2024

Community Health Needs Assessment and Implementation Strategy

southern new hampshire health

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INTRODUCTION

Southern New Hampshire Health is dedicated to providing exceptional care that improves the health and well-being of individuals and the communities we serve in greater Nashua, New Hampshire. Our vision is to be a provider of choice, delivering convenient access to high value, quality care in an environment that embraces dignity, compassion, and service to the people of our community.

We collaborated with the City of Nashua and many other area health partners to conduct this 2024 Community Health Needs Assessment ("CHNA"). Many of the references in this report are from the 2023 *Greater Nashua Public Health Region Data Dashboard* ("the Assessment") published in early 2024 by the City of Nashua Division of Public Health & Community Services as its Community Health Assessment.

Southern New Hampshire Health 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 fifth published CHNA, with the first published in 2012 and every three years since. All are available to the public on the Southern New Hampshire Health website, www.snhhealth.org > community health. Community members are invited to provide feedback at contact@snhhs.org. To date, we have not received any comments regarding past CHNA's.

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 2023 *Greater Nashua Public Health Region Data Dashboard* ("the Assessment") published in spring 2024 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. It is expected to serve as a powerful launch point for data-driven conversations. Detailed information can be found at: https://dashboards.mysidewalk.com/gnphr-cha

DPHCS research included two community-based research projects to identify the greatest health concerns facing our residents. The first involved hosting 12 listening sessions throughout the Greater Nashua Public Health Region, hosted in English, Spanish, and Portuguese, in which 112 people attended. Conversations were translated, transcribed, deidentified, and analyzed to identify common themes during the conversations.

The second project, The Community Portrait Survey, allowed DPHCS to engage 192 community members they were unable to reach for the listening sessions. Multiple strategies were used to reach underserved populations including advertising on the nashuanh.gov website, handing out flyers by community health workers, including it in Nashua DPHCS' weekly newsletter, sharing by community partners, and posting on social media. The survey asked a variety of questions covering topics such as:

- Basic demographics
- Community health priorities
- COVID-19
- Feelings and experiences with Nashua Public Health
- Needs for children and parents
- Accessing health care

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 Behavior Surveillance 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, Area Health Resource File/American Medical Association 2021 via RWJF County Health Rankings & Roadmaps 2024, Centers for Disease Control and Prevention, 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:

First	Last	Organization
Sarah	Aissis	Nashua Public Health
Mike	Apfelberg	United Way of Greater Nashua
William	Belecz	Harbor Care
Margo	Bell	Nashua Senior Center
Kimberly	Bernard	Nashua Public Health
Lyndsey	Bond	Nashua Public Health
Anthony	Burns	Mason Fire Department
Casey	Caster	The Youth Council
Matthew	Conley	Amherst Fire Rescue
Sheila	Considine-Sweeney	Gr. Nashua Mental Health
Sam	Durfee	Nashua Planning Department
Ashley	Fudala	Greater Nashua Boys and Girls Club
Kevin	Flynn	St. Joseph Healthcare
Gloria	Fulmer	Gateways Community Services
Monica	Gallant	Souhegan Valley Boys and Girls Club
Jane	Goodman	Nashua Soup Kitcen & Shelter
Jessica	Hagg	Arlington Street Community Center
Pamela	Hannon	Nashua Police Department
Betsy	Houde	Southern NH Health
Wendy	Hunt	Gr. Nashua Chamber of Commerce
Stacy	Hynes	Nashua School District
Foqia	Ijaz	Nashua Public Health
Mike	LaChance	YMCA

First	Last	Organization
Emily	Martuscello	Nashua Office of Emergency Services
Jennifer	McCormack	Nashua Public Library
Jay	Minkarah	Nashua Regional Planning
Justun	Monroe	Grow Nashua
Iraida	Munoz	Nashua Public Health
Everett	Olsen	Merrimack Police Department
James	Paquette	Hudson Fire Department
Heidi	Peek	Nashua Environmental Health
Brenda	Poznanski	Bishop Guertin High School
First	Last	Organization
Everett	Schelberg	Milford Ambulance Service
Candice	Sousa	Dartmouth Hitchcock
Jon	Spira-Savett	Nashua Interfaith Council
Julie	Stone	Home Health & Hospice
Lisa	Vasquez	Nashua Public Health
Pamela	Wellman	Family Promise of Southern NH
Christine	West	Girls Incorporated of NH
Greg	White	Lamprey Health
Cynthia	Whittaker	Gr. Nashua Mental Health
Paula	Williams	Rivier University

