Southern New Hampshire Health System

2021 Community Health Needs Assessment and Implementation Strategy

INTRODUCTION

Southern New Hampshire Health System's (SNHHS) mission is to improve, maintain, and preserve the overall health and well-being of individuals living in the greater Nashua area by providing information, education, and access to exceptional health and medical care services. In order to better serve our community, we collaborated with the City of Nashua and other area health partners to conduct this Community Health Needs Assessment ("CHNA"). Many of the references in this report are from the 2020 *Interactive Data Dashboard* ("the Assessment") published January 2021 by the City of Nashua Division of Public Health & Community Services as its Community Health Assessment. Southern New Hampshire Health System leaders worked together to develop the implementation strategy included in this report to best address the needs of the community based on the results of the data dashboard assessment.

This is our fourth published CHNA. The first was published in 2012 and every three years since. All are available to the public on the Southern New Hampshire Health System website snhhealth.org/community-health. To date, we have not received any comments regarding past CHNA.

COMMUNITY SERVED

SNHHS' community is defined by our service area which consists of nineteen New Hampshire and four Massachusetts towns. The service area is divided into a Primary Service Area (PSA) of thirteen New Hampshire towns (Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Mason, Merrimack, Milford, Mont Vernon, Nashua, Pelham and Wilton), a Secondary Service Area (SSA) of six New Hampshire towns (Derry, Londonderry, New Boston, New Ipswich, Salem and Windham) and a Massachusetts Service Area (MSA) of four neighboring Massachusetts towns (Dunstable, Pepperell, Townsend and Tyngsboro). SNHHS's PSA and SSA include all towns designated as part of the greater Nashua region by the New Hampshire Office of State Planning, the New Hampshire Department of Health and Human Services, and the Nashua Regional Planning Commission. The MSA towns were designated because of patient volume from those towns to Southern New Hampshire Medical Center.

The Assessment refers to the Greater Nashua Public Health Region which includes Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Mason, Merrimack, Milford, Mont Vernon, Nashua, Pelham, and Wilton, towns that are included in SNHHS's PSA and reflect the communities that make up the PSA, SSA and MSA.

ASSESSMENT PROCESS

The primary source of our CHNA is the 2020 *Interactive Data Dashboard* ("the Assessment") published January 2021 by the City of Nashua Division of Public Health & Community Services (DPHCS) as its Community Health Assessment. As the chief public health strategist for the Greater Nashua Region, and the first accredited health department in New Hampshire, the Division opted to utilize an interactive web-based application to share information about the health status of the community. This collaborative platform provides data from community level to national data. Tables and figures can be customized by age, gender, race/ethnicity, geographic location, etc. to explore different trends and patterns. It is expected to serve as a powerful launch point for data-driven conversations. Information can be found at: https://insight.livestories.com/s/v2/community-health-assessment-home-page/493790d2-caed-4265-9706-1d00800fdd9e

DPHCS research included a community based research project to assess the extent to which substance use occurs in Nashua to estimate the prevalence and define the degree of substance use disorder in the Greater Nashua Public Health Region. Data for this research was collected in 2019 and analyzed in 2020 and included both an online survey (222 participants) and in-person interviews (50 participants) with people that were actively using, in recovery, or had never used substances.

Other resources used in the preparation of the Assessment include Emergency Department and Inpatient Hospitalizations Database, New Hampshire Behavioral Risk Factor Surveillance System, New Hampshire Youth Risk Behavioral System, New Hampshire Environmental Public Health Tracking Program/Environmental Health Data Integration Network, NH Trauma and Emergency Medical Services Information Systems, data from the U.S. Census Bureau, 500 Cities' data on Nashua's most vulnerable Census Tracts and additional secondary data sources. The DPHCS Health Assessment Committee was comprised of a team of staff members from each department within the division. Their duties were to compile data for the needs assessment and work with the broader community to collect secondary data sources. The Community Health Assesment Committee also worked with the Public Health Advisory Council (PHAC) who, in addition to lending their expertise, reviewed the collected data, were advocates for the process, identified resources, and helped disseminate the information. PHAC members include:

Kimberly	Adie	YMCA
Mike	Apfelberg	United Way of Greater Nashua

Bobbie	Bagley	Nashua Division for Public Health
David	Bailey	Nashua Police Department
Ren	Beaudoin	Nashua Environmental Health Dept.
Kimberly	Bernard	Nashua Division for Public Health
Michael	Blau	Gateways Community Services
Lynn	Boyer	YMCA
Linda	Brodeur	Bishop Guertin High School
Robert	Cioppa	Nashua School District
Angela	Consentino	Nashua Division for Public Health
Sheila	Considine Sweeny	Greater Nashua Mental Health Center
Patricia	Crooker	Nashua Division for Public Health
Sandra	DeLosa	Nashua Welfare Department
Maura	Fitzpatrick	St. Gianna's Place
Kevin	Flynn	St. Joseph Healthcare
Jessica	Gorham	Greater Nashua Food Council
Betsy	Houde	Southern New Hampshire Health
Justin	Kates	Nashua Office of Emergency Services
Mike	LaChance	YMCA
Wendy	LeBlanc	Southern NH Aids Task Force
Bob	Mack	Nashua Welfare Department
Sarah	Marchant	Nashua Div. Community Development
Mark	McLaughlin	Merrimack School District
Jay	Minkarah	Nashua Regional Planning Commission
Justin	Monroe	Grow Nashua
Kurt	Norris	Greater Nashua Boys and Girls Club
Michael	Reinke	Nashua Soup Kitchen and Shelter
Denise	Roy	Merrimack Police Department
Anita	Rozeff	Lamprey Health Care
Pam	Small	Family Promise
Candice	Sousa	Dartmouth-Hitchcock
Jon	Spira-Savett	Nashua Interfaith Council
Julie	Stone	Home Health and Hospice
Lisa	Vasquez	Nashua Division for Public Health
Nicole	Viau	Nashua Division for Public Health
Greg	White	Lamprey Health Care
Cynthia	Whittaker	Greater Nashua Mental Health Center
Paula	Williams	Rivier University
Stephanie	Wolf-Rosenblum	Nashua Board of Health

COMMUNITY PARTNERS

This Assessment was conducted by the City of Nashua Division of Public Health & Community Services in collaboration with upwards of thirty local partners representing health providers, schools, police and fire departments and nonprofit organizations.

Partners included:

- Bishop Guertin High School
- Boys & Girls Club of Greater Nashua
- Dartmouth Hitchcock – Nashua
- Family Promise of Greater Nashua
- Gateways
- Gr. Nashua Chamber of Commerce
- Greater Nashua Food Council
- Greater Nashua Mental Health Center
- Grow Nashua
- Home Health and Hospice Care
- Lamprey Health Care
- Merrimack Fire Department
- Merrimack Police Department
- Merrimack School District
- Milford Ambulance
- Nashua Office of Emergency Mgmt.
- Nashua Police Department
- Nashua Reg. Planning Commission
- Nashua School District
- Nashua Soup Kitchen and Shelter
- Nashua Community Development
- Partnership for Successful Living
- Rivier University
- Southern New Hampshire Health
- St. Gianna's Place
- St. Joseph Hospital
- Temple Beth Abraham
- United Way of Greater Nashua
- YMCA of Greater Nashua
- The Youth Council

COMMUNITY HEALTH NEEDS

An analysis of the data collected during the Assessment resulted in several health needs emerging as priorities, including behavioral health and substance misuse, weight management and nutrition, and access to healthcare. The new interactive data dashboard format updates data in real time from local and national sources, precluding the publication of a comprehensive report. Hence, SNHHS reviewed the data points identified and prioritized needs based on alignment with the mission of SNHHS as well as the ability to impact those needs.

Key areas of impact include:

- ● priority and ability to impact
- ● indirect ability to impact
- ● minimal ability to impact

NEED AREA	IMPACT	NEED AREA	IMPACT
Behavioral Health	● (green)	Chronic Disease and Cancer	● (green)
Weight, Nutrition & Fitness	● (green)	Communicable Disease	● (yellow)
Access to Healthcare	● (green)	Emergency Preparedness	● (yellow)
Healthy Moms and Babies	● (green)	Social Determinants of Health	● (yellow)
Environmental Health	● (red)	Safety	● (red)

AREA RESOURCES TO ADDRESS COMMUNITY HEALTH NEEDS

The greater Nashua community has many health care resources available to address health care needs. These include Southern New Hampshire Health System, Lamprey Health Care, St. Joseph Healthcare, Greater Nashua Mental Health Center, Dartmouth-Hitchcock Nashua, Harbor Care, Greater Nashua Dental Connection, as well as other independent providers, service providers, home care agencies, long-term care providers, end-of-life care providers, senior centers and pharmacies.

In addition, we work closely with several non-profit organizations to improve the health and well-being of our community including United Way, Home Health & Hospice, YMCA, Front Door Agency, Bridges, Nashua Police Athletic League, Breathe NH, Granite State Fit Kids, Girls on the Run, Grow Nashua, Great American Downtown Farmers Market, Nashua Soup Kitchen and Shelter, Greater Nashua Food Council, Nashua Prevention Coalition, The Youth Council, MyTurn, Veterans Count, Nashua Senior Activity Center and Fitness University.

IMPLEMENTATION STRATEGY

Southern New Hampshire Health System has developed its implementation plan to address the health care needs of the City of Nashua and its surrounding communities. This implementation strategy can be found in Exhibit 1 of this CHNA.

