Greater Nashua Community Health Improvement Plan 2015-2018

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Greater Nashua Public Health Advisory Council
Greater Nashua • Greater Health

GREATER NASHUA

COMMUNITY HEALTH IMPROVEMENT PLAN

September 2015

CITY OF NASHUA, NEW HAMPSHIRE

DIVISION OF PUBLIC HEALTH

AND COMMUNITY SERVICES

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A Letter from the Director

Dear Regional Health Partners, Residents, Community Leaders, and Colleagues,

In looking back at the Greater Nashua region's public health achievements of the past three years, the depth of community support and collaboration is visibly evidenced in the completed efforts of the Community Health Improvement Plan. Using the 2012-2015 CHIP as a guiding document, we have experienced important community change as strategies became real for the community in the form of gardens and trail improvements, neighborhood forums, educational toolkits and resource guides, workgroup-sponsored community events and the initiation of scalable health promotion initiatives and programs. These are system wide health improvements that are easy to see. Less visible, but more important for long term sustainability, the network of partners in the Public Health Advisory Council (PHAC) has developed its identity and advanced its role in the health improvement process. Through the shared experiences of the PHAC, we have learned how to combine expertise and resources to achieve mutual goals and how to work cooperatively to bring positive and sustainable change to the health and wellness of the community.

As we move forward with a new set of CHIP goals, objectives and evidence informed strategies for the 2015-2018 CHIP improvement cycle, I am confident that our community capability is even stronger. With the support of state level partners and the established engagement of the regional PHAC that has evolved out of two completed Community Health Assessments and one CHIP, we now have the capacity to address larger policy and system improvements. PHAC participation in educational opportunities and information sharing has enhanced our awareness of evidence informed practices and of the social determinants that shape health in our region. This is the kind of system wide knowledge and experience that has prepared us for the challenges ahead.

I am especially proud of the departments and staff within the Division of Public Health and Community Services that have devoted their time and talent, not only to CHIP planning and implementation but also to the core programs and standards that define public health service. It is a reflection of their efforts that Nashua DPHCS is New Hampshire's first public health department to apply for national public health accreditation, with achievement status anticipated in 2016. I am so very proud of this team, and appreciative of the support for accreditation from our Mayor and Board of Health, that puts Nashua DPHCS in the position to be acknowledged for excellence in public health service.

Sincerely,

Kerran Vigroux, BS, MPH
Director
Division of Public Health and Community Services

Acknowledgements

Acknowledgements

DPHCS CHIP Planning Team

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Ashley Conley	Epidemiologist
Beverly Doolan	Program Coordinator
Jackie Aguilar	Community Health Manager
Heidi Peek	Health Officer
Patty Crooker	PHNS Coordinator
Shannon Davis	Program Assistant

2014-2015 Greater Nashua PHAC Executive Committee Members

Jen Bernier	Lamprey Health Care—Nashua Center
Bob Cioppa	Nashua School District
Jackie Clancy	Southern NH Health System
Kathy Cowette	St. Joseph Hospital
Mike Currier	Merrimack Fire Department
Mark Doyle	Merrimack Police Department
Carol Furlong	Partnership for Successful Living
Paul Hebert	United Way of Greater Nashua
Betsy Houde	The Youth Council
Justin Kates	Nashua Office of Emergency Management
Mike LaChance	YMCA of Greater Nashua
Patti Laliberte	Dartmouth Hitchcock-Nashua
Captain Jay Maloney	Nashua Police Department
Sarah Marchant	Nashua Community Development
Dana McAllister	Milford Health Department
Mark McLaughlin	Merrimack School District
Kurt Norris	Boys and Girls Club of Greater Nashua
Tony Paradiso	Greater Nashua Mental Health Center
Camille Pattison	Nashua Regional Planning Commission
Heidi Peek-Kukulka	Nashua Division of Public Health and Community Services
Deb Scheetz	Gateways
Eric Schelberg	Milford Ambulance
Pam Small	Family Promise of Greater Nashua at Anne-Marie House
Suzanne Tammaro	Southern NH Health System
Dee Twomey	Greater Nashua Dental Connection
Lisa Vasquez	Nashua Division of Public Health and Community Services SMP Program
Kerran Vigroux	Nashua Division of Public Health and Community Services
Greg White	Lamprey Health Care—Nashua Center
Chris Williams	Greater Nashua Chamber of Commerce
Paula Williams	Rivier University

Other Organizations Participating in 2012-2015 CHIP Implementation Efforts and the 2015 -2018 CHIP Strategy Planning Meeting held on May 28, 2015.

Beyond Influence Leadership Team
Bridges
Citizens Bank
Foundation for Healthy Communities
H.E.A.R.T.S. Peer Support
Harbor Homes
HEAL NH
Home Health and Hospice Care
Marguerite's Place Inc.
Merrimack School District-Thornton's Ferry
Nashua Public Library
Nashua Parks and Recreation Department
Nashua Pediatrics
Nashua Pediatrics
Nashua Police Athletic League
Nashua School District, Dr. Norman W. Crisp Elementary School
Nashua Soup Kitchen and Shelter
Neighborworks of Southern NH
NH CATCH Kids Club
NH Healthy Families
NH School Counselor Association
Rivier University
SAU 39 (Amherst, Mont Vernon)
Southern New Hampshire Services
Southern New Hampshire Health System
St. Joseph Hospital Patient Family Advisory Council
The PLUS Company
UNH Cooperative Extension

Acknowledgements

Executive Summary

This 2015-2018 Community Health Improvement Plan (CHIP) for the Greater Nashua Public Health Region (GNPHR) supports the ongoing cycle of a health improvement process initiated by the Nashua Division of Public Health and Community Services in 2010. The plan is based on the data and analysis published in the 2014 Community Health Assessment and builds on previous regional CHIP outcomes, documented in the *2012-2015 CHIP Final Summary Report*. Most significantly, the 2015 CHIP represents the collaborative decision making and commitment of the Greater Nashua Public Health Advisory Council (PHAC), the network of regional stakeholders that supports all public health efforts in the GNPHR.