COMMUNITY PARTNERS

This Assessment was conducted by the City of Nashua Division of Public Health & Community Services in collaboration with nearly 30 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
Harbor Care
Home Health and Hospice Care
Lamprey Health Care
Merrimack Fire Department
Merrimack Police Department
Milford Ambulance Service
Nashua Community Development
Nashua Office of Emergency Mgmt.
Nashua Police Department
Nashua Regional Planning
Nashua School District
Nashua Soup Kitchen and Shelter
Rivier University
Southern New Hampshire Health
St. Gianna's Place
St. Joseph Hospital
Temple Beth Abraham
The Youth Council
United Way of Greater Nashua
YMCA of Greater Nashua

COMMUNITY HEALTH NEEDS

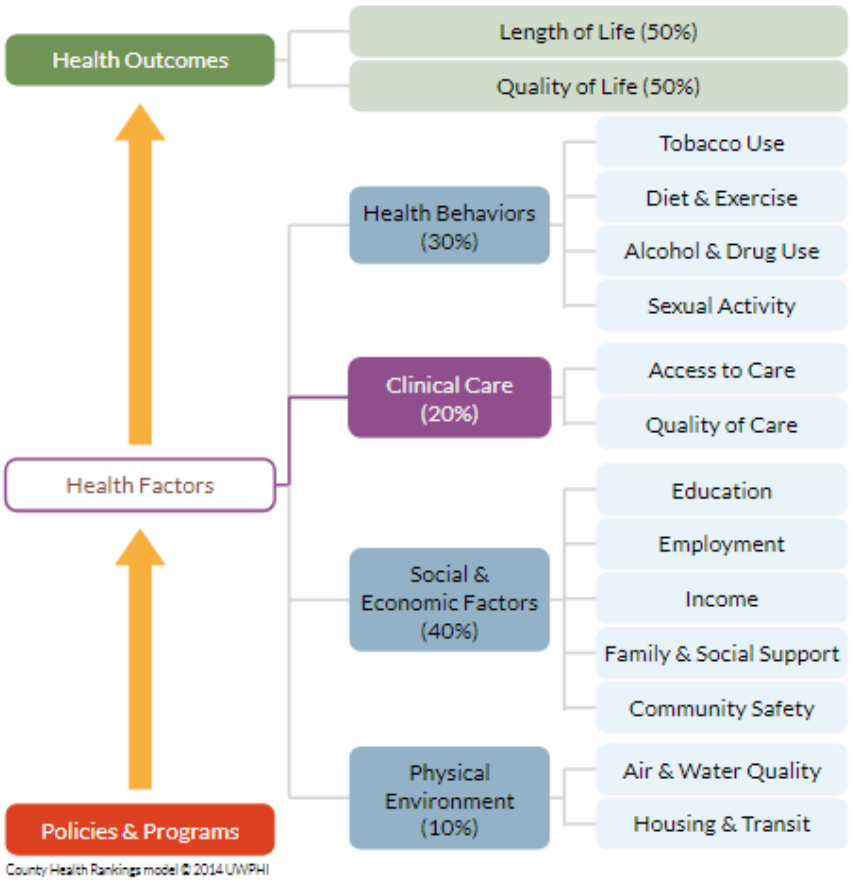
An analysis of the data collected from community conversations during the Assessment resulted in several health needs emerging as priorities:

*What are the biggest health issues or concerns **in your community**?*	*When you think about your community, what **most concerns you** in the next three years?*
1. Mental Health	1. Mental Health
2. Homelessness	2. Homelessness
3. Substance Use	3. Substance Use
4. Access to Care	4. Access to Care
5. Air and Water Quality	5. Air and Water Quality
6. Inequities in health	6. Education
7. Access to affordable and nutritious food	7. Public safety, like crime and vandalism
8. Public safety, like crime and vandalism	8. Access to affordable and nutritious food
9. Education	9. Inequities in health
10. Child Abuse and Neglect	10. Child Abuse and Neglect

Southern New Hampshire Health utilizes the nationally recognized *County Health Rankings & Roadmaps* to organize its strategies to address the health concerns of our community, focusing on those with which we can have the greatest impact.