The contents of this CHNA will be posted on the SNHHS web site and are available upon request. The CHNA will also be submitted as part of the Southern NH Medical Center 990 tax return.

southern new hampshire health
WE ARE SOLUTIONHEALTH

Exhibit 1

Implementation Strategy FY2021

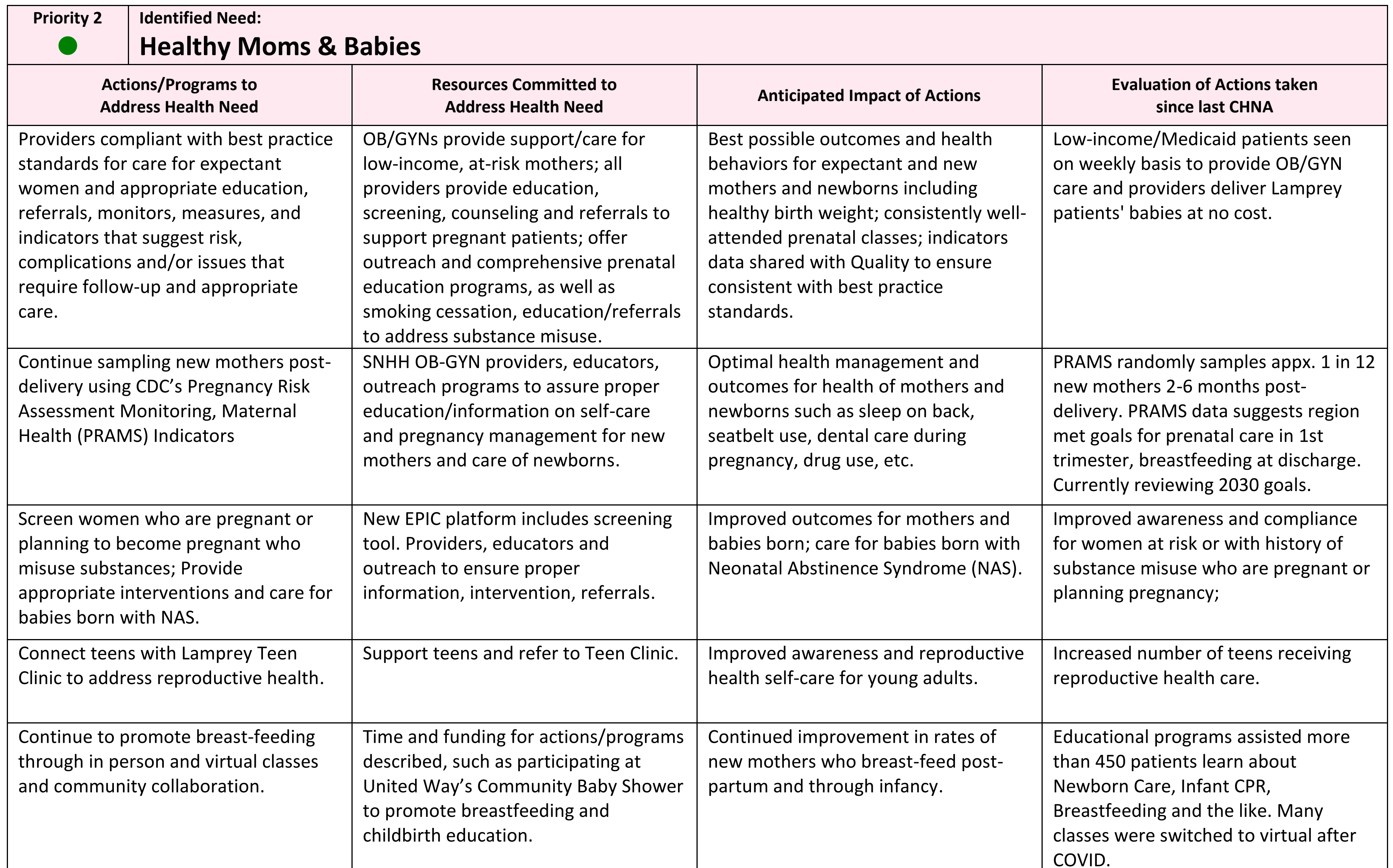
Priority 1	Identified Need: Behavioral Health, Mental Health, Substance Misuse, and Suicide Prevention		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Offer Inpatient Behavioral Health Unit (18 beds) for adult men and women	Requires 25 staff and 3.8 provider FTE's.	Enough capacity to support patients in need of care.	FY 2020: 416 patients benefited from 514 encounters with an average length of stay of 8.57 days
Offer Partial Hospitalization Program (PHP) 5 days/week	Requires staffing of 4.35 FTE's.	Enough capacity to support patients in need of care.	FY 2020: 423 patients benefited from 2,641 visits; Exploring expansion to include co-occurring disorders.
Offer Intensive Outpatient Treatment Program (IOP) for substance use disorders 4 evenings per week	Requires staffing of 2 FTE's.	Enough capacity to support patients in need of care.	FY 2020: 91 patients benefited from 972 visits
ED Annex for psychiatric patients offering a safe, quiet place to be assessed and to await appropriate disposition.	Requires staffing for patient care	Care provided in most appropriate setting.	FY2020: 479 patients benefited from 594 encounters. Average length of stay was 2.48 days
Provide consults through Emergency Department's Acute Community Crisis Evaluation Service System (ACCESS).	Requires staffing of 7.85 FTE's.	Consults available 24/7 for patients in need.	FY2020: Provided 2,037 consults for behavioral health needs
Continue Medication Assisted Treatment program launched in 2020 to augment treatment for substance use disorder.	22 providers have been trained in this service; 1 full time provider staffs our MAT clinic	Upwards of 2400 visits per year	**New program in 2020**
Continue operating the new Doorway program as resource for those seeking treatment for substance use disorder (SUD).	Services launched in May 2020; average of 17 people/week seeking support plus family members requiring assistance on behalf of their loved one	> 20 people per week seeking help	**New program in 2020**
Optimize capacity of new EPIC platform launched 12/2020 to screen all patients for behavioral health difficulties	Workflows need to be adopted once staff have fully embraced EPIC's utilization	Improved integration and coordination on behalf of pediatric and adult patients	**New resource in 2020**

