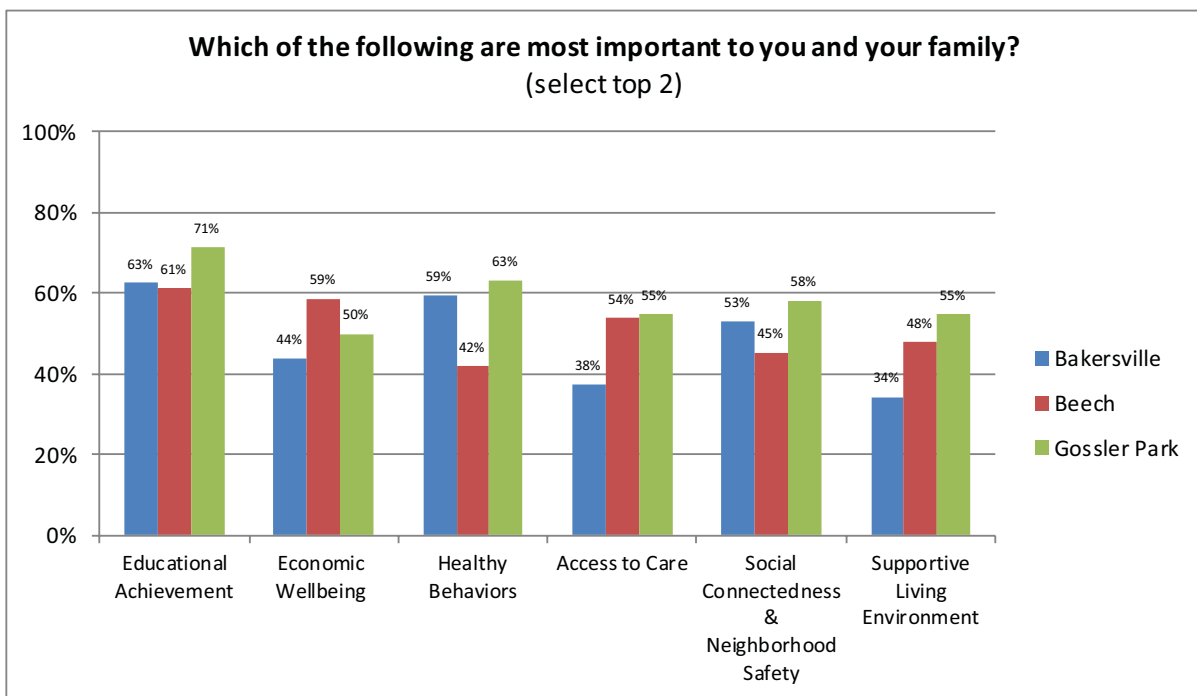
Surveys were distributed to residents of the Beech, Bakersville and Gossler Park catchment areas both in-person and via elementary schools, whose staff and administration sent surveys home with students and returned them to the MHD. Additionally, surveys were administered in high volume, public places, such as the local libraries and supermarkets, to capture a more intergenerational and diverse profile of residents beyond families with children in the Manchester School District. Surveys were translated to Spanish and respondents were offered language-related assistance, as needed. Residents provided feedback on a range of issues, including selecting which areas of concern were most important to them. These topics are derived directly from the framework for Neighborhood Health that is being utilized to frame this document (see page 17). To further focus on intervention planning and strategies, respondents were asked to identify which particular dimensions of these topics were most important to them and those living in their neighborhoods. While the survey tool requested that respondents select only two of these topic areas, approximately half of the respondents selected more than two topic areas. To date, a total of 246 residents responded to the survey, including 124 from Beech, 32 from Bakersville, and 89 from Gossler Park.

V. Resident Perspective on Neighborhood Health

RESIDENT SURVEYS

TOP CONCERNS AND BARRIERS TO ACHIEVING NEIGHBORHOOD HEALTH

Results pertaining to respondents' concerns regarding the various dimensions of the Neighborhood Health Framework appear below. As this figure illustrates, respondents tended to be split evenly across the board with respect to their concerns, and for the most part were equally concerned about each of these issues. However, Educational Achievement appears to be an exception, with just over two-thirds of respondents (65%) being more likely to state that Educational Achievement was the most important area.



Respondents were also asked to report what they perceived to be barriers to these domains. One clear obstacle to Educational Achievement stands out among those who ranked this topic as one of great concern, with nearly 57% of these respondents agreeing that neighborhood residents needed better access to after-school activities and sports for youth. Among the most commonly mentioned barriers to Educational Achievement included costs, lack of childcare, and lack of knowledge about how to access education services. Specifically, approximately 17% of respondents cited that they or their family members had a need/interest in 'GED Classes and Test Preparation' and 'Financial Aid' assistance.

V. Resident Perspective on Neighborhood Health

RESIDENT SURVEYS

- Additionally, respondents described a shortage of job opportunities and a lack of well-paying jobs as obstacles to economic wellbeing.
- Among those who ranked healthy behaviors as an area of concern, approximately half of the respondents said that access to free or affordable fitness programs was lacking.
- Lastly, 50% of those concerned with access to care said they agreed that a lack of health insurance coverage was problematic in their neighborhood, and 16% noted that cost was a barrier in attaining access.

IMPLICATIONS FOR FUTURE ACTION

There appears to be more continuity in concerns than differences across the three neighborhoods, and respondents have clearly identified barriers that need to be overcome in order to improve quality of life. Future analysis will shed light on whether respondents of different demographic and socioeconomic groups vary in the types of the barriers they identify. This feedback will be beneficial to informing the implementation of the systems-change recommendations that are outlined within this document.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

BACKGROUND

During the summer and early fall of 2013 the Manchester Health Department brought together key community leaders and residents to provide input to and help the City write the Neighborhood Health Improvement Strategy. Six community forums were hosted as informal conversations in which participants were actively engaged both in learning and teaching. Forums were facilitated by outside consultants.

The community forums were designed to: 1) inform local leaders and citizens about the status of health of the City's population, 2) provide knowledge about and propose evidence-based recommendations for improvement that could be incorporated into NHIS, 3) obtain input on enablers and barriers to health improvement efforts in general, and specifically to the proposed recommendations, and to 4) elicit public input on their vision and values for their neighborhoods and for the health of their families, friends and neighbors.

Specifically, the data and information obtained from the community forums helped Manchester City leadership develop the following key elements of the NHIS:

- Vision and mission
- Guiding principles
- Priority recommendations
- Communication/collaboration strategy
- Leadership structure
- Recognition of enablers and barriers

METHODOLOGY

The Manchester Health Department conducted learning/listening session for each of the six domains identified by the NHIS thematic framework. The forums were advertised by e-mail invitation based on established lists of community leaders obtained from the Manchester Health Department. The public was encouraged and invited to attend and actively participate in these meetings. Information specific to each domain was sent to all potential participants in advance of these meetings. This information included: a) a description of the health domain and its importance to neighborhood health, b) Manchester data specific to the domain, c) a summary of recommendations and evidence-based programs for consideration.