This also allows us to more easily compare and adapt our strategies as new information becomes available.

https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model



The Division of Public Health and Community Services 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
Health Behaviors		Social & Economic Factors	
• Tobacco Use/Vaping		• Education	
• Diet & Exercise		• Employment, Income	
• Alcohol & Drug Use		• Family & Social Support, Community Safety	
• Mental Health & Suicide Prevention			
• Sexual Activity			
Clinical Care		Physical Environment	
• Access to Care including primary & dental care, Medicaid, health insurance		• Air & Water Quality, Housing & Transit	
• Quality of Care including Screenings & Healthy Moms & Babies			

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, Home Health & Hospice Care, St. Joseph Hospital, 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, YMCA, Greater Nashua Food Council, Front Door Agency, Bridges, Marguerite's Place, Family Promise of Southern New Hampshire, Nashua Police Athletic League, Boys and Girls Club of Greater Nashua, Girls Incorporated, Breathe NH, Granite State Fit Kids, Girls on the Run, Grow Nashua, Great American Downtown Farmers Market, Nashua Soup Kitchen and Shelter, Nashua Prevention Coalition, The Youth Council, MyTurn job training program, Veterans Count, Nashua Senior Activity Center, Fitness University, and more.

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 using the County Health Rankings categories. 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. As indicated previously, community members are invited to provide feedback at contact@snhhs.org. The CHNA will also be submitted as part of the Southern NH Medical Center 990 tax return.

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Exhibit 1 – using County Health Rankings Categories

Implementation Strategy FY2024

1. Health Behaviors – Tobacco Use, Diet & Exercise, Alcohol & Drug Use, Sexual Activity

Priority	Identified Need:
●	**Tobacco Use (and Vaping)**

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
Provide education and programs to prevent and stop youth and adults from using tobacco and vaping.	Staff time, training costs, financial support to community organizations to deliver programming.	Decreased rates of smoking/vaping.	Supported Youth Council and Nashua Prevention Coalition's efforts to conduct student workshops.
Embedded referral information into EPIC electronic health record to ensure patients reporting tobacco use or vaping are provided resources.	State of NH QUIT line to share QUIT materials in English and Spanish. Staff time, printed materials.	Increased awareness of community support available to people that are ready to quit. Decreased rates of smoking/vaping.	Track number of patients referred.

Priority	Identified Need:
●	**Diet & Exercise**

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
Grow/expand Weight Management program to serve as comprehensive Weight Management Center.	Collaboration with YMCA for educational/support programming, Staff time to develop additional components, ongoing communication.	Increased self-esteem, healthy lifestyle, supportive peer group, offers healthy "second home" for patients struggling with isolation due to weight.	Added medical and surgical provider to expand services available to patients and to meet increased demand.
Record weights and BMI % in pediatric practices; Follow ED protocol to record weight on all patients <18yo.	Staff 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. Developing new services to launch in 2024 for high BMI children.
Continue to optimize capacity of EPIC platform to screen all patients for food insecurity.	Staff time to maintain/update formal technology platform that links patient directly with community resources.	Improved integration/ coordination for pediatric and adult patients struggling with food insecurity.	Enhanced resource listing, 70.17% of all inpatients screened with 4.29% scoring as food insecure.
Launch packaged food pilot for patients scoring as food insecure.	Care Coordinators' time, program guidelines, pre-packaged dried food from Outreach Project	Patients struggling with food insecurity will have access to a meal they can prepare immediately and referral tip sheet for local pantries, farm stands.	**New program in 2024.**

Priority	Identified Need:
●	**Diet & Exercise**

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 collaborate with Greater Nashua Food Council and its members to increase access to healthy food.	Leadership participation since Council was formed and continues currently. Sponsorship of GNFC- member activities.	Increased knowledge around gaps in food access and strategies to make a meaningful difference. Donation of insulated tote bags for those riding city bus to grocery store.	Food resource handouts shared with Care Coordinators and patients in English and Spanish. Added summer farm share program for staff with 46 participants in FY2023.
Continue sponsorship of community partner programs focused on nutrition, physical fitness, weight management.	Partners include YMCA, Girls on the Run, PAL, Boys and Girls Clubs, Girls Inc.	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, Healthy Habits for Teens.