Priority 1	Identified Need: **Behavioral Health, Mental Health, Substance Misuse, and Suicide Prevention**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Collaborated with 30 community partners as part of the DSRIP 1115 Waiver to improve access to behavioral health services in the greater Nashua Community.	Funded FTE's and non-funded gifts in kind for personnel resources such as legal, accounting, Information Technology, and management services to transform the delivery of behavioral health services.	Increased access to continuum of care and treatment options for behavioral health.	Reduction of overdoses and deaths related to behavioral health; improved ability for patients to return to their communities post-hospital; increased collaboration with treatment providers and focus on patient centered care.
Continue to provide clinical services through our certified Level III Patient Centered Medical Home in all locations. Continue to work closely with multiple groups to bring more professionals to the area to strengthen the behavioral health workforce.	Several medical and clinical providers offer treatment and collaborate with internal and external stakeholders. Leadership positions to assist with program development and strategic planning on a local, regional and statewide level.	Improved integration and coordination on behalf of patients at risk for or struggling with behavioral health issues	More than 1300 unique patients received integrated care. New bariatric program will provide behavioral health assessments and support groups.
Ongoing participation in Mayor's Opioid Task Force	SNHH leadership participation since Task Force was formed and continues currently.	Offers strategic and practical support of initiatives focused on substance use disorder.	Increased collaboration among community partners, opportunity to raise awareness of The Doorway.
Continue collaboration with Nashua Prevention Coalition to build awareness of risks/prevention/ early treatment of behavioral health issues for youth in grades 6-12.	Senior Leadership participation since Coalition was formed and continues currently.	Offers strategic and practical support of community based initiatives focused on substance use disorder.	Increased community collaboration in multiple sectors including schools, law enforcement, youth, parents, civic organizations, faith, business, government, and media.
Support Public Health Department's efforts to screen patients for Adverse Childhood Experiences (ACES) and connect to support to reduce likelihood of long term consequences.	Continue to build referral supports for patients needing extra help.	Children and adults will be connected to resources to help reduce health impact of toxic stress	**New focus in 2020**
Explore support of school-age programming started by The Youth Council's Project Impact to enhance "resilience training".	Staffing to review opportunities for engagement, outcomes of pilot initiative.	Improve coping skills, self-esteem, relationships to mitigate risk of substance misuse and importance of healthy lifestyle management.	Middle School Project funded through Integrated Delivery Network

Priority 1 ●	Identified Need: **Obesity, Weight Management, Physical Activity, and Nutrition**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Record weights and BMI % in pediatric practices; Follow ED protocol to records weight on all patients <18yo.	Patient Center Medical Home actively tracking and outreaching to patient population.	Monitoring and awareness; referral to Prescribe the Y for children with concerns re: BMI.	Care Management protocols followed
Optimize capacity of new EPIC platform to screen all patients for food insecurity.	Workflows need to be adopted once staff have fully embraced EPIC's utilization.	Improved integration/ coordination for pediatric and adult patients struggling with food insecurity.	**New Platform in 2020**
Collaborate with YMCA for programming with new Weight Management program.	Staff time to develop new program components, ongoing communication.	Increased self-esteem, healthy lifestyle, supportive peer group, offers healthy "second home" for patients struggling with isolation due to weight.	**New Program in 2020**
Collaborate with Greater Nashua Food Council and its members to increase access to healthy food.	Senior Leadership participation since Council was formed and continues currently. Sponsorship of GNFC activities.	Increased knowledge around gaps in food access and strategies to make a meaningful difference.	Sponsored 2500 insulated tote bags for those riding city bus to grocery store. Supported Food Council phone app showing pantry and resource locations.
Continue sponsorship of community partner programs focused on nutrition, physical fitness, weight management.	Partners include YMCA, Girls on the Run, Granite State Fit Kids for annual sponsorship contributions of ~$12,000.	Increased education, awareness, and opportunities to encourage individuals to adapt healthy lifestyles.	Funded/referred to "Prescribe the Y"; promoted programs like Girls on the Run, Fitness U, Granite State Fit Kids.