Considering that the previous CHIP priorities were access to health care, obesity, and mental health, it is not surprising that just three years later those topics have emerged again as priority health issues for the region. It takes time to understand these dense health topics, and even more time to influence them positively. However, there is a new planning perspective that accompanies these issues as they are included in the 2015-2018 CHIP. PHAC collaborators have gained additional understanding of access to health care, obesity, and mental health through the three year experience of 2012 CHIP implementation efforts as well as the publication and guidance provided by the 2013-2020 NH State Health Improvement Plan (SHIP). This new planning perspective is demonstrated through example: the Greater Nashua PHAC understands that it can strengthen its influence on **obesity prevention** by also prioritizing **heart disease and stroke** and **diabetes** as the related chronic diseases that can be improved through similar coordinated efforts. The 2015 CHIP plan addresses these as three separate, yet related, priorities. Similarly, **mental health** is now combined with the topics of **suicide prevention** and **substance misuse prevention**, both SHIP priorities that are supported by state level partnerships and programming efforts. Re-organizing our thinking to include all six pinpointed topic areas of obesity, heart disease and stroke, diabetes, mental health, suicide, and substance misuse prevention allows the GNPHR to address the issues with broader view and impact.

Access to health care remains a pressing issue for our region and our country, and is also included as a priority topic in the 2015 CHIP. While the 2012 CHIP Access to Health Care improvement strategies were largely focused on supporting and promoting insurance accessibility connected with the Affordable Care Act, in the 2015 -2018 improvement cycle the efforts will be more focused on sharing data to impact health equity, providing education to impact health literacy, and increasing specific access issues for cancer screenings and prenatal care. **Emergency preparedness**, historically a strongly supported health priority in the GNPHR, is the final health topic included in the 2015 CHIP. As the

2015 NH Emergency Preparedness Conference recipient of the "State of NH Most Valuable Partner Award", the GNPHR is highly regarded for its collaboration and innovation in emergency preparedness, response, and recovery. Including Emergency Preparedness as a priority issue in the 2015 CHIP gives us further opportunity to confirm our commitment to conducting exercises and trainings, and to maintaining the engagement of partners that play key roles in a health emergency.

The 2015-2018 CHIP is an aggressive but realistic plan that will assist the PHAC in its role to improve the health of the Greater Nashua Public Health region and its residents. It provides clear direction based on collaborative community planning and agreed upon statewide goals. It includes evidence based strategies that are measureable and appropriate for influencing the policies, systems, and environments that can bring change to the region. At the same time, the 2015-2018 plan is flexible. It allows for adjustments in timing, leadership, strategy initiation, and tactical planning. The 2015-2018 CHIP can be expanded to include the specific work plans that will be developed and used to guide the process and set responsibilities as strategies are implemented.

Introduction

As part of the ongoing process of community health improvement, every three years the City of Nashua, Division of Public Health and Community Services (DPHCS) conducts a Community Health Assessment (CHA) for the City of Nashua and the 12 surrounding towns that make up the Greater Nashua Public Health Region (GNPHR). The CHA identifies and measures the current health issues impacting the region and provides detailed information and statistics about those issues. Through the CHA, the community gains an understanding of the existing health concerns and community needs. Following the CHA, DPHCS continues the improvement process by developing a Community Health Improvement Plan (CHIP). Through the evaluation of health data and issues identified in the CHA, the CHIP process prioritizes health topics and creates an action plan to address those issues over the next three years.

In 2012, a year after the Nashua Division of Public Health and Community Services (DPHCS) published the first major CHA of the region in over a decade, collaborative partners in the region came together again to create an improvement plan that would ensure the public health issues included in the CHA would be prioritized and addressed with community wide support and commitment. The 2012 Community Health Improvement Plan (CHIP) identified the top three health issues in the GNPHR and provided specific goals and objectives for improving health conditions in the priority areas of obesity, mental health, and access to healthcare. To ensure implementation of identified initiatives, three workgroups were formed, one for each of the health priorities. Each workgroup was jointly facilitated by a staff member from the Nashua DPHCS and a partner organization from the planning group. During this same time, the State of NH Division of Public Health Services published a statewide improvement plan, the 2013 SHIP, a plan that identified State health priorities and highlighted ten key health areas for the state's public health networks to consider as they structured their regional assessments and improvement plans.

During 2014, DPHCS also began its internal work to develop a new strategic plan that would clearly highlight and support the focused work of community health improvement in guiding Division emphasis and efforts over the next five years. Specific goals around the CHA and CHIP were included, as were commitments to ongoing development and maintenance of the regional Public Health Advisory Council (PHAC) and an overall culture of quality and service. Combined with the CHA AND CHIP, a completed strategic plan gave DPHCS the final element needed to meet the prerequisite requirements and initiate an application to the national Public Health Accreditation Board.

Public health accreditation is the mechanism that assures stakeholders, partners, and clients that an organization is providing quality services and strives towards a culture of improvement.

Benefits of working towards accreditation include a strengthening of public health services and programs, enhancing public health departments and public health infrastructure, and increasing accountability and credibility. Currently, this national recognition of public health excellence is a voluntary process, however as time goes on, it is most likely that accreditation will become a national public health standard. When the Nashua Division of Public Health and Community Services achieves accreditation, anticipated in 2016, it will have the honor of becoming the first health department in New Hampshire to become accredited

DPHCS's continuous improvement process reached full circle in the fall of 2014, when DPHCS published a second CHA. The 2014 CHA, including updated data from primary and secondary sources and qualitative input from residents and health partners throughout the region, is useful to the community in understanding the current priority health issues of the region. As the next step in the process, the 2015-2018 CHIP Plan follows, and is fundamentally linked with, the 2014 CHA.