Priority	Identified Need:
●	**Alcohol & Drug Use (and Mental Health & 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
Partnered with NH Healthy Families as 1 of 2 hospitals to launch MOSAIC project to improve access to behavioral health in greater Nashua.	Peer recovery coaches based in Emergency Department (ED); Screening all ED patients for alcohol and other drug use.	Increased access to treatment options. Reduction of overdoses and deaths; improved ability for patients to return to their communities.	Three recovery coaches hired in FY2024 to launch new program.
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.	FY2023: Provided 1,673 consults for behavioral health needs
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.	FY2023: 480 patients benefited from services provided in the Annex, with an average length of stay of 2.44 days.
Continue operating the Doorway as resource for those seeking treatment for substance use disorder (SUD); launched in May 2020.	Staff and clinical training to support average of 10-12 new people per week seeking support plus additional 10 ongoing patients.	20+ people per day served through outpatient therapy, peer support groups and ongoing recovery coaching.	In FY2023, 720 people received care for SUD through direct support and referrals to higher levels of care as appropriate.
Continue using Columbia suicide risk assessment/screening in ED for patient ages 12+ or those under the age of 12 with behavioral health condition.	Staff time & resources	Identifies patients at risk for suicide and increases probability of providing appropriate real-time intervention	FY2024: Developing plans to pilot adolescent screening in our ambulatory practices.

Priority	Identified Need:
●	**Alcohol & Drug Use (and Mental Health & 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
Continue to maintain software in the ED to coordinate care for high utilizers of services, including those with SUD.	Software maintenance costs .	Support the appropriate discharge planning to improve outcomes.	Care coordination now embedded throughout patient care including PDMP alerts.
Continue Medication Assisted Treatment program to augment treatment for substance use disorder.	1 full-time provider staffs MAT clinic; provides immunizations, recovery support, care coordination, and short term chronic disease management.	We assist with connections to: primary care, mental health, detox, Doorway of Greater Nashua, residential treatment, SNHH PHP & IOP, Peer Support.	From inception in 6/2020 through 12/2023, 426 new patients were treated through 6,235 patient visits.
Optimize capacity of EPIC through seamless integration with NH's Prescription Drug Monitoring Program.	Technology team to ensure all providers trained in using platform, support from State to keep updated.	Improved integration and coordination to ensure patients are using medication as prescribed.	**New resource in FY2024**
Now offering Naloxone in all Primary Care and Immediate Care locations.	Naloxone kits, staff training and competency, staffing to provide information to patients in need.	Reduction in overdoses and overdose deaths. Improved communication between providers and patients.	**New program in FY2024.**
Ongoing participation in Mayor's Opioid Task Force (renamed Mayor's Task Force on Substance Misuse)	SNHH participation since Task Force was formed and continues currently.	Offers strategic and practical support and education around substance use disorder.	Increased collaboration among community partners, opportunity to raise awareness of The Doorway.
Continue collaboration with Greater Nashua nonprofit organizations to build awareness of risks/prevention/ early treatment of behavioral health.	Ongoing Senior Leadership mentoring of local organizational leaders and board service.	Improved coping skills, self-esteem, relationships to mitigate risk of substance misuse and importance of healthy lifestyle management.	Increased community collaboration to help our youth make healthy decisions.
Support Public Health's efforts to screen patients for Adverse Childhood Experiences, connect to support.	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.	Incorporated depression and suicide screening for all youth patients in FY2024.
Offer Intensive Outpatient Treatment Program (IOP) for behavioral health.	Requires staffing and staff training.	Enough capacity to support patients in need of care.	FY 2023: 34 patients benefited from 557 visits.
Place Master Licensed Alcohol and Drug Counselor (MLADC) in acute care setting for Substance Use Disorders.	Staffing	Provide SUD patients with education and most appropriate treatment/ discharge plan	# of patients treated by MLADC.
Offer Partial Hospitalization Program (PHP).	Requires staffing and staff training.	Enough capacity to support patients in need of care.	FY 2023: 1272 patients benefited from 12,295 sessions.
Offer Inpatient Behavioral Health Unit (maximum 18 beds) for adult men and women.	Requires 25 staff and 3.8 providers at full capacity. In FY23, staffed with 21.93 FTE's and 3.8 providers, 14 beds.	Enough capacity to support patients in need of care.	FY 2023: 410 patients benefited from 4,048 days of care with an average length of stay of 9.87 days

Priority	Identified Need: Sexual Activity		
●			
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
Connect teens with Lamprey Teen Clinic to address reproductive health.	Support teens and refer to Teen Clinic.	Improved awareness and reproductive health care for young adults.	Increased number of teens receiving reproductive health care.

