Southern New Hampshire Health System
2018 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 understand and serve our community's predominant health needs, 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 *A Community Committed to Health: Community Health Assessment* ("the Assessment"), published in September 2017, by the City of Nashua Department of Public Health. SNHHS 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 Assessment.

This is our third published CHNA. The first was published in 2012 and the second in 2015. Both are available to the public on the SNHHS website. To date, we have not received any comments regarding either CHNA.

Community Served

SNHHS's community is defined by our service area, which consists of nineteen New Hampshire and four Massachusetts towns. Our 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. SNHHS includes the MSA towns because of the substantial patient volume from these towns.

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 2017 *A Community Committed to Health: Community Health Assessment* which was published in September 2017. This Assessment reflects results of a survey of area residents, conducted by the City of Nashua Department of Public Health, and based on the Centers for Disease Control and Prevention's Community Assessment for Public health Emergency Response (CASPER). The survey process consisted of a two-stage random cluster sampling technique, with one-on-one interviews conducted by survey volunteers: the first stage consisted of interviews with individuals from 7 randomly selected households from each of 30 random census block groups. The second stage, responsive to low completion rates from stage 1, allowed volunteers to seek participation from every third house in each census tract. All participants were asked for answers to 41 health-related questions.

The Assessment also draws from additional resources, including 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, and data from the U.S. Census Bureau. Additional secondary data sources are listed on page I-5 in the introduction section of the Assessment.

The Assessment was organized and implemented, with results compiled and written by the Community Health Needs Assessment Committee of the Nashua Department of Public Health. This committee was comprised from representatives of each department within the division. This committee also worked with the Greater Nashua Public Health Advisory who lent their expertise to review the collected data, advocate for the process, identify resources and help disseminate the final report. A list of the Community Health Needs Assessment Committee and Public Health Advisory Committee members and their organizational affliations are listed in the acknowledgments.

Community Partners

Many regional partners contributed to the Assessment process, including Nashua Office of Emergency Management, Nashua GIS and Assessing, Lamprey Health Care, St. Joseph Hospital, Southern New Hampshire Health System, Dartmouth-Hitchcock Nashua, United Way of Greater Nashua, Greater Nashua YMCA, Rivier University, and Nashua CERT.

Community Health Needs

The survey was designed to evaluate the health status of the greater Nashua community and to identify and prioritize health needs. The top three health issues identified were 1) behavioral health and substance misuse 2) weight management and nutrition, and 3) access to healthcare. Additional health needs were also identified, and are outlined in the Assessment "Table of Contents." SNHHS has evaluated all of the needs identified and prioritized to assure consistency with our mission, alignment with the Assessment, and our ability to have direct or indirect impact in specific areas via our clinical, educational and/or outreach programs.

- Priority & Ability to Impact
- Indirect Ability to Impact
- Minimal Ability to Impact

Section	Topic:	Priority/ Impact
I	**Introduction**	
1	**Social Determinants of Health**	
2	**Access to Healthcare***	
2-1	Access to Healthcare	
2-1	Primary and Dental Care	
2-5	Medicaid	
2-6	Health Insurance Marketplace	
3	**Healthy Moms & Babies**	
3-3	Pregnancy Risk Assessment	
3-4	Maternal Health Indicators	
3-5	Pre-term Birth and Birth Weight	
3-7	Teen Pregnancy	
3-9	Smoking and Pregnancy	
3-10	Neonatal Abstinence Syndrome (NAS)	
3-13	Breastfeeding	
4	**Environmental Health**	
4-1	Lead Poisoning	
4-4	Air Quality	
4-8	Radon	
4-9	Carbon Monoxide	
4-10	Water Quality	
4-12	Rabies	
5	**Chronic Disease & Cancer**	
5-1	Heart Disease	
5-9	Stroke	
5-12	Diabetes	
5-14	Asthma	
10-1	Cancer Burden	
10-3	Cancer Mortality	
10-5	Colorectal Cancer and Screening	
10-8	Breast Cancer and Screening	
10-9	Cervical Cancer and Screening	