Regional Public Health Network

The Greater Nashua Public Health Network is one of the 13 regional public health networks in New Hampshire. More information about each of New Hampshire's Public Health Networks can be found at http://nhphn.org/who-we-are/public-health-networks/. Each Regional Public Health Network (RPHN) includes a host agency that has a contract with the NH Department of Health and Human Services to create public health infrastructure by convening, coordinating and facilitating work with public health partners in their region. These partners, collectively, are the Public Health Network, and members are asked to participate as a Public Health Advisory Council (PHAC) in providing input and support for public health efforts throughout the region. In the Greater Nashua region, Nashua DPHCS supports the PHAC by hosting meetings, maintaining communications, monitoring membership for multi-sector engagement and providing organizational support for the PHAC's Executive Committee. By coordinating the PHAC, DPHCS ensures a more synchronized community connection and response to Public Health Emergency Preparedness, Substance Misuse Prevention, Community Health Assessment, Community Health Improvement Planning, and other regional public health related programs. By participating in the PHAC, health partners gain awareness of issues, supports, trainings, resources, and opportunities for efficiency and shared responsibility. The Greater Nashua PHAC has actively participated in the development of this 2015-2018 CHIP.

As the Greater Nashua Public Health Region moves forward on the journey towards a healthier region, the PHAC will continue its engagement in the collaborative work that will bring changes in the policies, systems and environments impacting public health and well-being. Currently, total PHAC membership consists of 122 organizations with representation from these sectors:

Municipal Government, County Government, Hospitals, School Administrative Units, Community Health Centers, Community Mental Health centers, Businesses, Cultural/Faith Based Organizations, Social Service Agencies, Housing and Sheltering Organizations, Media and Senior Services.

To facilitate collaborative efforts and decision making, the Greater Nashua PHAC includes an Executive Committee, a smaller, multi-sector group of decision makers with an established history of working together to achieve community successes. The PHAC Executive committee functions with written roles and responsibilities and adopted guidelines that outline the principals and purpose of the network. Currently, there are 30 representatives on the Executive PHAC. The names and organizations of 2015 Executive Committee Members who participated in the 2015-2018 CHIP planning process are included in the Acknowledgements section of this document. For a list of current PHAC Executive Committee Members, visit the Division's website at www.nashuanh.gov.

Distinction between the PHAC and PHAC Executive Committee is clarified in the Guiding Principles:

The **Greater Nashua PHAC** is a network of organizations and individuals that work collaboratively to improve the health of the Greater Nashua Public Health region and its residents.

The **PHAC Executive Committee**, comprised of decision-makers from a variety of **Greater Nashua PHAC** partner organizations, provides leadership guidance to support health related efforts in the Greater Nashua Public Health Region.

In early 2015, the PHAC Executive Committee voted to incorporate a branding strategy that would clearly identify all PHAC efforts as community endorsed initiatives. All PHAC member organizations are encouraged to use the selected PHAC logo and to maximize impact by promoting evidence of collaborative commitment that supports public health initiatives in the GNPHR. Written guidelines for appropriate use of the branding tools were distributed to all PHAC Executive Committee members. Images, template presentation designs, and guidelines for use are available on the City of Nashua DPHCS website.

Community Profile

The City of Nashua is situated along the Merrimack River in the southern portion of New Hampshire's Hillsborough County. Known as "The Gate City," it has a history as an "economic engine" in the state and was twice voted as "One of the Best Places to Live in the U.S". The City's 31 square miles are home to an estimated 86,823 people, making up 6.6% of the total population of NH and giving it the title of the second largest city in the state. The Greater Nashua Public Health region includes the City of Nashua, as well as the twelve surrounding towns of Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Mason, Merrimack, Milford, Mont Vernon, Pelham and Wilton. The total population of the GNPHR is close to 206,000. The 2014 CHA provides detailed demographics for the region and also gives insight into how existing social determinants of health such as income level, housing status, race and ethnicity, connection with health resources, and other life influences are connected to health disparities within the region. Discussions and presentations that preceded the PHAC Executive Committee's selection of 2015 CHIP priorities included an overview of the social determinants of health to reinforce awareness of health equity.

Figure 1. Greater Nashua Public Health Region

Source: City of Nashua, GIS Department

The Vision and Mission of Greater Nashua Community Health Improvement Plan

The Greater Nashua PHAC is a network of organizations and individuals that work collaboratively to improve the health of the Greater Nashua Public Health region and its residents. Together, they participated in the 2011 and 2014 Community Health Assessments, developed the 2012-2015 Community Health Improvement Plan and implemented the strategies that continue to bring change in the region. Participating in the prioritization of health issues and corresponding plan for improvement is one way the network fulfills its responsibilities. Other areas of responsibility include engaging in emergency preparedness planning and exercises, assisting with data collection for health assessments and coordinating and sponsoring forums on public health issues. During the six month process of developing the 2015-2018 CHIP, PHAC members agreed to retain the same vision and mission statements developed during the 2012 planning process for the 2015-2018 Greater Nashua Community Health Improvement Plan.

VISION

Working towards a healthier Nashua region.

MISSION

To achieve a healthier Nashua region through collaboration, education and the coordination of resources.

Process for Community Health Improvement Planning

Through the evaluation of health data and issues identified in the CHA, the Greater Nashua CHIP process prioritizes health topics and creates an action plan to address those issues over the following three years. Community engagement is key to the CHIP process so that the resulting plan reflects not only the shared commitment to priority issues, but also considers the full community's assets, strengths, resources and needs for bringing about positive change. In this way, no single organization within the PHAC is burdened with full responsibility for the decisions or actions required to improve health, but all contribute in various ways to the improvement efforts. In addition, in order to maximize health impact and gain widespread support for improvement, the Greater Nashua CHIP coordinates with state level partners and aligns shared health priorities with the goals and objectives outlined in the NH State Health Improvement Plan (SHIP).

The process outlined here itemizes the steps for developing the CHIP that were completed over a six month timeframe, from December 2014 to May 2015, and includes summary information about the roles of the internal DPHCS planning group, the Public Health Advisory Council (PHAC) and the PHAC Executive Committee. The chronology of planning meetings explains the tools and inputs used, the collaborative agreements determined, and the achievements realized at each step in the 2015-2018 CHIP planning process.