Priority 1 ●	Identified Need: **Access to Healthcare, Primary and Dental Care, Medicaid, and Health Insurance Marketplace**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Offer Immediate Care locations enabling care for many health issues that don't require Emergency Department level of care.	Programs and staffing located at our West Campus, South Nashua, Hudson and Pelham locations.	Over 18,000 visits so far during FY21 across our four locations.	Analysis of FY20 utilization indicated these four locations provide best use of our staff resources. Two other locations repurposed.
Provide staff to help with applications for Medicaid and financial assistance, participation in Exchange and premium assistance programs.	5-6 FTE's committed to helping patients complete applications.	Self-Pay <3.0 % of revenue	Successfully assisted uninsured patients with obtaining Medicaid and financial assistance resulting in Self Pay patients of 2.7% in FY20.

Priority 1	Identified Need: **Access to Healthcare, Primary and Dental Care, Medicaid, and Health Insurance Marketplace**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Massachusetts General Hospital (MGH) partnership provides local access to over 35 Boston area specialists.	Funding of Professional Services Agreement with MGH.	Local access to services that patients would otherwise need to travel for.	Current specialties include vascular, gyn oncology, breast surgery, plastics, MGH for children, thoracic.
Continue to offer Interpreter Services Program	Utilizes 6.33 FTEs and invests $766k in Interpreter Services Program to assist patients with their care.	Improved responsiveness and appropriate care delivery to non-English speaking patients	Continue to meet multicultural needs of our patients.
Continue OB/GYN hospitalists and residency program	Unfunded program costs of $1,000,000.	Expands access to Women's Health in collaboration with Lamprey	Secured a Tufts residency program for OB/GYN to augment current offerings.
Continue focus on patient-centered care	All physician practices are NCQA Certified Patient Centered Medical Homes; Participating in Medicare ACO.	Improved ability to meet acute and chronic health care management needs of Foundation patients.	Achieved recertification as PCMH in 12/2020.
Emergency Department works with Dental Connection to streamline clinic referrals for patients that present to ED with toothaches and infections.	Provide financial support to Dental Connection which offers low cost dental care to low income Nashua area residents.	Assist Patients with getting their dental care in the correct care setting.	Continue collaboration, provided board leadership.
Launching Call Center model to ensure patients are matched with best provider fit and given a timely appointment	Staff resources for planning and development, preparing to launch summer 2021.	Patients will be matched with provider that fits their needs, toward building long term trusting relationship.	**New service in 2021**
Continued sponsorship and support for Front Door Agency initiatives	$5,000 annual sponsorship	Resources, education, support for individuals and families coping with crisis and homelessness	Sustaining partner for the past 3 years
Continue collaboration with Bridges to support patients experiencing domestic violence	Ongoing collaboration with Emergency Department, board members and $5,000 annual sponsorship.	Patients experiencing domestic violence will be connected to services and supports to help keep them safe.	Sponsored Bridges’ Children’s Room for safe play while mother is interviewed.
Enhance community collaboration to increase the number of people receiving preventive care each year	Senior leadership participation on Public Health Advisory Council, sponsorship of local initiatives	Increase in attending annual physicals and other recommended screenings and preventive health measures (immunizations)	**Exploring new options with collaborative partners**