Section	Topic:	Priority/ Impact
6	*** Weight Management, Nutrition, & Physical Fitness**	
6-1	Obesity	
6-1	Weight Management	
6-5	Physical Activity	
6-8	Nutrition	
7	**Communicable Disease**	
7-1	Sexually Transmitted Infections (HPV)	
7-2	Adolescents and Sexual Behavior	
7-4	Hepatitis C	
7-5	Tuberculosis	
7-5	Healthcare Associated infections	
7-6	Clostridium difficile	
7-7	Antibiotic Stewardship	
7-8	Vaccines and Preventable Illnesses	
7-12	Vector-borne Diseases	
7-13	Tick-borne Diseases	
7-14	Mosquito-borne Diseases	
7-15	Foodborne and Waterborne Diseases	
8	*** Behavioral Health**	
8-1	Behavioral Health	
8-1	Substance Misuse	
8-18	Mental Health	
8-20	Suicide	
9	**Emergency Preparedness**	
9-1	Emergency Preparedness Background	
9-1	Public Health Emergency Preparedness	
9-2	Regional Emergency Preparedness	
9-3	Community Preparedness	
9-4	Disaster Training	
9-5	Volunteerism	
9-6	Personal Preparedness	
9-8	Evacuations	
9-10	Inclusive Disaster Planning	
9-11	Community Resilience	

* **Identified as top priority**

Area Resources Available to Address Community Health Needs

The greater Nashua community has many healthcare resources available to address healthcare needs. These include SNHHS, Lamprey Health Center, St. Joseph Healthcare, Greater Nashua Mental Health Center, Dartmouth-Hitchcock Nashua, Harbor Homes, Inc., 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.

Implementation Strategy

SNHHS has developed an implementation strategy to address the health care needs as identified with green or yellow indicators above. Those needs identified with red indicators reflect health issues that SNHHS has minimal ability to impact. As such, they are not included in the implementation strategy, though SNHHS will lend resources or expertise as appropriate to any initiatives led or sponsored by other community-based organizations or collaborations. This implementation strategy can be found in “Exhibit 1” of this CHNA.

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

Exhibit 1

Implementation Strategy to be reviewed in meeting

Exhibit 1

Implementation Strategy

Priority	Identified Need	Impact	Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
	Priority & Ability to Impact	●				
	Indirect Ability to Impact	●				
I	**Behavioral Health**					
I	Behavioral Health, Mental Health, Substance Misuse, and Suicide Prevention	●	Inpatient Behavioral Health Unit	Staff 18 beds with 25 staff FTE's and 3.8 provider FTE's; investment into provider coverage through purchased service agreement with MGH in 2018	>527 Admissions	Avg of 543 (14% inc.) admissions since expansion
			Partial Hospitalization Program (PHP)	Staff PHP with 3.8 FTE's	>918 Registrations	Avg of 956 (29% inc.) registrations since expansion
			Intensive Outpatient Treatment Program (IOP) for substance use disorders	Staff IOP with 2 staff FTE's	>126 Registrations	Avg 139 registrations over past two years since inception
			ED Annex for psychiatric patients with a quieter place to be assessed and to await appropriate disposition	Opening in 2018 at a cost of $550,000 and annual operating costs of $800,000 to staff	Care provided in most appropriate setting	New program
			Acute Community Crisis Evaluation Service System (ACCESS) Available for consults in ED 24/7	Staff access with 8.34 staff FTE's	>2,536 Evaluations	Avg 2,680 evaluations over past thee years
			Administrative Lead for Integrated Delivery Network as part of the DSRIP 1115 Waiver. Working with 30 community partners to try 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 implement 6 statewide and community based projects to transform the delivery of behavioral health services	Increased access to continuum of care for mental health and substance use disorders. Enhanced array of treatment options will result in a reduction of emergency room visits for behavioral health needs, a reduction in overdoses and deaths related to behavioral health, improved ability to return consumers to their communities post hospital level of care, improved collaborations with all treatment providers and increased focus on patient centered care	New program