Step 1: Convene a Planning Group (December 2014)

- The DPHCS planning team agrees to responsibilities for planning and facilitating all CHIP planning meetings, developing prioritization processes and tools and maintaining written records of each CHIP-related meeting. The Program Coordinator is the lead coordinator for both this group and the overall development of the CHIP.

Step 2: Create Vision and Mission Statements & Establish Priorities (December 2014)

- The DPHCS Planning Team organized the first of three PHAC Executive Committee meetings through which the 2015-2018 CHIP would be developed. Participants were presented the vision and mission statements of the previous, 2012-2015 CHIP and asked if the statements were still appropriate reflections of the core values of Greater Nashua's commitment to health improvement. The PHAC Executive Committee

approved both the vision and mission statements and they will be used for 2015-2018 CHIP.

- The DPHCS Epidemiologist led a comprehensive overview of each health topic covered in the 2014 CHA and provided each committee member a 2014 CHA Data Highlights packet with key indicators for each health issue covered in the CHA. DPHCS Planning Team then led the Executive Committee through a prioritization process. The prioritization of health issues is essential to the CHIP planning process as it enables the community to maximize its impact and efficiently use its resources on the issues of greatest significance to the community. Prior to or during the meeting, committee members were provided all primary and secondary data sources including the *2014 Nashua Community Health Assessment* and the *2014 Community Health Assessment Focus Group Report* to guide their decision making. They also received copies of the *NH State Health Improvement Plan* (SHIP) in order to consider opportunities for alignment with state priorities.

Step 3: Develop One or More Goals for Each Program and Priority Area and Develop Objectives to Support Each Goal (January-March 2015)

- In January 2015, the DPHCS CHIP Planning Team worked to develop a survey for PHAC Executive Committee members in order to identify which aspects of the prioritized health issues were most ready for stakeholders to impact. Consisting of 85 questions, the *2015-2018 CHIP Goals and Objectives Survey* was disseminated to 27 PHAC Executive Committee representatives using SurveyMonkey. Questions in the survey were designed to solicit organizational perspective on topics related to community health and the prioritized health issues, and included the following topics:
    - Definition of health and a healthy community
    - Is health issue related to organizational mission?
    - Organizational willingness to participate
    - Level of interest in addressing specific areas of the health issue
    - Available resources to address the issue
    - What organizational barriers and/or external forces could impact the ability to make change in the health issue?
- The DPHCS Planning team analyzed and consolidated the information provided from the 19 PHAC organizations that completed the survey into a summary report which was e-mailed to the PHAC Executive Committee. The DPHCS Planning team reviewed the results and developed draft goal and objective statements. Each objective statement

was designed using the "SMART" model to ensure that objectives were "Specific, Measureable, Achievable, Relevant and Time-bound." Goals and objective statements were also created with the intention of aligning with State Health Improvement Plan (SHIP) and/or Healthy People 2020 Objectives.

- In March 2015, the second of the three CHIP-focused, PHAC Executive Committee meetings was held. Committee members listened to a summary presentation of results from the *2015-2018 CHIP Goals and Objectives Survey* and received a *2012-2015 Workgroup Summary* report that highlighted 2012-2015 CHIP results, lessons learned from implementation efforts, and suggestions for improving the 2015-2018 CHIP. As part of the meeting, PHAC Executive Committee members divided into priority area breakout groups. Facilitated by DPHCS CHIP Planning Team members, breakout groups were asked to review the draft goals and objective statements, make any necessary changes and approve final statements, discuss options for evaluation measures and the optimal leadership structure to achieve the desired change. Notes from these sections were collected and used to modify the goals and objectives statements accordingly.

Step 4: Identify Potential Strategies for Accomplishing Objectives (April-May 2015)

- The DPHCS CHIP Planning Team convened four times to prepare for the 2015 Greater Nashua Public Health Advisory Council's Annual Conference. At this conference, additional partners and community members representing the larger, full PHAC network would have the opportunity to determine specific strategies to be implemented in the 2015-2018 Community Health Improvement Plan.
- Prior to the May 28, 2015 Annual Conference meeting, DPHCS CHIP Planning Team members contacted subject matter experts and researched evidence-informed strategies that would support the selected goals and objectives. They reached out to regional and state partners, reviewed available state and regional plans and also considered the 2012-2015 workgroup feedback in order to develop a preliminary list of 6-8 potential strategies for each goal. Where priorities were common, deliberate effort was made to align local strategies with state goals and objectives.
- Regarding initiative leadership, members of the CHIP Planning Team began to reach out to PHAC member organizations to identify leadership options for the strategies. Written guidelines and expectations for leaders were outlined in a document, *CHIP 2015 Leadership*, and shared with potential initiative leaders. Formal agreements were not completed.
- During the Annual Conference, attendees participated in facilitated sessions to discuss and select strategies for the region. Attendees were given handouts of the already

determined goals and objectives and at least one suggested strategy that would support them. In the sessions, participants heard a brief overview of the identified strategies and had an opportunity to ask questions and discuss the policy, system, or environmental changes needed to accomplish the strategies. Through discussion and group consensus, attendees selected a minimum of one strategy to support each objective. Notes for each session were recorded by members of the DPHCS CHIP Planning Team.

Step 5: Create Work Plans (June-September 2015)

- After the selection of the goals, objectives and strategies for the 2015-2018 CHIP, implementation groups will be formed to ensure community actions in the topic areas continue in the direction of the agreed improvement strategies.. While a multi-sector workgroup led efforts for the 2012-2015 CHIP, the 2015-2018 CHIP implementation efforts will include identified partner leadership for each initiative. In this way, organizations may participate in some but not all improvement efforts, according to their organizational priorities, funding, and current work. The structure will also allow for variable levels of partnership, according to the strategies currently being implemented.
- Work plans for the Behavioral Health, Chronic Disease, Access to Healthcare and Emergency Preparedness implementation groups will be initiated in the first quarter of the 2015-2018 improvement cycle. Confirmation of leadership and accepted responsibilities will need to be verified and included in the plans. The DPHCS CHIP Planning Team intends to maintain a majority of administrative leadership responsibilities for managing the agreed-upon strategies and will continue partnership efforts to engage PHAC organizations to take operational responsibility for specific actions outlined in the work plans. DPHCS facilitators for each implementation group will collaborate with PHAC lead organizations for each strategy to assist in facilitating group engagement, activities, and performance management.