“ One of the most sincere forms of respect is actually listening to what another has to say. ”

Bryant H. McGill

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

The conversation at each meeting focused on one domain of health and the meeting discussions were framed by the following seven questions:

1. What do you think of when you hear the phrase (list the domain name here, e.g., educational achievement)?
2. When you think of people, places or events in the community that help to support (the domain, e.g., educational achievement), what comes to mind?
3. What is happening in the community now that gets in the way of, or undermines (the domain, e.g. educational achievement)?
4. Based on the list you just made do you think more work in these areas would help to improve (the domain, e.g. educational achievement) in the community?
5. Based on the list of proposed recommendations that we have established during this meeting and the discussion that we have just completed, which of these issues do you believe are the most important for your community to address to help improve (the domain, e.g., educational achievement).
6. Who is and who should be involved in working on these issues?
7. What type of support or resources do these people/organizations need to get started?

Learning from what participants said

Community input was captured on flip charts and in computer notes taken by the facilitators during the meeting. The meetings were not taped or transcribed. Every effort was made to capture community input accurately.

Notes from the forums were transcribed and imported into the statistical program NVIVO9 for analysis. Qualitative data were analyzed using an iterative coding and data reduction process in which a preliminary coding scheme was developed based on principles of collective impact. Themes were identified through content analysis, and compared across domains for similarities and differences, enabling the identification of overarching themes. Two data coders agreed upon how data were coded, providing a measure of reliability.

Who were the participants?






A total of six forums were held. Each forum was hosted at a venue appropriate to the domain, for example the meeting on educational achievement was held at Beech Street Elementary School. A faculty member from the Dartmouth Institute for Health Care and Clinical Practice and the Director of the Community Health Institute (CHI) facilitated the forums. Data were analyzed by CHI.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

The forums were well attended. Participants actively participated in the discussions and decision-making process. Many different viewpoints were represented at the meetings as evidenced by the number and diversity of organizations attending. The 105 persons attending the meetings represented 50 different community agencies providing input from an organizational perspective as well as from their own perspectives as community members.

NHIS community forums - description

Date	Domain	Venue
 June 10	Educational Achievement	Beech St. Elementary School http://beech.mansd.org
 July 18	Economic Wellbeing	Manchester Community Resource Center http://www.mcrnh.com/home.html
 July 25	Access to Timely & Appropriate care	Manchester Health Department http://www.manchesternh.gov/Departments/Health
 August 15	Supportive Living Environments	Southern NH Planning Commission http://www.snhpc.org
 August 22	Social Connectedness & Neighborhood Safety	Manchester Police Department http://www.manchesternh.gov/Departments/Police
 September 5	Healthy Behaviors	Manchester YMCA http://www.yogm.org

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

FINDINGS

Resident vision of educational achievement: “the ideal”

Participants described a city that values educational achievement as one that makes a bold effort to address the education of its children.

In this city, educational achievement takes into account each individual “whole child”, including his/her academic, cultural, and health needs - both physical and mental. Through collective and coordinated efforts of the school board, public and private community systems, and parents, this city prioritizes the needs families and children. The school/educational system is adequately resourced. This city values educational achievement as a key to individual growth and promotes collaboration and effective communication between parents, teachers, staff, and students.

Participants identified the following elements as being vital to the educational achievement of Manchester’s children.

- Students need to be supported to be in school on time everyday ready to learn.
- A clear agreed upon definition of truancy that includes grades K-12 is needed, with an appropriately resourced truancy office.
- Supports are essential to help parents learn to manage behavior, teach responsibility, interact with their children in educational ways, promote healthy social interaction and invite involvement in their children’s education.
- A network that includes well-supported teachers and staff, social workers, tutors, and mentors, particularly for students who have fallen behind as a result of attendance issues, is crucial to enabling student success.
- Increased resources for after-school programs, school resource officers, and especially for transportation to these programs was considered essential to educational achievement.
- Non-judgmental interaction is essential to effective communication – within organizations, across organizations and programs, and between schools and parents. This is critical in a community such as Manchester where there is a broad diversity of families with varying cultural issues and languages who use system services daily.
- Many of Manchester’s children are transient and move from school to school within the city during the school year. Addressing the needs of these children and their families for stable safe homes as well as the needs of teachers working to help these children achieve is paramount for success of this initiative.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

Resident vision of economic wellbeing: “the ideal”

Participants described a community that supports the economic wellbeing of its neighborhoods as a place where revitalization efforts reflect the values and priorities of residents.

Building upon a strong sense of community, this ideal city aims to foster environments that promote healthy relationships and activities through collaboration and coordination between stakeholders and community member organizations. This city also seeks to foster economic health and development of the community by supporting individuals to meet their greatest potential for self-sufficiency and by promoting the sustainability of successful programs. Residents value transparency, collaboration, communication, strong strategic planning and on-going assessment and evaluation.

The following key elements crucial to improving Manchester’s economic wellbeing were described by forum participants.

- Earning a livable wage is vital to economic wellbeing. Many families struggle to survive on minimum wage, working multiple jobs to make ends meet, often without health or child care benefits.
- Collaboration and coordination are required between key stakeholders and community members to better integrate available supports for those who need it. Families new to poverty may require support to understand how to access benefits.
- Care coordination is essential to effectively assist families in navigating existing resources, particularly those who are disabled, with special need for coordinated supports in order to live with a reasonable level of safety, comfort and health. Health benefits should address prevention as well as treatment.
- Adequate resources are needed to address crime and substance abuse among Manchester residents.
- The City should organize existing community efforts to support initiatives that promote educational improvement, and focus on reducing barriers to needed resources. Systems are needed that communicate to students that they are valued.
- There is a need to ascertain from the residents of City neighborhoods the gaps in services promoting safety, economic wellbeing, and knowledge and utilization of existing services.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

Resident vision of supportive living environments: “the ideal”

Participants described a city with supportive living environments as one in which the basic needs of all residents are met, including access to safe housing, healthy food, education and safe places for children and adults – to work, play and live.

All individuals and families have access to safe and affordable housing, and can access resources and services to meet their needs. The city has the necessary resources to ensure that all homes are safe. Neighborhoods are developed to promote health, encourage social connectedness, and provide opportunities for all residents to contribute to a positive neighborhood environment. In this city, neighbors value physical and mental safety, connections with others, and neighborhood pride.

The following elements crucial to improving Manchester’s supportive living environment were described by forum participants.

- Big picture coordinated planning for programs and services should be implemented across City organizations toward common goals and outcomes.
- More affordable housing for lower income residents as well as healthy homes that are safe, smoke-free, mold-free, and rodent and pest-free. Such a development effort should be supported by better housing codes and resources to support them.
- Safe and clean neighborhood places for children and families to congregate are vital to encouraging social connectedness and collective efficacy.
- Accessible and available resources, services, and programs within neighborhoods that provide opportunities for families to connect and engage in healthy activities, including healthy eating active living will support improvement of health outcomes.
- Good schools and educational programs, more public-private partnerships and a reformed tax structure are essential to support these desired transitions.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

Resident vision of access to appropriate care: “the ideal”

Participants defined appropriate care as timely, culturally sensitive services that foster “whole health for whole wellness”.