2. Clinical Care – Access to Care, Quality of Care

Priority	Identified Need: Access to Care (Including Primary and Dental Care, Medicaid, and Health Insurance)		
●			
Actions/Programs to Address Health Need	**Resources Committed to Address Health Need**	**Anticipated Impact of Actions**	**Evaluation of Actions taken since last CHNA**
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, recommended screenings, preventive health measures (immunizations)	Expanded number of primary care panels, reduced wait times for care.
Call Center model ensures patients are matched with best provider fit and given a timely appointment.	Staffing and technology. All patients enrolled in MyChart to improve communication.	Patients matched with provider toward building long term relationship.	Added self-scheduling of appointments through MyChart in FY2024.
Continue to offer Interpreter Services Program.	Utilizes 5.44 FTEs and invests $825k in Interpreter Program to assist patients with their care.	Improved responsiveness and appropriate care delivery to non-English speaking patients.	Incorporated Stratus technology to improve program. Now offering live interpretation for hard-of-hearing.
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. Technology for virtual Immediate Care visits in FY23.	In FY2023, served 52,311 patients across four locations, an increase of 12,000+ patient visits over FY2022.	Launched telehealth option for minor, non-life-threatening conditions in May 2023, serving 392 people through June. First half of FY24 saw 1986 visits.
Provide staff to help with applications for Medicaid and financial assistance, premium assistance programs.	3 FTE's committed to helping patients complete applications.	Self-Pay <3.0 % of revenue.	Successfully assisted uninsured patients resulting in Self Pay patients of 1.7% in FY23.
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: vascular, gyn oncology, breast, plastics, MGH for children, thoracic, pediatric gastro.
Continue OB/GYN hospitalists and residency program.	Unfunded program costs of $757k over past 3 years.	Expands access to Women's Health in collaboration with Lamprey .	Secured a Tufts residency program for OB/GYN to augment current offerings.
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.	Continued collaboration, provided board leadership.

Priority	Identified Need:
●	**Quality of Care (Including Screenings and 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
UNE medical students continue to be educated on social determinants of health (SoDH) 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.	EPIC platform enables medical providers to have greater access to resources to assist patients that screen positive for SoDH.
Collaborate with Public Health and Lamprey to share importance of cancer screenings, breast cancer awareness in multiple languages. Continue reminders to patients based on age.	Staffing and resources to support programming. Introducing new electronic gap closure solution in FY25 to ensure all patients are screened.	Improved awareness of importance of screenings and early detection, especially in women age 40-55.	Now offers 3 mammogram units to meet demand. Patients are also able to self-schedule appointments through MyChart.
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.	Added “GI Genius” AI technology – first in state of NH – to increase polyp detection during colonoscopies.
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 through addition of Vitalicy program tracking level of handwashing compliance among front line care staff.	Dedicated staff and staff education; increased compliance 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.
Screen women who are pregnant or planning to become pregnant who misuse substances; Provide appropriate interventions and care for babies born with NAS.	EPIC EMR 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;
Link low-income moms/newborns with available resources for newborn care.	Social worker, maternal child health staff collaboration with Legacy Trust for resources.	Babies will have safe start in life through safe transportation and safe sleep practices.	New resource in FY2023.

Priority	Identified Need:
●	**Quality of Care (Including Screenings and 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
Manage heart disease/hypertension via Cardiac and Pulmonary rehab performance based standards; Offer array of supports for patients and families; Promote Go Red celebration, Cardiac Rehab and Pulmonary Rehab weeks, Stroke Awareness.	Continue sponsorship of BreatheNH's educational programs. Investment of time and funding for actions/ programs; Continue 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.	Maintained accreditation by DNV as a Primary Stroke Center/DNV Center for Excellence. Beat targeted global measurements for AMI & CHF. Adding new educational information for patients to reduce readmission in FY24.
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, Care Coordinators to ensure patients' needs are met.	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.
Continue to ensure access to same day appointments for patients struggling with asthma; Follow evidence-based protocols for adults and children. Continue accredited Pulmonary Rehab program to educate patients about early symptom recognition and mitigation strategies.	Time and funding for actions/programs described. Increased space needed to meet demand for pulmonary function testing.	Asthma patients will be educated and cared for in the correct environment and in a timely manner. More patients able to be tested in timely manner.	Followed evidence based protocol and decision support to assess and identify disease severity and evidence based protocol for patients admitted with COPD. Responded to increased demand by adding second room for pulmonary function testing.
Continue partnering with MGH for Oncology Specialists; Continue integration of palliative, behavioral health into oncology; Collaborate with SolutionHealth Cancer Institute to align support across region. Provide community 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.	In 2023, provided information to 40 older adults and 63 young parents about the dangers of tobacco use and QUIT resources through Nashua Senior Activity Center and United Way's Community Baby Shower. Further, 19 patients attended skin cancer screenings with 4 scheduling follow up appointments due to concerns raised.