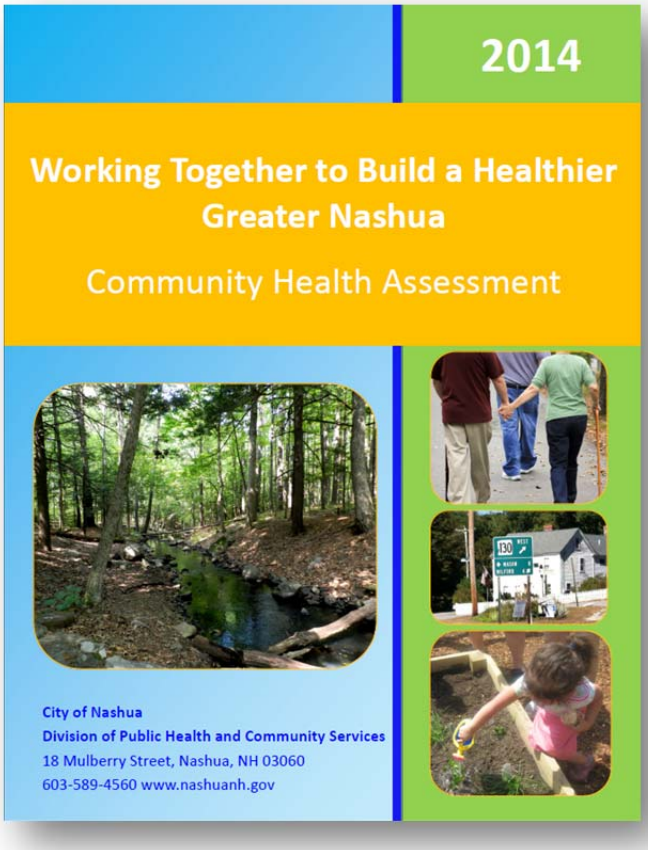
Inputs for Community Health Improvement Planning in the Greater Nashua Region

The Greater Nashua PHAC Executive Committee has a role to maintain active engagement in the ongoing and cyclical work of continuous improvement. Members are expected to ask, advise, assess, assure and advocate for public health excellence and to share their expertise at various intervals. The CHIP plan is one stage of a quality process. It establishes a written documentation for agreed-upon community priorities and gives structure for the everyday

events, programs, marketing campaigns, interventions, conversations and committee and taskforce efforts that need to be accomplished in order to achieve the long term policy, system, and environmental changes that will impact the selected priority areas. The CHIP is a guidebook, one that shares regional health goals with all members of the community and identifies the evidence informed strategies that can be used to reach identified targets. By aligning with NH SHIP priorities, the Greater Nashua CHIP supports large scale health change through coordination of focused effort. As a published document, the CHIP holds the community accountable for its health goals and for measurable progress in addressing priority areas.

Community Health Assessment (CHA)

A CHA is a process by which community members gain an understanding of the health concerns and needs of the community. The steps for conducting a CHA are included in the 2014 Greater Nashua Community Health Assessment.



In November 2013, the DPHCS formed the CHA Committee, a team of staff members from each department within the Division, that worked together to formalize a plan of action, write the CHA and perform internal duties such as scheduling and organizing events. The Epidemiologist was identified as the lead coordinator for the project. Also during this time, the CHA Committee started to recruit medical, collegiate and social service organizations for the CHA Advisory Board, a precursor name for the Public Health Advisory Council Executive Committee. The CHA Advisory Board was composed of 24 individuals from 22 organizations. The responsibilities of the Board were to attend four meetings, lend expertise to the DPHCS, review materials and data, become an advocate for the process, identify resources, and help disseminate the final report. Two subcommittees were developed under the Board to assist with planning: the Focus Group Subcommittee and the Data Collection Subcommittee

Prioritization Tools and Resources

Prioritization is a key step in the community health improvement process. Using findings from the Community Health Assessment (CHA), focus groups, surveys and other data collection methods, a health department is able to identify target priority areas where a population may have increased risk for poorer health outcomes. This information is then developed into a community health improvement plan (CHIP) in order to guide strategies and programs that will improve health and wellness in the greater Nashua region. Prioritizing health issues enables the health department to focus efforts and funding to health areas where it is most able to have the greatest impact.

A summary of the process by which the City of Nashua, Division of Public Health and Community Services (DPHCS) and the Greater Nashua Public Health Advisory Council (PHAC) determined health priorities for the 2015-2018 Greater Nashua Public Health Community Health Improvement Plan is included here. The complete protocol, including materials and spreadsheet records, is available.

Step 1: Set Up the Health Ranking Matrix

The Prioritization Matrix method was used and an Excel spreadsheet to record all of the results from the process.[1]

Step 2: Establish Voting Criteria for Health Priorities

To prioritize health issues for the 2015-2018 Community Health Improvement Plan, DPHCS used the four following criteria.

[1] Duttweiler, M. 2007. Priority Setting Tools: Selected Background and Information and Techniques. Cornell Cooperative Extension.

Criteria	Description
BURDEN How great is the health, emotional, economic and social impact of this health issue on the individual, family and our community?	1 = Low health, emotional, economic & social impact 2 = Moderate health, emotional, economic & social impact 3 = High health, emotional, economic & social impact
PREVALENCE How many people in our community are affected by this health issue?	1 = Not a significant amount 2 = A significant amount 3 = A very significant amount
RESOURCES Does our community have the ability to obtain personnel, finances and infrastructure to affect change with this health issue?	1 = Unable to affect change with present resources 2 = Able to affect change with present resources 3 = Highly able to affect change with present resources
IMPACT Are there short and long term benefits of addressing this health issue?	1 = Few short and long term benefits 2 = Some short and long term benefits 3 = Many short and long term benefits

Data sources provided to PHAC participants were:

- 2014 Community Health Assessment
- Focus Group Reports
- Survey Results

Step 3: Review Voting Process and Health Issues

DPHCS staff briefed the PHAC Executive Committee members on the most pertinent data indicators for the health issues. Participants were given time to discuss the issue. Participants then voted on each of the health criteria by holding up a numbered placard to rank the issue as a 1 (High), 2(Medium) or 3(Low) according to how they judged the health issue against the criterion. Participants voted only once for each Health Issue criterion and were encouraged to vote every single time regardless of experience or expertise.