In an ideal city, all residents have access to affordable, high-quality, and conveniently located preventive and medical services that promote the highest possible individual level of health and functioning. Services are user-friendly, culturally appropriate and convenient to those who need services on the weekend or after work. City residents value the principles of healthcare for all with a focus on services that help to increase self-sufficiency and advocacy.

The following key elements crucial to providing Manchester residents appropriate care were described by forum participants.

- There is a crucial need for equitable health care coverage for all Manchester residents, regardless of citizen-status or type of insurance, which includes outreach and education focusing on prevention and wellness. It is essential to explain the importance of screening and care, and correct misinformation about existing services as well as changes implemented through health reform. Workforce training is critical to ensuring that the best care and accurate information are provided.
- An expanded community health system that provides culturally-sensitive services to Manchester residents where they live, work and play, and that fosters connectivity among community-based organizations is essential to improving access to services. Co-positioning of behavioral health and primary health care services in clinics and in schools is needed to promote integrated services.
- A proactive model of health service delivery is essential to providing care where people live work and play. Home visits for residents, beyond those who are under 21 and pregnant, are needed to provide early assessment. School health clinics, not hampered by bureaucracy, regulations and rules are critical to ensure the health of Manchester’s youth.
- Public transportation should be available to any resident that needs it to access health services.

V. Resident Perspective on Neighborhood Health

COMMUNITY FORUMS

Resident vision of healthy behaviors: “the ideal”

Participants describe healthy behaviors as consuming nutritious food, engaging in physical activity and fostering social connectedness.

In an ideal city, fostering healthy behaviors is a priority among community leaders, including local government, city planners, teachers, and health care providers. Neighborhoods provide safe environments for residents to engage in a diverse range of affordable, healthy, family-focused recreational activities. City residents are aware of the range of healthy opportunities available, and can access them regardless of income or geography. In this city, residents value family-centered intervention rather than child or individually focused intervention. Residents also value good communication systems and trust building between stakeholders and residents.

The following key elements crucial to improving Manchester’s supportive living environment were described by forum participants.

- The most basic need to support healthy behaviors among Manchester residents is livable wages. In addition, all residents should have health insurance that covers education and other preventive services. Education specific to health and wellness, standardized core messages, incentives, and tools are fundamental to promoting healthy behaviors among Manchester residents.
- A “Gold Standard” system for all families with new babies should be in place, that includes community support around breast feeding. Support for family strengthening education and initiatives -- such as cultural events, inter-generational activities and conflict resolution education – are essential, and should be connected with schools [and transportation available] to all who need it.
- City planners who advocate for Healthy Neighborhood safe planning are essential to designing healthy city services. Public figures are needed as Champions of healthy behaviors.
- Tiered membership to clubs, or cost-free activities that are inclusive of all community residents are vital to promoting healthy behaviors. Affordable, accessible public transportation is essential so that residents can take advantage of available healthy activities.

V. Resident Perspective on Neighborhood Health

RESIDENT SURVEYS

Resident vision of social connectedness and neighborhood safety: “the ideal”

Participants described a city with strong social connections and neighborhood safety as a place where neighbors have trusting relationships with each other, socialize together, feel like they belong to and are part of a community.

In this ideal city, neighborhoods provide safe environments for individuals and families to come together around positive community events. Residents know one another, feel that they belong to and are part of their communities, and develop shared histories over time. Neighbors can count on one another. Community organizations, schools, business associations, police departments, and community centers form strong community networks that communicate with one another and share ideas and resources to support the needs of neighborhood residents. Local business is supported, and main streets are vibrant. In this city, residents value knowing their neighbors.

The following key elements described by forum participants are important to building a culture of social connectedness and neighborhood safety in Manchester.

- First and foremost stakeholders and residents need to build an operational plan with includes development of activities and events as well as programs that intentionally bring neighbors together with the intent of them getting to know each other, build trust together, and get involved in their community. This plan would be well served by a strong communication strategy designed to engage and inform residents not only about events and activities and programs, but about each other.
- Activities and events to foster social connectedness and safety might include athletic activities, block parties, community meetings, know your neighbor events, music, school open houses and family friendly gatherings.
- Neighborhood watch groups need to be supported as a key program in communities for bringing neighbors together to work together to improve the safety and connectedness of residents.
- Places where neighbors can meet, gather, work and play are essential for building a sense of community and belonging. Such places might include farmers markets, theaters, community gardens, parks and schools. These places should be built to promote safety and connectivity for example, sidewalks with good lighting, schools with resource officers, parks that are clean beautified with flowers and trees.
- Most importantly the City needs to find a way to address the fear of each other which was expressed at the forums. Participants stated that they don't know their neighbors and are often afraid of what they do not know.



VI. Recommendations for Action

VI. Recommendations for Action

EDUCATIONAL ACHIEVEMENT

Several evidence-based databases and national reports were utilized in formulating the NHIS recommendations to ensure alignment with the most current health research and national priorities. These resources include, but are not limited to, U.S. Department of Health and Human Services' Guide to Community Preventive Services (<http://www.thecommunityguide.org>), County Health Rankings and Roadmaps' What Works for Health Database (<http://www.countyhealthrankings.org/roadmaps/what-works-for-health>), and Institute of Education Sciences' What Works Clearinghouse (<http://ies.ed.gov/ncee/wwc/>), as well as the Office of the Surgeon General's National Prevention Strategy (<http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf>).

Ensure that all children and families have the early developmental support that they need for a healthy start, including intensive programs that promote healthy child development, school readiness and parental skill development.

Early Childhood Development and Family supports

Comprehensive early childhood development programs enhance the cognitive and social development of low income children prior to kindergarten. These intensive programs promote healthy child development, school readiness, and parental skill development. Such programs usually include high-quality preschool and often offer additional services, such as home visiting, health, and family services.

Provide intensive community services and programming for at-risk elementary-aged youth and their families to prevent truancy and promote attendance.

Mentoring and 'Cradle to College to Career'

Mentoring programs provide adult mentors to guide students through academic and personal challenges. A trained mentor meets regularly with the at-risk student, establishes a personal relationship, helps the students overcome obstacles in and out of school, and models positive behavior and decision-making skills.

Strengthen the focus of behavioral and mental health care by co-locating providers in the elementary school environment.

Comprehensive School Behavioral Health

Research increasingly points to the link between students' academic success and social, emotional, and behavioral health. However, schools are generally not measured and evaluated on social, emotional, and behavioral health outcomes for students. As a result, they are often unable to justify and provide the attention, data infrastructure, and funding necessary to embed social, emotional, and behavioral health initiatives into school culture. Comprehensive school behavioral health systems include district- and school-level educational and local behavioral health professionals working in concert with families to improve prevention, early intervention, and intervention strategies within the school and community to meet students' social, emotional, and behavioral health needs.