Priority	Identified Need:
●	**Quality of Care (Including Screenings and 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, 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.
Ensure proper education/information on self-care and pregnancy management for new mothers and care of newborns.	SNHH OB-GYN providers, educators, outreach programs.	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.	CDC's Pregnancy Risk Assessment Monitoring, Maternal Health (PRAMS) Indicators randomly samples appx. 1 in 12 new mothers 2-6 months post-delivery suggests region met goals for prenatal care in 1st trimester, breastfeeding at discharge.
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 helped 139 parents learn about newborn care, infant CPR, breastfeeding, and the like. "Mom's Room" created in FY23 for employees needing to pump during work hours.

3. Social & Economic Factors – Education, Employment, Income, Family & Social Support, Community Safety

Priority	Identified Need:
●	**Education**

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
Collaborate with community partners to develop strategies to increase workforce pipeline; 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.	SNHH continuing to develop new partnerships to help improve the health of Nashua's most vulnerable neighborhoods in a meaningful way.	Added Workforce Development Director in FY24 to develop "earn to learn" apprentice programs. Will expand MA and LNA program to serve multiple areas.

Priority	Identified Need:
●	**Education**

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
UNECOM Medical Students offered opportunity to do 6-week rotation at Nashua Public Health impact community's health.	Collaboration with University of New England College of Medicine to support 8 students during third and fourth years of 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	Identified Need:
●	**Employment, Income**

Actions/Programs to Address Health Need	Resources Committed to Address Health Need	Anticipated Impact of Actions	Evaluation of Actions taken since last CHNA
Continued sponsorship and support for Front Door Agency initiatives helping to transform lives of single mothers.	$5,000 annual sponsorship	Resources, education, support for individuals and families coping with crisis and homelessness.	Deepening collaboration with new Workforce Development track in FY24.
Utilize Anchor Network resources to prioritize local hiring/promoting.	Staff outreach, support from Human Resources	Increased economic mobility in local neighborhoods	Leadership growing apprenticeship programs, ESOL classes for employees.

Priority	Identified Need:
●	**Community 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 providing dedicated Sexual Assault Nurse Examiner (SANE) in emergency department.	Dedicated/trained staff, collaboration with community for ongoing support	Specialized care by trained staff, faster treatment for victims, better evidence collection	# patients treated & # trained staff
Continue collaboration with Bridges to support patients experiencing domestic/sexual violence.	Ongoing collaboration with Emergency Department, SANE program staff, and $5,000 annual sponsorship.	Patients experiencing domestic violence will be connected to services and supports to help keep them safe.	Continued strong relationship between Bridges, SANE program staff, and high quality care for victims.
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. Personal preparedness training of SNHH staff through new employee orientation.	SNHH will prepare for, respond, recover from and mitigate 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 CDC. SNHH works in tandem with Nashua Police and Nashua Fire Rescue, for training exercises. Instrumental in creation of Health Care Workplace Safety Commission (RSA 151-J), and our EMS Director is first chairperson.

Priority	Identified Need: **Community 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.

4. Physical Environment – Air & Water Quality, Housing & Transit

Priority	Identified Need: **Air & Water Quality, Housing & Transit**		
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 to screen all patients for additional needs around food, housing, safety, etc. Connect patients in need to local resources.	Workflows developed for inpatient screening and referral, staff members to conduct screening	Dashboard created to track and understand how to best support patients. Improved integration and coordination on behalf of pediatric and adult patients	Continuing to develop strategies to respond to needs we can impact. Increased collaboration with community partners.
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.	Currently participating in state pilot to increase testing efficiency in one pediatric practice in FY24.
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.

End