Step 4: Record Results and Calculate Rank

DPHCS tallied the PHAC Executive Committee voting results. All health issues were ranked numerically by the value of the corresponding Health Issue Total. The results of the health issue rankings were announced at the conclusion of the Prioritization Meeting.

The final results of the prioritization voting were as follows:

Table 1. Prioritization of Health Priorities

Health Priority
1. **Behavioral Health*:** **Suicide** **Substance Misuse** **Mental Health**
2. **Weight Management/ Obesity**
3. **Heart Disease and Stroke**
4. **Diabetes**
5. **Access to Health Care**
6. **Emergency Preparedness****

*Behavioral Health was the broad topic heading used to encompass the priority health issues of Suicide, Substance Misuse, and Mental Health.

**Emergency Preparedness was not ranked as a top health issue for the community. In fact, there were four health priorities that received higher voting scores. However, it is required by New Hampshire Department of Health and Human Services funding for CHIP initiatives that Emergency Preparedness be included in each public health region's CHIP.

Public Health Executive Committee

The PHAC and PHAC Executive Committee include multi-sector representation from healthcare, schools, municipalities, non-profit service providers, and businesses. While not all Executive Committee members attended all three of the 2015-2018 CHIP Planning meetings, all received communications about the meetings and the topics covered. 70% of Committee members provided topic specific input regarding their organization's available assets, resources, current programs, barriers and external issues via an electronic survey. A list of the 2015 Greater Nashua Public Health Advisory Council Executive Committee individuals and their organizations is included in the Acknowledgements section as evidence of the inclusive and comprehensive representation that were part of the CHIP decision making process. Without exception, organizations represented on the 2015 PHAC Executive Committee have maintained consistent engagement with regional public health planning since 2009, when DPHCS first established the collaborative process that would become the decision making framework for public health improvement in the region. While individuals representing organizations vary due to staffing changes or organizational shifts, the organizations committed to the PHAC has remained constant.

Community Priority Areas

The top eight public health priority areas, listed in the priority order determined by the Greater Nashua Public Health Advisory Council Executive Committee, include:

1. Suicide Prevention*
2. Mental Health
3. Substance Misuse*
4. Obesity and Weight Management*
5. Heart Disease and Stroke*
6. Diabetes*
7. Access to Health Care
8. Emergency Preparedness*

*These priority areas are common to both the Greater Nashua Public Health Region and the State Health Improvement Plan.

In the *2015-2018 CHIP Goals and Objectives Survey*, PHAC Executive Committee members identified their organizational connection to the priority areas and their commitment to participating in improvement efforts, as evidenced in Table 2 below. Community support for improvement efforts is indicated by the "willing to participate" responses. It is encouraging to note that although there are many organizations with a mission that does not include a specific call to address the identified health priorities, those same organizations have nevertheless committed their support for improvement efforts. The 2015-2018 implementation efforts will include evidence informed strategies, determined through community-based processes and supported by the PHAC goals and objectives for the Greater Nashua Public Health Region. The remainder of this plan provides more in-depth information about the goals, objectives and strategic approach for improvement for the eight public health priority areas addressed in the 2015-2018 CHIP.

Table 2. PHAC Organizations with Mission Alignment and Willingness to Participate in CHIP

Health Priority	Included in Mission	Willing to Participate
Mental Health	57.9%(n=11)	78.9% (n=15)
Substance Misuse	52.6% (n=10)	78.9% (n=15)
Suicide	26.3% (n=5)	52.6% (n=10)
Obesity	42.1% (n=8)	63.2% (n=12)
Heart Disease and Stroke	31.6% (n=6)	47.4% (n=9)
Diabetes	31.6% (n=6)	42.1% (n=8)
Access to Health Care	42.1% (n=8)	63.2% (n=12)
Emergency Preparedness	57.9% (n=11)	68.4% (n=13)
19 Total Responses		

Priority Area 1: Suicide Prevention

Background

According to the CDC, in 2010, suicide was the 10th leading cause of death for all ages in the United States with 38,364 suicides; averaging 105 suicides each day. It was the leading cause of death among 15-24 year olds in the United States. That same year, there was a nationally estimated $34.6 billion in medical costs and loss of productivity due to suicide and suicide attempts. About 1/3 of suicide decedents tested positive for alcohol, 23% for antidepressants and 20.8% for opiates. In the United States, 8.3 million adults reported having suicidal thoughts, 2.2 million made plans to commit suicide, and 1 million reported making a suicide attempt. Suicide is four times higher in males, but females are more likely to have had suicidal thoughts. For males, firearms are the most commonly used method of suicide (56%) and for females, poisoning is the most common method (37.4%).[i]

There were 124 suicides in the GNPHR and 919 suicides in NH between 2008 and 2013. The majority of suicides in the GNPHR were in males ages 35 to 64 years old. From 2008-2013, the suicide rate for the GNPHR was 11.2 per 100,000. The Healthy People 2020 goal is to reduce the suicide rate to 10.2 per 100,000, which Nashua and the GNPHR do not currently meet.[ii]

Table 3. Suicide Rate by Gender (per 100,000), 2008-2013

	Nashua	GNPHR	NH
Total	11.9 (CI 9-15.5)	11.2 (CI 9.2-13.3)	13.8 (CI 12.1-13.8)
Female	*	4.1 (CI 2.6-6.1)	5.3 (CI 4.6-6.1)
Male	19.2 (CI 14-25.6)	18.8 (CI 15-22.7)	21.1 (CI 9.6-22.7)
*Source: NH DHHS; * repressed due to small numbers*			