VI. Recommendations for Action

ECONOMIC WELLBEING

Establish a coalition of key stakeholders to conduct an asset mapping and gaps analysis of local resources that are essential to supporting economic self-sufficiency and community economic development.

Coalition Formation and Robust Environmental Scan

To get a better understanding of the major stakeholders and resources available for both economic self-sufficiency and community economic development, a robust asset mapping and gaps analysis should be conducted. In addition to providing a more in depth review of services by population characteristic (i.e. age, gender, race/ethnicity, income level, geography, etc) and the type of service/resource provided, one of the primary objectives of this process should be to establish a Coalition of key stakeholders to facilitate shared decision making and ongoing community planning as it relates to improved economic wellbeing within the City.

Reduce barriers to improving employability and financial literacy by developing capacity to coordinate/provide intensive community services and programming for families directly within neighborhoods.

Employability and Financial Literacy

The combination of increasing skills for both employability and financial literacy will begin to strengthen economic self-sufficiency or a person's ability to provide for themselves and their family with limited outside assistance. Families need to be able to readily access services for skill building, and moreover, be given assistance and support to navigate the existing system of local employment and financial resources the may be available to them, such as Earned Income Tax Credit (EITC) and job development and placement programs.

VI. Recommendations for Action

SUPPORTIVE LIVING ENVIRONMENTS

Create a coordinated and sustainable “Healthy Homes” system comprised of multi-disciplinary partnerships and approaches that effectively and efficiently address living conditions which impact resident health, safety and wellbeing.

Comprehensive Approach to Healthy Homes

In 2009, the Office of the Surgeon General released The Call to Action to Promote Healthy Homes and defined the Healthy Homes as a holistic and comprehensive approach, which provides public health professionals, including environmental public health practitioners, public health nurses, and housing specialists, the requisite training and tools necessary to address the broad range of housing deficiencies and hazards associated with unhealthy and unsafe homes. A comprehensive, coordinated approach to healthy homes that includes a proactive ability to reach families with needed services before they are in crisis will result in the greatest public health impact.

Improve streetscape design to support access to key goods and services such as healthy foods, and access to neighborhood destinations for recreation, walkability and livability.

Improved Neighborhood Walkability and Livability

There is strong evidence that improvements to streetscape design increase physical activity, particularly when implemented as part of a multi-component intervention. Living in neighborhoods with greater street connectivity, more streetlights and bikeways, and related environmental characteristics is associated with higher levels of walking and lower rates of overweight and obesity. Moreover, connected sidewalks, street crossing safety features, and bicycle lanes can reduce injury risk for pedestrians and cyclists.

Invest resources in improving municipal parks/trails/school playgrounds and indoor recreational facilities to increase year round access to safe and affordable places for physical activity for residents of all ages.

Enhanced Places for Physical Activity

Enhancing access to places for physical activity involves changes to local environments (i.e., creating walking trails), building exercise facilities, providing access to existing nearby facilities, and reducing the cost of opportunities for physical activity. Moreover, increasing access in conjunction with efforts to address the quality, cleanliness, and potential safety and security of those facilities/sites over the long-term may be even more effective at increasing physical activity levels than increasing access alone.

VI. Recommendations for Action

SUPPORTIVE LIVING ENVIRONMENTS

Employ policy, systems, and environmental change strategies to improve the availability, accessibility, affordability of healthy foods in all neighborhoods.

Access to Healthy, Affordable Food Sources

The availability of healthy foods—in grocery stores and restaurants, in schools and on the job, at a street-corner stand and at a Saturday morning farmers’ market—is the hallmark of a thriving community that supports the health of its residents. Healthy people require healthy environments—healthy neighborhoods, schools, childcare centers, workplaces, and key community institutions. All these must be structured in ways that allow everyone to obtain healthy foods more easily and affordably.

Intentionally design neighborhoods with affordable public transportation systems that help neighbors connect to each other and to the services that they need.

Local Transportation Systems

Neighborhoods will be intentionally designed with affordable public transportation systems that help neighbors connect to each other and to the services that they need.

Better systems and health care and social services, revitalization efforts, enhanced educational programs, and programs that support social connectedness are all important to health outcomes. One infrastructure need associated with each of these health promoting activities is the need for local, affordable transportation services that make it possible to benefit from these services when they are provided.

VI. Recommendations for Action

ACCESS TO APPROPRIATE CARE

Strategically align and connect the health care delivery system with community and public health services to improve individual outcomes and overall neighborhood health through care coordination/case management in the elementary school environment.

Community Care Coordination

One of the biggest opportunities for improving health care and overall population health is improving the way we prevent and manage chronic illness, such as diabetes and asthma. Clinicians can offer evidence-based recommendations about how to stay healthy to individuals and families, but making changes in diet, exercise, and other health behaviors is often difficult without community support and resources. Moreover, the upstream factors that influence health status, such as low educational achievement and living in poverty, are often the root causes of lack of access to timely and appropriate health care. Community care coordination can link the medical home with community-based resources to address the social factors that contribute to our health status and to more comprehensively prevent adverse health outcomes.

Create systems to support timely and appropriate access to health services for the most vulnerable populations, such as low-income children or frail seniors, to reduce costs and improve the quality of care.

Eliminate Health Disparities

Experts agree that reducing costs while increasing quality is at the crux of America's health care challenge. A relatively small number of patients (5%) account for the bulk of healthcare spending. Patients who use the most health care services typically suffer from multiple chronic conditions, requiring frequent care provided by a number of different doctors. Many also have complicated social situations that directly impact their ability to get and stay well. Targeting the most vulnerable populations with intensive care management services will enable communities to achieve health equity and improve health outcomes by eliminating health disparities, which is defined as differences in length/quality of life and rates and severity of disease and disability because of social position, race/ethnicity, age, education, or other factors.

VI. Recommendations for Action

ACCESS TO APPROPRIATE CARE

Employ strategies that enhance the health care systems' ability to more effectively and efficiently provide services that treat the whole person, including aspects of an individual's psychological, physical, and social wellbeing.

Holistic Health Care

When health care services are fragmented, necessary care is often delayed. Other times, patients fail to get the care they need altogether. Often, this occurs when a patient needs behavioral health or other specialty services that fall outside the traditional scope of primary care services. Moreover, patients may seek care for conditions, like substance abuse and dental disease, in emergency settings, which by design are primarily based on a “treat and street” delivery model of care. To address this gap, the Health Resources and Services Administration’s National Quality Strategy recommends that communities enhance the coordination between primary care, behavioral health, and other specialty services to ensure that health systems treat the “whole person” and all of his or her health needs. Furthermore, urgent and emergency care settings can be enhanced to ensure patient linkages with medical homes and ongoing specialty services, such as substance abuse treatment. Obtain healthy foods more easily and affordably.

Enhance access to health insurance and to the supports needed to navigate this complex system.

Supports for Navigating Complex Systems

The health care and health insurance systems are not affordable to everyone, may be difficult to understand and are often hard to navigate. Improving access to affordable, high-quality and conveniently located preventive and medical services through health insurance will make people better off in the long run. However, research suggests that people also need to be provided supports to help them navigate and understand the complexities and nuances of obtaining, keeping and using insurance coverage to assure that they are receiving the right care, at the right time, in the right and most cost effective place.