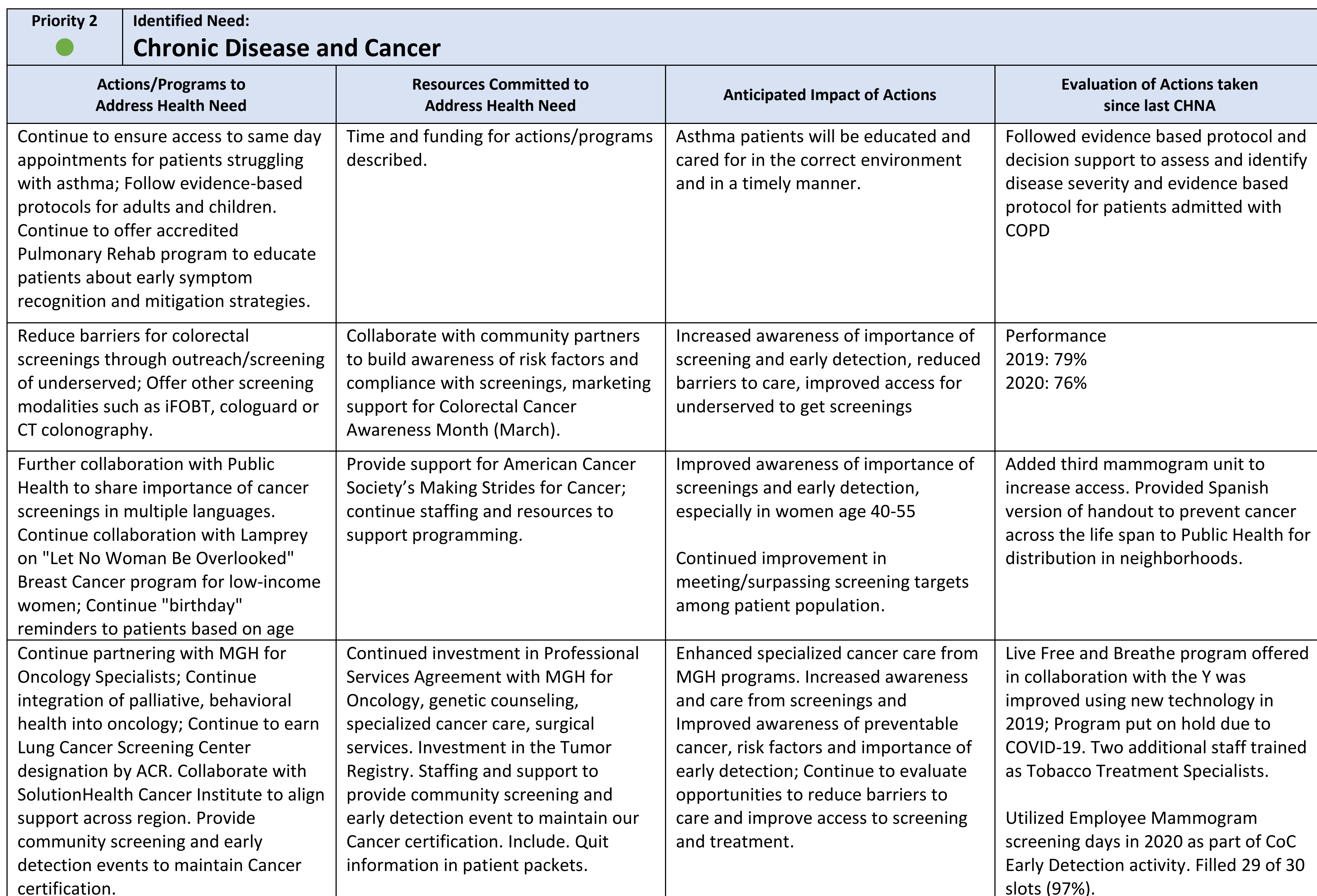
Priority 2 | **Identified Need:**

Healthy Moms & Babies

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
Providers compliant with best practice standards for care for expectant women and appropriate education, referrals, monitors, measures, and indicators that suggest risk, complications and/or issues that require follow-up and appropriate care.	OB/GYNs provide support/care for low-income, at-risk mothers; all providers provide education, screening, counseling and referrals to support pregnant patients; offer outreach and comprehensive prenatal education programs, as well as smoking cessation, education/referrals to address substance misuse.	Best possible outcomes and health behaviors for expectant and new mothers and newborns including healthy birth weight; consistently well-attended prenatal classes; indicators data shared with Quality to ensure consistent with best practice standards.	Low-income/Medicaid patients seen on weekly basis to provide OB/GYN care and providers deliver Lamprey patients' babies at no cost.
Continue sampling new mothers post-delivery using CDC's Pregnancy Risk Assessment Monitoring, Maternal Health (PRAMS) Indicators	SNHH OB-GYN providers, educators, outreach programs to assure proper education/information on self-care and pregnancy management for new mothers and care of newborns.	Optimal health management and outcomes for health of mothers and newborns such as sleep on back, seatbelt use, dental care during pregnancy, drug use, etc.	PRAMS randomly samples appx. 1 in 12 new mothers 2-6 months post-delivery. PRAMS data suggests region met goals for prenatal care in 1st trimester, breastfeeding at discharge. Currently reviewing 2030 goals.
Screen women who are pregnant or planning to become pregnant who misuse substances; Provide appropriate interventions and care for babies born with NAS.	New EPIC platform includes screening tool. Providers, educators and outreach to ensure proper information, intervention, referrals.	Improved outcomes for mothers and babies born; care for babies born with Neonatal Abstinence Syndrome (NAS).	Improved awareness and compliance for women at risk or with history of substance misuse who are pregnant or planning pregnancy;
Connect teens with Lamprey Teen Clinic to address reproductive health.	Support teens and refer to Teen Clinic.	Improved awareness and reproductive health self-care for young adults.	Increased number of teens receiving reproductive health care.
Continue to promote breast-feeding through in person and virtual classes and community collaboration.	Time and funding for actions/programs described, such as participating at United Way's Community Baby Shower to promote breastfeeding and childbirth education.	Continued improvement in rates of new mothers who breast-feed post-partum and through infancy.	Educational programs assisted more than 450 patients learn about Newborn Care, Infant CPR, Breastfeeding and the like. Many classes were switched to virtual after COVID.