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Priority & Ability to Impact ●						
Indirect Ability to Impact ●						
			1. Continuing collaboration with IDN and Department of Public Health, Nashua Prevention Coalition and other organizations working to build awareness and support preventive strategies 2. Expand collaboration with other local groups in surrounding towns including Merrimack Safeguard and Pelham Community Coalition	Staff time and programmatic support via in-kind donation of services as well as funding support	Improved awareness, education, support, referrals and outreach/collaboration to support appropriate access to care and service	Sponsored community education program "In Plain Sight" for parents concerned with illicit drug use of teens; Sponsored and presented at first annual BH Conference in the fall of 2017
			Ongoing participation in Mayor's Opioid Task Force	Senior Leadership participation since Task Force was formed and continues currently	SNHH's leadership offers strategic and practical support of community based initiatives focused on substance use disorders. This is consistent with our efforts to expand collaboration with community partners.	
			• Foundation Medical Partners is certified as Level III Patient Centered Medical Home in all locations • Foundation Medical Partners has added two psychiatric APRN's who are embedded in primary care offices as part of our integrated care efforts • There are 5 clinicians who provide clinical services in PCP offices throughout the system and several more at our centralized location at 19 Tyler Street • The Foundation also employs a psychiatrist who provides medication evaluations, medication management and consultation to PCP's • We are working closely with multiple groups to bring more professionals to the area to strengthen the behavioral health workforce	Several medical providers, and many clinicians who provide direct clinical 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 care coordination on behalf of pediatric and adult patients at risk for or struggling with behavioral health issues.	1,749 unique patients annually receive integrated care
			• Explore opportunity to pilot "resilience" training in area middle school(s) to proactively address risk factors • Develop new community education programs to build awareness of risks/prevention/early treatment of behavioral health issues • Explore involvement/support of Youth Council (youthcouncil.org) Project Impact		Improve coping skills, esteem and relationships to mitigate risk of substance misuse and importance of healthy lifestyle management; support community-wide initiatives to reduce substance misuse, overdose deaths and improved access to supportive care and treatment	

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	Indirect Ability to Impact	●				
I	**Weight Management, Nutrition, & Physical Fitness**					
I	Obesity, Weight Management, Physical Activity, and Nutrition	●	• All pediatric practices record weights & BMI % • SNHMC protocol in ED to record weight on all patients <18 yo	Patient Center Medical Home actively tracking and outreach patient population	Monitoring and Awareness	Care management protocols followed
			Pursue plans to sponsor and collaborate with other community resources for programs to improve awareness and address needs specifically related to nutrition, physical fitness and weight management, including: • School based program to promote health eating • Partnership with Y to offer lifestyle management programs to patients and community • Expand Hannaford nutrition education programs and classes • Sponsor "Girls On The Run" at Mt. Pleasant school in Nashua to encourage fitness • Continue to support Fitness U and Granite State Fit Kids • Help 5-2-1-0 in local schools • Connect with new patients who visit IC locations by sending post-visit follow up email with new doctor info, health tips and upcoming classes and events	• $3,000 for Girls on The Run • $1,500 for Fitness University annually • $2,500 Granite State Fit Kids annually • SNHH rep on Nashua School District Wellness Committee	Increased education, awareness and opportunities to encourage individuals to adapt healthy lifestyles and reduce obesity	Foundation providers use "prescribe the Y" referrals to encourage overweight patients to pursue fitness and weight management practices; funded and promoted various programs like Fitness "U" & Granite State Fit Kids; Held various community classes
			Clinical Nutrition Department: opportunity to better understand programs and services for outpatients and promotions	Funding at a cost of $558,000	Education & Awareness	
			Explore weight management and nutritional education opportunities through SolutionHealth			
I	**Access to Healthcare**					
I	**Access to Healthcare, Primary and Dental Care, Medicaid, and Health Insurance Marketplace**	●	Immediate Care programs in Nashua, South Nashua, Merrimack, Hudson, Pelham, Pepperell and Amherst enhance access to timely care.	Opened Pepperell, MA and Amherst, NH Immediate Care locations in 2015 and 2016; overall 77.7 FTE's are committed to Immediate Care sites	>63,132 Visits	Immediate Care visits have grown 43% over last 3 years and continues to expand