VI. Recommendations for Action

SOCIAL CONNECTEDNESS AND NEIGHBORHOOD SAFETY

Create resident leadership training opportunities for youth and families to be engaged and empowered to lead/participate in efforts to improve neighborhood safety and overall quality of life.

Resident Engagement and Empowerment

More often than not, residents are asked to identify community concerns, but are not engaged in the solutions. Creating more opportunities for authentic resident engagement and empowerment, such as promoting neighborhood watch groups and supporting their efforts, can be an effective mechanism to build social connectedness, reduce crime, and improve perceptions of neighborhood safety. Moreover, some residents may benefit from tools and training opportunities for skill building to feel they are empowered to be effective resident leaders.

Invest resources in the development and coordination of a comprehensive youth empowerment initiative to ensure that Manchester's children and teens have the skills and services they need for success.

Youth Empowerment

Youth empowerment programs help prepare children and youth to be active members of their communities and society as a whole. Programs teach youth to work well with peers and can include job skill development and placement; mentoring; intensive case management; and writing and communication skills services. Youth empowerment programs can operate in a variety of settings including communities, schools, and within households. The majority of programs operate in more than one setting, which may be a key factor in their success, and are commonly implemented through youth councils, teen centers, community-based participatory research programs, and social action/advocacy groups.

Employ a community schools approach to establish school-based, neighborhood hubs or centers that provide programming/services and events aimed at increasing social capital, neighborhood connectedness, and community safety.

Schools as Neighborhood Hubs/Centers

A community school is both a place and a set of partnerships between the school and other community resources. Schools become centers of the community and are open to everyone – all day, every day, evenings and weekends. Using public schools as hubs, community schools bring together many partners to offer a range of supports and opportunities to children, youth, families, and the neighborhood-at-large.

VI. Recommendations for Action

HEALTHY BEHAVIORS

Establish a model for comprehensive school health education for middle school aged children that includes a focus on media literacy and incorporates health and physical education in afterschool and childcare settings.

Comprehensive Health Education

Developmentally, many unhealthy or risky behaviors begin at a middle school age with a surge in independence and an emerging sense of self. Health education provides students with opportunities to acquire the knowledge, attitudes, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes courses of study (curricula) for students in pre-K through grade 12 that address a variety of topics, such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. In addition to the school setting, opportunities for health and physical education should also be coordinated in afterschool programming and other childcare facilities.

Explore the use of technology as an innovative and effective way to deliver evidence-based information, strategies, and behavioral support, such as for tobacco cessation interventions.

Technology Use For Health Behavior Change

Technology-supported, multicomponent coaching or counseling interventions use technology to facilitate or mediate interactions between a coach or counselor and an individual or group, with a goal of influencing health behaviors or outcomes. Technology-supported components for health behavior change may include use of the following: computers (e.g., internet, CD-ROM, e-mail, kiosk, computer program), video conferencing, personal digital assistants, pagers, pedometers with computer interaction, and computerized telephone system interventions that target physical activity, nutrition, or weight.

Create a standardized set of indicators with a tracking system to provide a mechanism for monitoring infant and child health status and their connections to resources that support healthy childhood development.

Child Health Profiles and Tracking

Local efforts to monitor and track the health and wellbeing of children through community report cards demonstrate a vital interest on behalf of communities to understand how children are faring. More importantly, these profiles help communities develop strategic priorities for action that can improve children's health and can even be tracked at a neighborhood level. In addition to population data, systems can be established to track individual access to key programs and services to facilitate community care coordination and identify if more intensive family case management is needed.

VI. Recommendations for Action

HEALTHY BEHAVIORS

Design fitness and nutrition programs that are based on individually adapted health behavior change to teach the behavioral skills necessary for residents of all ages to incorporate physical activity and healthy eating into their daily routines.

Individually-Adapted Health Behavior Programs

Individually-adapted health behavior change (IAHBC) programs teach behavioral skills that can help participants incorporate physical activity into their daily routines. There is strong evidence that IAHBC programs increase physical activity and physical fitness in both children and adults. Additionally, programs that focus on goal-setting, self-monitoring, building social support, behavioral reinforcement, and structured problem solving have been shown to increase physical activity and physical fitness in a variety of settings, including worksites, schools, and communities. IAHBC programs in combination with the expanded use of community health workers may prove to be an effective mechanism for the delivery and/or recruitment efforts for these initiatives. Community health workers, sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. IAHBC programs should be culturally and linguistically appropriate.

Conduct family training sessions using family systems and cognitive behavioral approaches to increase resilience, reduce risk factors and improve family relationships, parenting skills and youth's social and life skills.

Family-focused health-related behavior change

One framework for examining health-related behavior change focuses on the family. The good influence of supportive family relationships is widely accepted in the scientific community.²⁵⁻²⁷ Family relationships have greater emotional intensity than do most other social relationships, and research suggests that there is a substantive, positive association between the specific bonds within families and chronic-disease management and outcomes.^{28,29}



VII. Creating a Strategy for Improvement

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COLLECTIVE IMPACT

Collective Impact occurs when organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success.³⁰

Collective Impact is a significant shift from the social sector’s current paradigm of “isolated impact,” because the underlying premise of Collective Impact is that no single organization can create large-scale, lasting social change alone.³¹ There is no “silver bullet” solution to systemic social problems, and these problems cannot be solved by simply scaling or replicating one organization or program.³¹

Isolated Impact vs. Collective Impact	
Isolated Impact	Collective Impact
<ul style="list-style-type: none"> • Funders select individual grantees that offer the most promising solutions. 	<ul style="list-style-type: none"> • Funders and implementers understand that social problems, and their solutions, arise from the interaction of many organizations within a larger system.
<ul style="list-style-type: none"> • Nonprofits work separately and compete to produce the greatest independent impact. 	<ul style="list-style-type: none"> • Progress depends on working toward the same goal and measuring the same things.
<ul style="list-style-type: none"> • Evaluation attempts to isolate a particular organization’s impact. 	<ul style="list-style-type: none"> • Large scale impact depends on increasing cross sector alignment and learning among many organizations.
<ul style="list-style-type: none"> • Large scale change is assumed to depend on scaling a single organization. 	<ul style="list-style-type: none"> • Corporate and government sectors are essential partners.
<ul style="list-style-type: none"> • Corporate and government sectors are often disconnected from the efforts of foundations and nonprofits. 	<ul style="list-style-type: none"> • Organizations actively coordinate their action and share lessons learned.

Source: Kania, J., Kramer, M. Collective Impact. Source: Kania, J., Kramer, M. Collective Impact. Stanford Social Innovation Review, 2011.

Research shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.³² A research initiative that helped to inform the development of collective impact is the Federal Reserve Bank of Boston’s Resurgent Cities Initiative.³³ Through this initiative, they identified 10 cities that had fared better than similar cities in terms of socioeconomic characteristics during the time period of 1960–1980 and then attempted to explore why these cities were different. They determined that these 10 cities had exercised many of the conditions of collective impact outlined on the following page.