Priority 2 ●	Identified Need: **Environmental Health**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Pediatric practices currently conduct screening for Lead Poisoning and/or testing within appropriate age groups; Physician practices comply with latest lead screening recommendations.	Time and funding for actions/programs described, including staff time working with Division for Public Health to raise awareness of lead concerns.	Education and awareness	Continuation of care management protocols, enhanced collaboration with Division for Public Health.
UNECOM Medical Students integrated into Nashua Public Health for 6-week rotation to impact community's health.	Collaboration with University of New England College of Medicine to support 8 students during third year of medical school.	Expose students to environmental challenges as they are making decisions for their patients.	Build strong understanding of community health and relationships with community health workers.

Priority 2 ●	Identified Need: **Chronic Disease and Cancer**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Manage heart disease/hypertension via Cardiac and Pulmonary rehab performance based standards; Offer array of supports for patients with and families; Promote Go Red celebration, Cardiac Rehab and Pulmonary Rehab weeks, Stroke Awareness.	Continue sponsorship of BreatheNH's Team Orange at $3500/year; AHA Life's Simple 7; Investment of time and funding for actions/programs including .33 FTE for support groups; Offering training for community partners around stroke awareness.	Maintain and improve targeted global measurements for Acute Myocardial Infraction (AMI), Congestive Heart Failure (CHF) and Stroke. 2020 American Heart Association Gold Plus Stroke Designation.	Established accreditation by DNV as a Primary Stroke Center. Beat targeted global measurements for AMI & CHF.
Continue to coordinate care with multiple specialties to reduce diabetic complications; Follow evidence based inpatient protocols for diabetes care, including education on diet, exercise and medication management as well as cues for outpatient follow-up nutrition counseling.	Time and funding for actions/programs described; Staffing to support Diabetes Prevention Program at the YMCA.	At risk diabetes patients will be educated and cared for in the correct environment and in a timely manner.	Evidence based protocols established and followed. Diabetes Prevention Program and Intro to Diabetes Education classes offered.



Priority 2	Identified Need: **Chronic Disease and Cancer**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Continue to ensure access to same day appointments for patients struggling with asthma; Follow evidence-based protocols for adults and children. Continue to offer accredited Pulmonary Rehab program to educate patients about early symptom recognition and mitigation strategies.	Time and funding for actions/programs described.	Asthma patients will be educated and cared for in the correct environment and in a timely manner.	Followed evidence based protocol and decision support to assess and identify disease severity and evidence based protocol for patients admitted with COPD
Reduce barriers for colorectal screenings through outreach/screening of underserved; Offer other screening modalities such as iFOBT, cologuard or CT colonography.	Collaborate with community partners to build awareness of risk factors and compliance with screenings, marketing support for Colorectal Cancer Awareness Month (March).	Increased awareness of importance of screening and early detection, reduced barriers to care, improved access for underserved to get screenings	Performance 2019: 79% 2020: 76%
Further collaboration with Public Health to share importance of cancer screenings in multiple languages. Continue collaboration with Lamprey on "Let No Woman Be Overlooked" Breast Cancer program for low-income women; Continue "birthday" reminders to patients based on age	Provide support for American Cancer Society's Making Strides for Cancer; continue staffing and resources to support programming.	Improved awareness of importance of screenings and early detection, especially in women age 40-55 Continued improvement in meeting/surpassing screening targets among patient population.	Added third mammogram unit to increase access. Provided Spanish version of handout to prevent cancer across the life span to Public Health for distribution in neighborhoods.
Continue partnering with MGH for Oncology Specialists; Continue integration of palliative, behavioral health into oncology; Continue to earn Lung Cancer Screening Center designation by ACR. Collaborate with SolutionHealth Cancer Institute to align support across region. Provide community screening and early detection events to maintain Cancer certification.	Continued investment in Professional Services Agreement with MGH for Oncology, genetic counseling, specialized cancer care, surgical services. Investment in the Tumor Registry. Staffing and support to provide community screening and early detection event to maintain our Cancer certification. Include. Quit information in patient packets.	Enhanced specialized cancer care from MGH programs. Increased awareness and care from screenings and Improved awareness of preventable cancer, risk factors and importance of early detection; Continue to evaluate opportunities to reduce barriers to care and improve access to screening and treatment.	Live Free and Breathe program offered in collaboration with the Y was improved using new technology in 2019; Program put on hold due to COVID-19. Two additional staff trained as Tobacco Treatment Specialists. Utilized Employee Mammogram screening days in 2020 as part of CoC Early Detection activity. Filled 29 of 30 slots (97%).