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Priority & Ability to Impact ●						
Indirect Ability to Impact ●						
			Staff available on site to help with Medicaid, expanded Medicaid and financial assistance applications; participation in exchange programs and premium assistance program. Work with NHHA to develop plan for state to reauthorize expanded Medicaid	2 FTE's Committed to Medicaid & Expanded Medicaid Applications; fund $140,000 to third party agency to assist with applications for Medicaid, prescription assistance, and financial assistance	Self-Pay <3.0 % of revenue	SNHH successfully assisted uninsured patients with obtaining Medicaid and financial assistance resulting in self pay patients <3%
			Partnership with Massachusetts General Hospital (MGH) provides local access to over 35 Boston area specialists	Funding of Professional Services Agreement with MGH	Access to services that patients would otherwise need to travel for	
			Interpreter Services Program	SNHH invests $614,000 in our Interpreter Services Program to assist patients with their care	Improved responsiveness and appropriate care delivery to non-English speaking patients	
			OB/GYN hospitalists and residency program	Unfunded program costs of $1,000,000	Expands access to women's health in collaboration with Lamprey	
			Primary Care Access - focus on time to appointment	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	New patients 95% of 100% target; Specialty access 81% of 75% target
			Our Emergency Department (ED) works with the Dental Connection to streamline referrals to their clinic; some patients that present to our ED with toothaches and infections are referred to their dentist's office	SNHH has committed $10K to the Dental Connection, a community organization that offers low cost dental care to low income Nashua area residents	Assist patients with obtaining dental care in the correct care setting	
			Continued sponsorship and support for Front Door Agency initiatives	$5,000	Resources, education and support for individuals and families coping with crisis and homelessness	Sustaining partner for the past 3 years
			Explore opportunities to provide more services locally through SolutionHealth		Improved ability to meet acute and chronic health care management needs locally	

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	Indirect Ability to Impact	●				
II	**Healthy Moms & Babies**					
II	Pregnancy Risk Assessment Monitoring, Maternal Health Indicators PRAMS - CDC Initiative	●	PRAMS is a CDC-initiative that randomly samples appx. 1 in 12 new mothers 2-6 months post delivery to assess behaviors associated with risk (sleep on back, seatbelt use, dental care during pregnancy, drug use, etc.); revamp patient education materials prenatal/post partum patients and include distribution to Lamprey	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 consistent with health of mothers and newborns	PRAMS data suggests region met HP202 goals for prenatal care in 1st trimester, breastfeeding at discharge
II	Maternal Health Indicators (identified as women receiving prenatal care in 1st trimester, smoking during pregnancy, breast-feeding at discharge, vaginal versus c-section deliveries)	●	• Dr. Martinez & Dr. Maynard see low-income/Medicaid patients on weekly basis to provide ob/gyn care and Foundation providers deliver Lamprey patients' babies at no cost • Foundation OB/GYN 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; SNHH compiles/shares indicators data as quality metrics	Best possible outcomes and health behaviors for expectant and new mothers and newborns	C-section rates and other related performance metrics tracked and documented as consistent with best practice standards; consistently well-attended prenatal classes
II	Pre-term Birth and Birth Weight	●	Foundation OB/GYN providers compliant with best practice standards for care for expectant women and appropriate monitors, measures and indicators that suggest risk, complications and/or issues that require follow-up and appropriate care	Outreach, support, education to reduce risks		
II	Teen Pregnancy	●		Run weekly "Teen Clinics" for reproductive health education at Lamprey Health	Improved awareness and reproductive health self-care for young adults	
II	Smoking and Pregnancy	●	Interventions and counseling of patients pregnant or planning to become pregnant	Standard of OB Care		
II	Neonatal Abstinence Syndrome (NAS)	●	Screening, intervention, referrals for women pregnant or planning to become pregnant who report or demonstrate substance misuse symptoms; appropriate interventions and care for babies born with NAS		Improved awareness and compliance for women at risk or with history of substance abuse who are pregnant or planning pregnancy; improved outcomes for mothers and babies born with NAS	