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The Five Conditions of Collective Impact	
Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

PROCESS OF COLLECTIVE IMPACT IN MANCHESTER

The collective impact model should be utilized to determine the necessary elements for supporting the community's approach in implementing the recommendations within this document. In fact, the process to-date has encompassed the five components of the model to ensure an efficient and effective mechanism for creating the Neighborhood Health Improvement Strategy (NHIS). This included determining priority areas of concern to support the development of a common vision for neighborhood health, the identification of multi-sector, cross-cutting strategies, outreach to existing and new communication channels for the collection and dissemination of information, and a focus on intentional outcomes with technology that supports shared measurement.

1. BACKBONE ORGANIZATION:

Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies. The Manchester Health Department (MHD) formally established a Division of Neighborhood Health in 2007 to begin to conduct analysis of neighborhood level indicators and lead strategy implementation for reducing the upstream factors that are known to affect population health status, such as neighborhood deprivation/poverty or a lack of access to basic resources and services related to quality of life.

“Leaders of successful collective impact initiatives have embraced a new way of seeing, learning, and doing that marries emergent solutions with intentional outcomes”

John Kania, Embracing Emergence:
How Collective Impact Addressing Complexity, January 2013

VII. Creating a Strategy for Improvement

Strong leadership from multiple sectors is critical to ensuring that the implementation of the NHIS is successful. Collective impact requires collective action from all facets of community from the highest levels of City leadership to neighborhood residents. To build this capacity, MHD has established an anchor entity known as the NHIS Leadership Team that will direct NHIS implementation. This Team is currently comprised of the Mayor, Superintendent, Police Chief, Public Health Director, health care administrators, business leaders, social services executives, philanthropists, and neighborhood residents.

It will be important for the NHIS leadership to build on the following collaborative initiatives. Manchester Health Department has recently secured a large grant to establish a community schools approach in three elementary schools in the City to improve community safety by increasing neighborhood connectedness and social capital. Grant funding for this initiative is provided by the Robert Wood Johnson Foundation with matching funds from the New Hampshire Charitable Foundation, Granite United Way, Endowment for Health, and Cogswell Benevolent Trust. This funding source has enabled the MHD to build staff capacity that includes a full-time Coordinator for the Community Schools Project, a part-time Community Liaison to work directly with children and their families and other neighborhood residents, and a contract with The Carsey Institute to assist with data analysis and evaluation. The Carsey Institute is well known nationally for conducting policy research on vulnerable children, youth, and families and on sustainable community development. In addition, MHD employs a full-time Violence Prevention Coordinator to oversee the City's Weed & Seed Strategy, among other related initiatives, and a part-time Tobacco Treatment Specialist to prevent and reduce tobacco use, which is the leading cause of preventable disability and death. The Department also contracts with Makin' It Happen to create a continued community response around substance misuse.

2. COMMON AGENDA:

All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. In addition to developing an official framework for Neighborhood Health (see page 17), the NHIS Leadership Team has identified a common vision to guide the community's efforts.

VISION

Manchester will be a thriving "City of Neighborhoods" designed to (1) Support Opportunities for Educational Achievement and Economic Wellbeing; (2) Increase Access to Appropriate and Timely Care for both medical services and community-based resources; (3) Provide Supportive Living Environments, including both home and neighborhood; (4) Foster Social Connectedness and Safety; and (5) Promote Healthy Behaviors.

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The NHIS Leadership Team has also created a core set of Guiding Principles to inform the development and implementation of the recommendations within this document.

GUIDING PRINCIPLES

- Residents should be empowered to be part of the solution along with community partners, and both facets of community share the responsibility of neighborhood health improvement.
- True collaboration is practiced – with an emphasis on strategies aimed at systems and policy change, not individual agencies and/or programs.
- Data should be utilized for decision-making, including performance monitoring, quality improvement and shared accountability of population health outcomes.
- Scientifically-based/evidence-based models that are focused on the upstream factors that influence health and are intergenerational and culturally appropriate should serve as the foundation for strategy selection.
- Strategy implementation should strengthen available assets and leverage steward leadership (power) and long-term investing (money) through collective impact.
- Community intervention should teach and reinforce a “culture of learning” including lessons learned from philanthropy and the value of giving back.

3. MUTUALLY REINFORCING ACTIVITIES:

Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.³⁰ The NHIS recommendations are based on higher level policy, systems and environmental changes that are cross-cutting and multi-sectoral to foster collective action. The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action.³² Subsequently, an effective business plan for the implementation of NHIS recommendations should be created to garner strategic investments in strategies that synergistically combine for greater impact. The Priority Recommendations (listed on page 62) are intended to serve as a starting point for collective action.

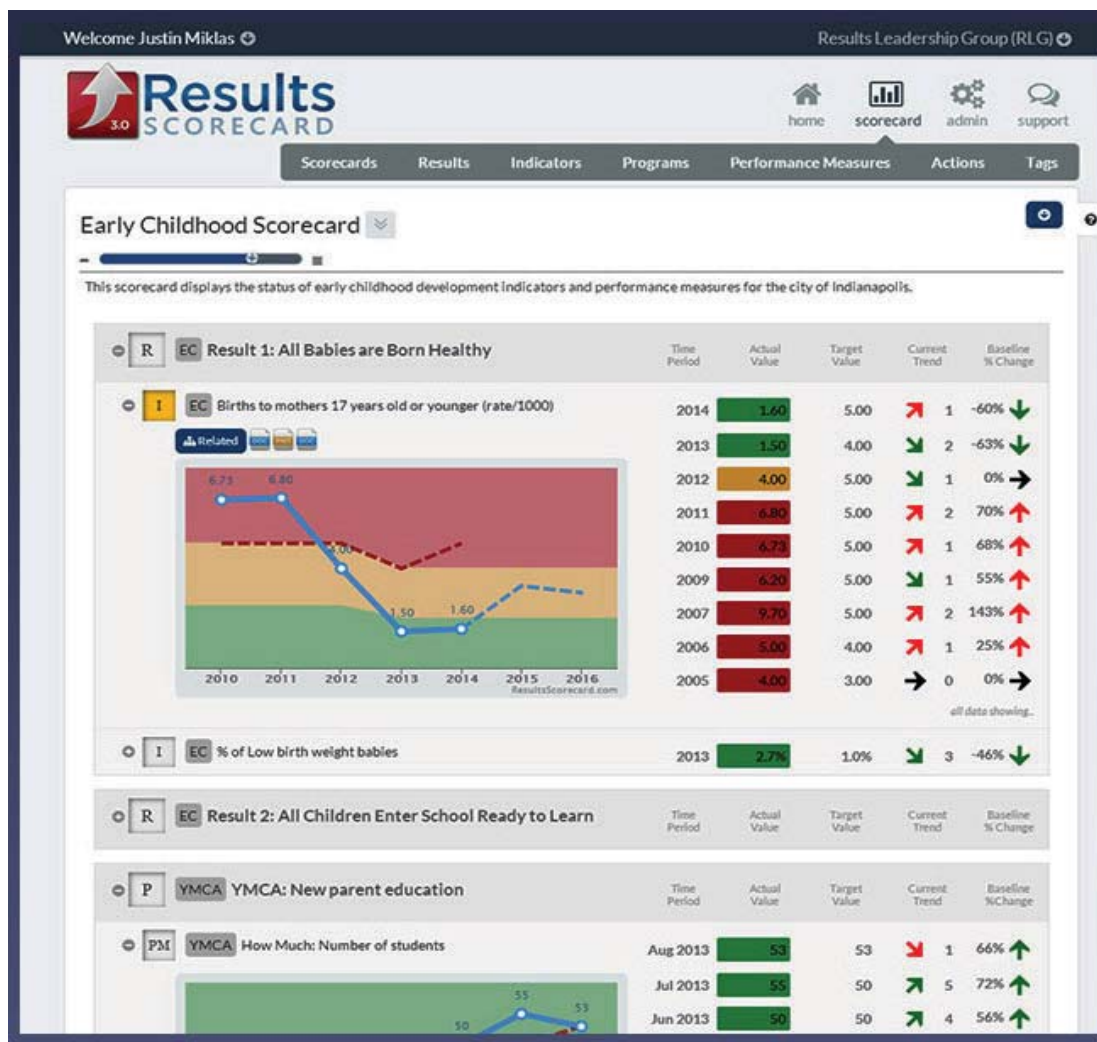
4. CONTINUOUS COMMUNICATION:

Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation.³⁰ To assist in facilitating continuous communication, MHD has been working closely with the City’s Information Systems Department and Eisenberg, Vital, and Ryze Advertising to develop a web platform to support NHIS communications. One goal of the web platform will be to serve as a planning and information tool for funders, community partners, and officials by assisting users to find gaps and needs within the city for investment, as well as opportunities for networking to support NHIS implementation. Additionally, many community coalitions and committees are already established and align nicely with the thematic areas outlined in the framework for Neighborhood Health. This robust infrastructure of working groups can serve as a key mechanism for continuous communication.

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5. SHARED MEASUREMENT:

Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures.³⁰ Through the funding provided for the Manchester Community Schools Project, MHD has purchased a dynamic new decision-making software tool for results-based collaborations that links stakeholders through an interactive web interface. Known as Promise Scorecard, the tool enables community's to create a dashboard that monitors progress in achieving intended outcomes for both population data at a city/neighborhood level and program-level data for performance accountability of mutually-reinforcing activities.³⁴ This tool is currently being utilized by all of the communities who received Promise Neighborhoods funding nationally.



VII. Creating a Strategy for Improvement

PRIORITY RECOMMENDATIONS

There are many worthwhile recommendations that were generated from the NHIS process. However, it would be highly challenging and resource intensive to attempt to implement ALL of these recommendations simultaneously. To establish a solid foundation in which to grow, the NHIS Leadership Team has identified the following as priority recommendations for action in launching the NHIS.

- Create resident leadership training opportunities for youth and families to be engaged and empowered to lead/participate in efforts to improve neighborhood safety and overall quality of life.
- Establish a coalition of key stakeholders to conduct an asset mapping and gap analysis of local resources essential for supporting economic self-sufficiency on the individual level as well as community economic development.
- Create a coordinated and sustainable “Healthy Homes” system comprised of multi-disciplinary partnerships and approaches that effectively and efficiently address living conditions which impact resident health, safety and wellbeing.
- Ensure that all children and families have the early developmental support that they need for a healthy start, including intensive programs that promote healthy child development, school readiness, and parental skill development.
- Strategically align and connect the health care delivery system with community and public health services to improve individual outcomes and overall neighborhood health through care coordination/case management in the elementary school environment.
- Strengthen the focus on behavioral and mental health care by co-locating providers in the elementary school environment.
- Provide intensive community services and programming for at-risk, elementary-aged youth and their family to prevent truancy and promote attendance.

The priority recommendations were selected based on their ability to synergistically combine for greater impact. Overall, the NHIS Leadership Team believes that the Manchester community should first invest in building systems and mechanisms for empowerment aimed at improving family stability for younger children. Therefore, the beginning work of the NHIS has also been further prioritized for early childhood and elementary school aged children.

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NEXT STEPS

BUSINESS PLAN FOR PRIORITY RECOMMENDATIONS BASED ON THE PRACTICES OF CATALYTIC PHILANTHROPY

As part of the movement to collective impact, funding practices have been redefined to include the concept of Catalytic Philanthropy.³¹ Catalytic Philanthropy is a shift from conventional funding strategies for grant-making of programs/services and capacity building of individual organizations to include the funder as a core partner in the development, implementation, and evaluation of community initiatives by providing both human and fiscal resources. In other words, catalytic philanthropists take responsibility for achieving results by going beyond thinking about which organizations to support, to thinking about how to solve a social problem.³¹

Types of Philanthropy

	CONVENTIONAL PHILANTHROPY	VENTURE PHILANTHROPY	CATALYTIC PHILANTHROPY
What is the key question?	Which organizations should I support and how much money should I give them?	How can I help to scale up effective nonprofit organizations?	How can I catalyze a campaign that achieves measurable impact?
Who is responsible?	Nonprofits	Nonprofits	Funders
What gets funded?	Individual nonprofits	Capacity building at individual nonprofits	Multi-sector campaigns
What tools are used?	Nonprofit programs	Nonprofit programs	All possible tools and donor resources
How is information used?	To compare grant requests	To increase organizational effectiveness	To support the campaign and motivate change

Source: Kramer, M. *Catalytic Philanthropy*. Stanford Social Innovation Review, 2009.

The successful implementation of the Priority Recommendations requires the creation of a written business plan that promotes collective action through a deeper-level of investment, such as the practices of catalytic philanthropy, to support a large-scale, multi-sector initiative. The business plan should incorporate ongoing support for existing initiatives that serve as a critical foundation for the priority recommendations, such as the Manchester Community Schools Project and Promise Scorecard. Additionally, the business plan should consider the potential phasing of funding to support the staggered implementation of the Priority Recommendations over several years; including ways to diversify funds to support blended resourcing for the long-term sustainability of systems changes, as well as for promoting shared accountability. Moreover, the business plan should identify innovative multi-sector partnerships and should look to leverage public-private opportunities for collaboration and resource development.

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MOBILIZE THE COMMUNITY'S COLLECTIVE LEADERSHIP

It is not possible for a single organization or individual to achieve the large scale impact necessary to improve overall neighborhood health. The success of this endeavor hinges on the ability of the community to embrace a shared vision and common agenda, and capitalize on expertise by ensuring that it is “invested” effectively and efficiently. The NHIS Leadership Team challenges YOU to find a way to utilize your strengths – both personally and organizationally – to support the implementation of the NHIS. We must all share in the pinnacle responsibility of caring for our community’s children, as the future growth and vitality of Manchester relies on it.