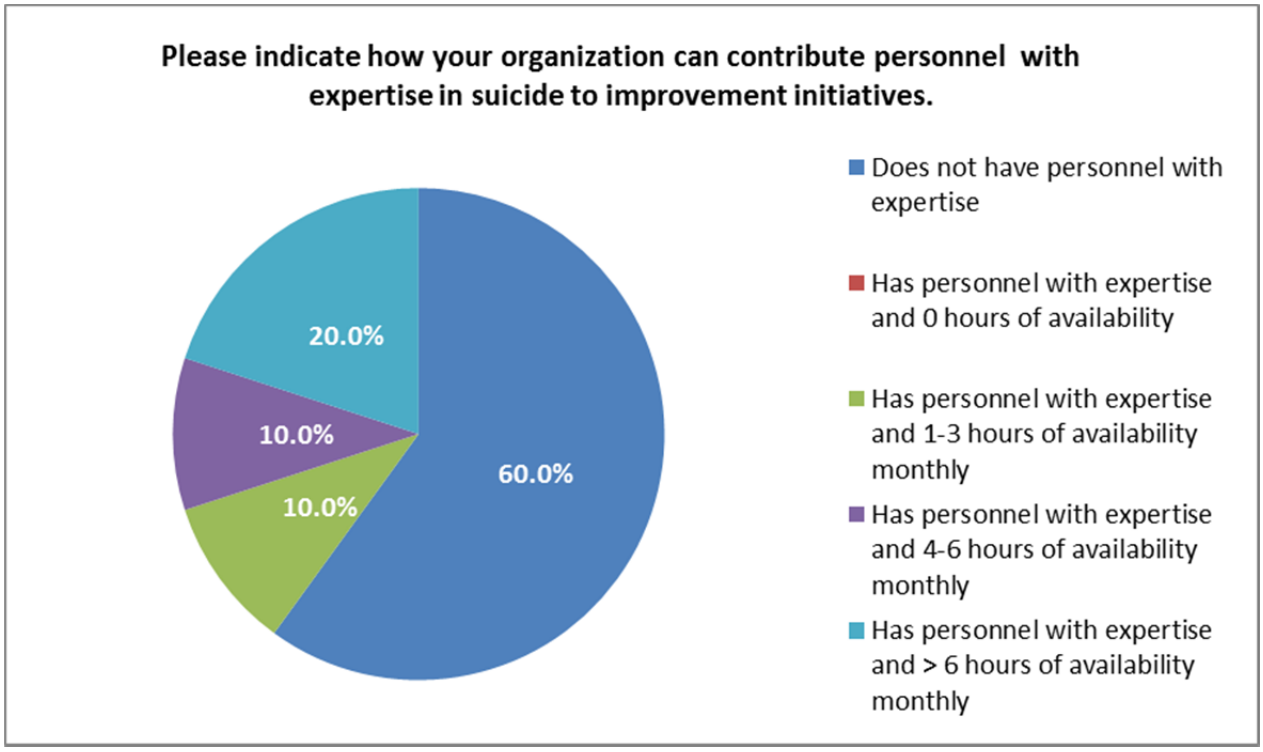
Nationally, 15 to 24 year olds account for 20% of suicides annually and 15.8% of students reported that they had seriously considered attempting suicide. In the GNPHR, 16.4% of high school students seriously considered attempting suicide, 7.1% actually attempted suicide one or more times in the past year and, of those that attempted suicide, 31.6% had to be treated by a doctor or nurse.[ii]

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around suicide prevention.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in suicide to improvement initiatives." Out of the 10 respondents who indicated that they wanted to participate in suicide prevention initiatives, 60.0% (n=6) reported having no personnel with expertise in suicide improvement initiatives. Of those who did have personnel with expertise, the majority (n=2) were able to dedicate more than 6 hours of time each month to suicide improvement initiatives.

Figure 2. Experts in Suicide Prevention



In addition to identifying personnel that can be a resource for improvement efforts, survey respondents were asked to indicate what existing programs their organizations had to support suicide prevention, awareness, or education efforts. Of the 10 respondents who indicated willingness to participate in suicide prevention efforts, 80% also indicated they did not have any existing, in house programs related to suicide prevention.

When asked to identify existing partnerships to address suicide, the most commonly indicated partnerships among respondents were partnerships with organizations providing mental health services (90%), followed by partnerships with organizations providing crisis support services and substance misuse services at 70% each.

Goals, Objectives and Strategic Approach

GOAL	**Increase awareness of suicide prevention, indicators, and prevention resources in the GNPHR**
OBJECTIVE	**1. Identify at least one evidence based suicide prevention program for common use among community partners by December 2015**

Strategic Approach

- **CONNECT Suicide Prevention. CONNECT provides training in suicide prevention across the lifespan for professionals and laypersons. CONNECT is included in the Best Practices Registry that is used to disseminate information about best practices that address specific objectives of the National Strategy for Suicide Prevention**.

Summary

Viewed together, the goal, objective, and suggested strategy for suicide prevention suggest a coordinated and finely directed method for addressing this issue in the GNPHR. The idea of supporting consistent prevention training will ensure that messaging, terms, and best practices are understood and communicated throughout the continuum of care. The lack of existing programs, as identified in the *2015-2018 CHIP Goals and Objectives Survey* results, can be improved when evidence informed trainings, like CONNECT, are initiated throughout the system of care.. The existence of state funding through the Public Health Network Services grant will support initial efforts, and additional resources and strategies can be added as more detailed work plans are developed during the last quarter of 2015.

Priority Area 2: Mental Health

Background

Healthy People 2020 defines mental health as a "State of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges".[iii] Mental disorders are health conditions characterized by alterations in thinking, mood and/or impaired function. Mental illnesses refer to all diagnosable mental disorders.