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	Indirect Ability to Impact	●				
II	Breastfeeding	●	Continued promotion of breast-feeding through on-going classes; also continued efforts to support programs in collaboration with community partners • Opportunity to connect with large employers (BAE, Fidelity) to offer onsite child birth education OR employee discount • Partner with United Way for Community Baby Shower - breastfeeding & childbirth education with CB educators	Investment of time and funding for Actions/ Programs described	Continued improvement in rates of new mothers who breast-feed post-partum and through infancy	Maternal Child Health programs consisted of more than 200 education sessions and were held in 2016/17 in 11 areas ranging from Breastfeeding to Infant CPR
II	**Environmental Health**					
II	Lead Poisoning	●	Pediatric practices currently conduct screening and/or testing in appropriate age group; physician practices compliant with latest lead screening recommendations	This practice is embedded into our care management protocols; investment of time and funding for Actions/Programs described	Education & Awareness	Continuation of care management protocols
II	**Chronic Disease & Cancer**					
II	Heart Disease	●	Manage hypertension based on performance based standards; cardiac and pulmonary rehab; support group for patients and families with heart disease; Go Red celebration; Cardiac Rehab week; Pulmonary Rehab week; arthritis exercise class; Exercise RX for provider offices; PEP for pulmonary rehab; Healthy Living presentation at Senior Supper; Participation in National Measure Up Pressure Down Program; BreatheNH Team Orange lead state sponsor ($3,000 financial commitment); partner with BreatheNH on COPD patient/family educational event (May 30, 2018); offer blood pressure screenings at every community education class; partner with Million Hearts Campaign 2022 (CDC) goal to prevent 1 Million heart attack & strokes in 5 years	AHA Life's Simple 7 / Investment of time and funding for Actions/Programs described including .33 FTE for support groups; purchased EKG transmitter for Pelham EMS in effort to improve cardiac care enabling field activation and decreasing D2B time for STEMIs	Maintain and improve targeted global measurements for Acute Myocardial Infraction (AMI), Congestive Heart Failure (CHF) and Stroke. *2018 American Heart Association Get With the Guidelines Gold Plus Stroke Designation	Established accreditation by DNV as a Primary Stroke Center; beat targeted global measurements for AMI & CHF; free blood pressure screenings offered every Wednesday morning
II	Stroke	●	DNV accredited Primary Stroke Center; AHA Gold+ award for "Getting with the guidelines"; Stroke awareness included in education/outreach plans			

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	Indirect Ability to Impact	●				
II	Diabetes	●	Coordination of care with specialties to reduce diabetic complications; multiple 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; evidence based protocol with decision support in EMR with cues for best practices and tracking of compliance; developing mechanisms to identify high risk patients through medical intelligence software and to target these patients for evidence based interventions; working with community to develop motivational intervention and exercised based programs; explore collaborating with Nashua YMCA to offer DPP program on-site at Y with our Diabetes Educators and gym access to the Y; explore opportunity to offer DPP onsite at local large corporations (BAE & Fidelity example); Pre-target DPP referral from primary care practices with patient emails	Investment of time and funding for Actions/Programs described; SNHH added .5 MD FTE to improve access; SNHH employs a clinical educator at .75 FTE; 50% employee discount on all DPP Programs	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
II	Asthma	●	Outpatient practices maintain access for same day appointments; through medical intelligence software, evidence based protocol and decision support to assess and identify disease severity; evidence based protocol for patients admitted with asthma; pediatric asthma protocol for admitted patients with tracking and trending national best practices for children's asthma care (CAC); state of the art and accredited pulmonary rehab program educates patients about early symptom recognition and mitigation strategies; asthma action plan for every adult & child; participation in National Heart, Lung, Blood Institute Studies; asthma education for children at Nashua Library	Investment of time and funding for Actions/Programs described; educational article in 2018 Spring Simply Healthy Community Newsletter (distributed to 150K households)	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
II	Cancer Burden; Cancer Mortality	●	Prevention screening and treatment			

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	Indirect Ability to Impact	●				
II	Colorectal Cancer and Screening	●	Explore opportunities for outreach/screening of underserved and coordinating access and reducing barriers to care by offering other modalities of screening such as iFOBT, cologuard or CT colonography; collaborate with local senior centers and other community partners to build awareness of risk factors and compliance with age-appropriate screenings; explore other opportunities for outreach/education on risk factors and importance of early detection; introduce "birthday" reminders to patients based on age	Investment of time and funding for Actions/Programs described; March 27, 2018 Colorectal presentation by Endoscopy nurses at Nashua Senior Center	Need to reduce barriers to care; access to underserved to get screenings; awareness of importance of screening and early detection; continued improvement in meeting/surpassing screening targets among patient population	2017: Target 77% Performance 74% 2018 Target: >74%
II	Breast Cancer and Screening	●	SNHMC works with Lamprey to provide screening, diagnosis and treatment for women who are part of NH "Let No Woman Be Overlooked" program for low-income women age 21-26 who qualify; explore other opportunities for outreach/education on risk factors and importance of early detection, especially among women age 40-55; continue to encourage women age 40+ to have screening mammograms; introduce "birthday" reminders to patients based on age; explore provider specific communications for patient information on mammo/colorectal screenings; partner with American Cancer Society to participate at local Relay for Life and Breast Cancer Walks	Investment of time and funding for Actions/Programs described	Improved awareness of importance of screenings and early detection, especially women age 40-55; continued improvement in meeting/surpassing screening targets among patient population	2017 Target: 71% Performance 70% 2018 Target: >70%
II	Cervical Cancer and Screening	●	Review and understand guidelines (ongoing efforts); OBs educate PCPs on standards			2017 Target: 81% Performance 80% 2018 Target: >80%