“My Manchester – Our City, Our Future”

For Manchester residents who want a better life for themselves and their children, neighborhood-based connections can provide opportunities for becoming more involved in the local community, taking advantage of available resources for personal growth.



One tool that has helped residents in other communities connect with each other, as well as to existing resources and services, is a community-focused website. Thus, in an effort to develop a method for on-going, updated, and continuous communication for Manchester neighborhoods, the City of Manchester Health Department, in partnership with the Community Health Institute and Eisenberg, Vital & Ryze Advertising, is working hard to design and develop a website for the City’s Neighborhood Health Improvement Strategy.

The “MY MANCHESTER” website will provide a mechanism for connecting residents, community partners and city leaders to neighborhood-related projects, programs and resources that aim to improve overall health and quality of life within the city.

The goals of the web site are to:

1. Promote neighborhood pride and community involvement among residents. The website will be a source of information for residents helping them to connect to each other, to activities, services and resources within their own neighborhoods. The interactive component of the website will help residents to have a voice in developing local community solutions to improve the health and well-being of their neighborhoods.
2. Serve as a planning and information tool for funders and officials. The back end of the website will help funders invest in projects that will make a difference. It will be designed to assist these credentialed users find gaps and needs within the city that they can help improve.

Please contact the Manchester Health Department about ways you or your organization can contribute to the overall strategy and design of the website.

Endnotes

1. United States Department of Commerce. American Community Survey United States Census Bureau 2008-2012 [cited 2013]. Available from: <https://www.census.gov/acs/www/>.
2. Manchester School District. Enrollment Statistics Data SY 2012-2013.
3. Wauchope B, Ward, Sally. Mapping Food Insecurity and Food Sources in New Hampshire Cities and Towns Carsey Institute and Childrens Alliance of New Hampshire, 2012.
4. Division of Vital Records Administration. Concord, New Hampshire: New Hampshire Department of State; [2013]. Available from: <http://www.sos.nh.gov/vitalrecords/ELIGIBILITY.html>.
5. New Hampshire Department of Education. Youth Risk Behavior Data. Available from: <http://www.education.nh.gov/education/doe/organization/instruction/HealthHIVAIDS/youthrisk.htm>.
6. United States Bureau of Justice Statistics. Office of Justice Programs.[2013]. Available from: <http://www.bjs.gov/>.
7. NH HealthWRQS [Internet]. NH Institute for Health Policy and Practice. 2005-2007. Available from: <http://nhhealthwrqs.org/>.
8. Committee on Using Performance Monitoring to Improve Community Health. Improving Health in the Community. Durch JS, Bailey LA, Stoto MA, editors. Washington D.C.: Institute of Medicine, National Academy Press; 1997.
9. The Robert Wood Johnson Foundation. Where We Live Matters for Our Health: Neighborhoods and Health. Princeton, NJ: Commission to Build a Healthier America, 2008. Report No.
10. Fine A, Kotelchuck,M., Adess, N.,Pies C. A New Agenda for MCH Policy and Programs: Integrating a Life Course Perspective. Martinez, CA.; Contra Costa Health Services, 2009.
11. Caceres I. and Cohen B. Inequalities in Infant Mortality: The Interaction of Race and Socioeconomic Status St. Louis, MO: 2010 June 6 – June 10. Report No.
12. Callahan K., Scaramella L., Laird R., Sohr-Preston S. Neighborhood Disadvantage as a Moderator of the Association of Harsh Parenting and Toddler-Aged Children’s Internalizing and Externalizing Problems Journal of Family Psychology. 2011;25(1):68.
13. California Newsreel. Unnatural Causes Discussion Guide 2008 [cited 2014]. Available from: www.unnaturalcauses.org.
14. Rolland D. Disparities in the District: Poverty Is Major Cause of Social Problems in the District of Columbia. DC Fiscal Policy Institute, 2006 November 2. Report No.
15. Wodtkea GT HD, Elwert F. Neighborhood Effects in Temporal Perspective: The Impact of Long-Term Exposure to Concentrated Disadvantage on High School Graduation. American Sociological Review. 2011;vol. 76 (no. 5):713-36.
16. Diez-Roux AV, Merkin S, Arnett D, Massing M. Neighborhood of Residence and Incidence of Coronary Heart Disease. New England Journal of Medicine. 2001;345 (2):7.
17. Puntenney D, Zappia B. Grassroots Activism and Community Health Improvement. [Draft manuscript]. In press 2010.
18. The Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. The County Health Rankings and Roadmaps [cited 2013]. Available from: <http://www.countyhealthrankings.org/>.
19. Booza J.C., Cutsinger J., Galster G. Where Did They go? The Decline of Middle-Income Neighborhoods in Metropolitan America Washington, D.C: The Brookings Institution, 2006.
20. Mattingly M, Carson J, Schaefer A. National Child Poverty Rate Stagnates at 22.6%: New Hampshire Child Poverty Jumps 30% Since 2011. University of New Hampshire: Carsey Institute, 2013.
21. New Hampshire Department of Health and Human Services Division of Public Health. New Hampshire Environmental Public Health Tracking Concord [2013]. Available from: <https://www.nh.gov/epht/health/childhood-lead-poisoning-data.htm>.

Endnotes

22. New Hampshire Department of Health and Human Services. Office of Medicaid Business and Policy Concord: New Hampshire Department of Health and Human Services [2013]. Available from: <http://www.dhhs.state.nh.us/ombp/>.
23. Manchester School Nurse Data. Manchester, New Hampshire: Manchester Health Department 2012.
24. New Hampshire Division of Public Health. Concord, New Hampshire: New Hampshire Department of Health and Human Services, 2011.
25. Broadhead WE, Kaplan BH, James SA, Wagner EH, Schoenbach VJ, Grimson R, et al. The epidemiologic evidence for a relationship between social support and health. *Am J Epidemiol*. 1983;117(5):521-37.
26. House J, Landis, K., Umberson, D. Social Relationships and Health. *Science* 1988;241(4865):540-5.
27. Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The Relationship Between Social Support and Physiological Processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health. *Psychological Bulletin*,. 1996.
28. Institute of Medicine: Committee on Health and Behavior: Research Practice and Policy. *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences*. Washington D.C.2001.
29. Primomo J, Bernice CY, Woods NF. Social Support for Women During Chronic Illness: The Relationship Among Sources and Types to Adjustment. *Research in Nursing & Health*. 1990;13(3):153-61.
30. Kania J, Kramer, M. Embracing Emergence: How Collective Impact Addressing Complexity. *Stanford Social Innovation Review*,2013.
31. Kramer M. Catalytic Philanthropy. *Stanford Social Innovation Review*. 2009.
32. Kania J, Kramer, M. . Collective Impact. *Stanford Social Innovation Review*: 2011.
33. Federal Reserve Bank of Boston. *Lessons From Resurgent Cities*. Boston: 2009.
34. Results Leadership Group. *Promise Scorecard* [cited 2014]. Available from: <http://resultsleadership.org/promise-scorecard/>.