Priority 2	Identified Need: **Communicable Disease**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Continue to promote importance of vaccinations—including pneumococcal, influenza, HPV and COVID-19 vaccine.	Collaboration with Quality and Public Health to share information about risks/benefits of HPV immunizations.	Increased awareness and improved compliance with immunization recommendations.	Continued efforts to ensure equitable access to vaccinations.
Prevent healthcare Associated infections; Clostridium difficile, Antibiotic Stewardship.	Stringent quality processes and procedures, required training and compliance reporting appropriate preventive measures and quality reporting/on-going staff education.	Dedicated staff and staff education/compliance management and reporting.	Optimally safe environment of care with reported incidences of infections above standards of quality care benchmarks. Reduction in infection consistent with high quality standards.
Improved awareness of Hepatitis C screenings among target demographics.	Decision Support Logic in EMR. Staffing and support	Patients will be aware of risks and be tested as appropriate.	Continued efforts to provide patient education and testing.
Increase awareness of prevention strategies for vector-borne, tick-borne, and mosquito-borne diseases.	Education to improve awareness of preventive strategies, collaboration with community partners to offer information.	Investment of time and funding for actions/programs described.	Promoted safety strategies on social media. Recently invited to present virtual workshop for parents of young children at Nashua Public Library.

Priority 2	Identified Need: **Public Health Emergency Preparedness**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Active participation in planning, preparedness drills and response development with local and regional public health emergency preparedness teams, Healthcare Emergency Response Coalition (HERC), Local Emergency Preparedness Committee (LEPC) and the Statewide Health Care Coalition.	Work to enhance community preparedness through ongoing participation in the CRASE program with the Nashua Police. Community wide development and participation of a pediatric MCI event. Personal preparedness training of SNHH staff through new employee orientation.	SNHHS will prepare for, respond, recover and mitigate from emergencies or disasters that impact the region's healthcare infrastructure. Enhance communications and understand the capabilities of emergency response partners. Provide a safe environment for patients, staff and families during a crisis.	Established SNHH as Chempack distribution site in collaboration with the CDC. SNHH with Nashua Police and Nashua Fire Rescue, conducted a mass casualty drill on school playground and developed a training video for public use. Increased level of community collaboration to address response to COVID supply and staffing shortages and distribution of vaccines.

Priority 2	Identified Need: **Social Determinants of Health**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Optimize capacity of EPIC platform launched 12/2020 to screen all patients for additional needs around food, housing, safety, etc. Connect patients in need to local resources.	Workflows need to be adopted once staff have fully embraced EPIC's utilization	Improved integration and coordination on behalf of pediatric and adult patients	**New resource in 2020**
Collaborate with community partners to develop strategies to increase High School completion; Partner with City's Imagine Nashua 10-year plan process to address need for improved access to housing and barriers to employment.	Leadership to participate in collaborative planning activities; financial resources to help support identified strategies.	SNHHS will develop new partnerships to help improve the health of Nashua's most vulnerable neighborhoods in a meaningful way.	**New initiative in 2021**
UNE medical students will continue to be educated on social determinants of health and the impact they have on patient care – with a focus on interdisciplinary care.	UNECOM students, leadership, department directors of pharmacy, nursing, social work and other community health assets.	Health care providers will have greater understanding of the impact social determinants of health have on their ability to help patients achieve optimal health.	Addition of new EPIC platform will enable medical providers to have greater access to resources to assist patients.

Priority 2	Identified Need: **Safety**		
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Continue to host Prescription Drop Box in lobby for unneeded medication.	Pharmacist/security oversight and monitoring. Promote Take Back Days held by Nashua Police and DEA.	Removing unneeded medication from people's homes will reduce likelihood for misuse/diversion to others.	Since installation, our Prescription Drop Box has collected 1170 pounds of unneeded meds.
Create Safe Room in Med/Surg for patients with mental health concerns.	Resources for anti-ligature and other equipment to outfit room.	Patients with acute medical needs and behavioral health problems will have safer environment.	**New initiative**
Adding Doorway Program to help people access safe place to go for care and connect with resources 24/7.	Staffing and supports offered to people seeking help for substance misuse. Partnership with Gatehouse to supplement staff hours.	People needing help for substance use disorder will have access to help quickly.	**New initiative**