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	Indirect Ability to Impact	●				
II	Other Cancer & Screenings	●	Transitioned Oncology to MGH bringing their Oncology Specialists locally; started multi-disciplinary clinics for breast cancer; added and expanded genetic counseling services; integrated palliative and behavioral health care into oncology program; enhanced specialized cancer care surgical services; participation in national database for benchmarking; Lung Cancer Screening Center designation by ACR; adding low-dose CT screening program to identify lung cancer; participation in clinical trials; skin cancer screenings; Launched community-based Smoking Cessation program with the YMCA; member of NH Cancer Collaborative; evaluate and update any patient education materials and pursue strategies to improve compliance with benchmarks for best practice; utilize patient emails to refer patients who smoke to Low Dose CT Scan	Investment in Professional Services Agreement with MGH for Oncology, genetic counseling, palliative care, specialized cancer care surgical services; investment in the Tumor Registry; provide yearly skin cancer screenings; "10 Steps to Quit" information sheet included in patient packets	Enhanced specialized cancer care from MGH programs; increased awareness and care from screenings; improve awareness of preventable cancers, risk factors and importance of early detection; continue to evaluate opportunities to reduce barriers to care and improve access to screening and treatment	MGH Oncology was brought to SNHH. 2014-2017 ongoing education courses included skin cancer, GYN cancer, lung cancer, palliative care, breast cancer, and prostate cancer
II	**Communicable Disease**					
II	Sexually Transmitted Infections (HPV)	●	Appropriate counseling and immunizations in pediatric practices; evaluate opportunities to promote/support HPV immunizations and risks		Indirect but improved compliance with immunization recommendations	
	Adolescents and Sexual Behavior	●	Lamprey Health reproductive health clinics		Improved awareness of risks and preventive care	
	Hepatitis C	●	Decision support logic in EMR; mproved awareness of screenings among target demographics	TBD		
	Tuberculosis	●				
	Healthcare Associated infections; Clostridium difficile, Antibiotic Stewardship	●	Stringent quality processes and procedures in Medical Center and Foundation practices; required training and compliance reporting	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	2017 data: 0 central line associated infection (benchmark target <1.013. catheter associated infection: 0 (<0.983)
			Appropriate preventive measures and quality reporting/on-going staff education		Reduction in infection rate consistent with high quality standards/benchmarks	2017: CDIF rate 0.512 (benchmark target of <0.997)

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	Indirect Ability to Impact	●				
	Vaccines and Preventable Illnesses	●	Care coordination / cross accountability engagement of non-primary care to promote and vaccinate patients with the pneumococcal vaccine			
	Vector-borne Diseases; Tick-borne Diseases, Mosquito-borne Diseases	●	Education to improve awareness of preventive strategies	Investment of time and funding for Actions/Programs described		
II	**Emergency Preparedness**					
II	Emergency Preparedness Background, Public Health Emergency Preparedness, Regional and Community Preparedness, Disaster Training, Volunteerism, Personal Preparedness, Inclusive Disaster Planning, and Community Resilience	●	• 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 State Wide 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 • Partnership with Nashua Emergency Management to present Community Preparedness Training May 2018.	Investment of time and funding for Actions/Programs described	To prepare for, respond, recover and mitigate from emergencies or disasters that impact the regions healthcare infrastructure; enhance communications and understand the capabilities of emergency response partners; provide a safe environment for patients, staff and families during a crisis	Emergency management, with the pharmacy, emergency department and security completed a re-evaluation of the state wide Chempack distribution program. SNHH deployed Ping 4, mass notification system. Planned and conducted community wide heli-pad crash exercise and developed a training video. Established SNHH as Chempack distribution site in collaboration with the CDC. SNHH with Nashua Police and Nashua Fire Rescue, conducted an active shooter event in the hospital, developed a training video for public use. Attended all LEPC and HERC collaboration meetings