In the United States, mental health disorders are the leading cause of disability accounting for 25% of all years of life lost to disability and premature mortality. According to the National Institute of Mental Health, approximately 13 million adults in the U.S. have a serious, debilitating mental illness. The overarching Healthy People 2020 goal for mental health is to improve mental health through prevention and ensuring access to quality mental health services by 10%.[iii]

About 11% (CI 8.7-13.6%) of adults 18 years and older in the GNPHR self-rate their health as fair or poor and the number of mentally unhealthy days experienced by adults is about 3.5 days (CI 1.8-5.3) per month. Generally, mentally unhealthy days include any days when a person experiences problems with their emotional wellbeing. For women in the GNPHR of childbearing age, 16% have 14 or more mentally unhealthy days each month. In high school students from the GNPHR, 18.7% reported that they purposely hurt themselves by cutting or burning and 28% reported that they felt so sad or hopeless that they stopped doing some usual activities.[iv]

In the United States, mental health disorders are the leading cause of disability accounting for 25% of all years of life lost to disability and premature mortality.

Table 4. Mental Health Indicators, BRFSS and YRBS

	Nashua	GNPHR	NH
Adults self-rating their health as fair or poor (2012)	12.8% (CI 8.8-16.9%)	11.2% (CI 8.7-13.6%)	13.5% (CI 12.4-14.6%)
Adults and the number of mentally unhealthy days each month (2012)	3.8 (CI 0.8-6.8)	3.5 (CI 1.8-5.3)	4.2 (CI 3.4-5)
Women of childbearing age with 14 or more mentally unhealthy days (2012)	11% (CI 0.4-21.5%)	16.3% (CI 8.8-23.7%)	17.3% (CI 14-20.5%)
High school students cutting or burning themselves on purpose without wanting to die* (2013)	19.9%	18.7%	18.7%
High school students feeling sad or hopeless and stopped usual activities* (2013)	31.3%	28%	26.2%
*Source: NH DHHS; BRFSS and YRBS**			

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around mental health.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in mental health to improvement initiatives." Seven respondents indicated having staff with no expertise in mental health (46.7%). Of those having personnel with expertise, 20.0% (n=3) are able to dedicate 1-3 hours monthly to mental health improvement initiatives.

Of 15 respondents, 40% indicated having no existing programs to address mental health. 26.7% (n=4) of respondents had mental health services/resources and crisis support programs currently in place.

Figure 3. Expertise in Mental Health

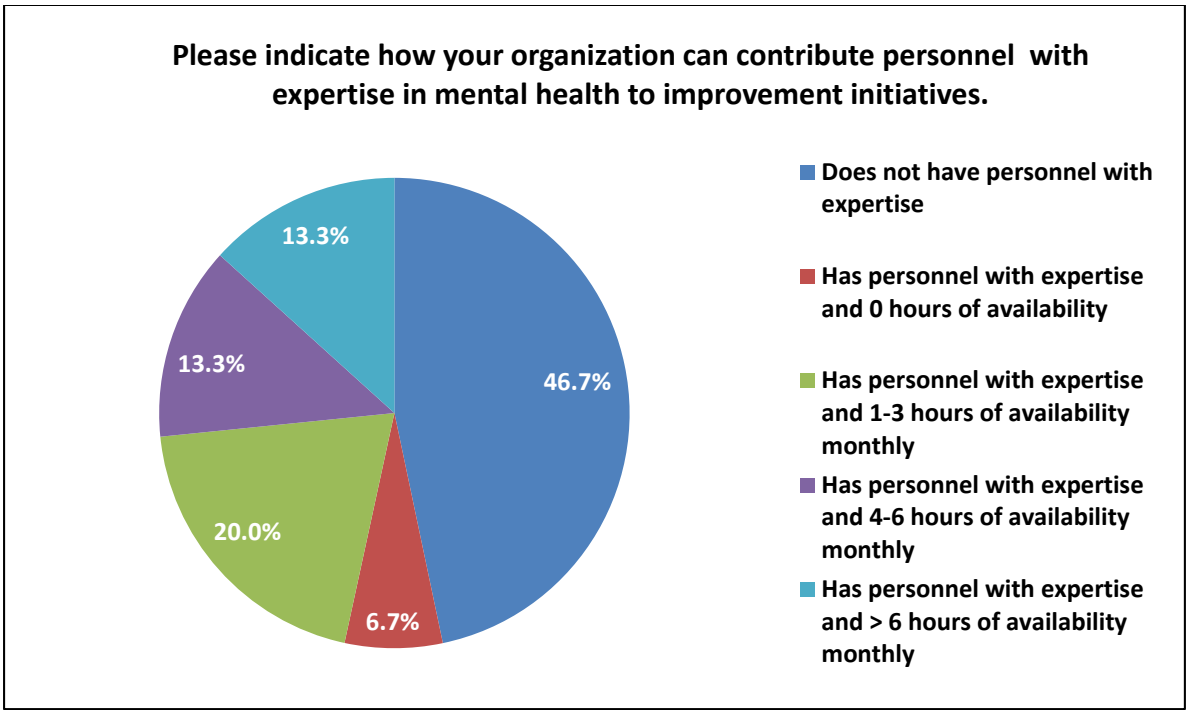


Table 5. Programs to Address Mental Health

Please indicate what existing programs your organization has to address mental health. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
None	40.0%	6
Mental health services/resources	26.7%	4
Crisis Support	26.7%	4
Other	20.0%	3
Mental health education programs for professionals	13.3%	2
Mental health education programs for adolescents/young adults - school/college-based	13.3%	2
Prevention and early intervention strategies	6.7%	1
Mental health education programs for seniors	6.7%	1
Recovery Support for individuals with mental illness (e.g. housing, work, job training)	6.7%	1
For each area that your organization has a program, specify the name of the program.		6
Total Responses		**15**

Respondents specified the following names of the internal or regional programs already established to address mental health.

- Internally, Critical Incident Management certified team.
- No programs - just participation on workgroup
- Collaboration with Greater Nashua Mental Health Services
- integrated behavorial health counselors in primary medical care medical clinic
- Harbor Care Health and Wellness Center and The Training Institute
- We offer counseling in our downtown Nashua office for children and teens. We also offer an array of other programs in-house that lend themselves to counseling referrals.

When asked to identify existing partnerships to address mental health, the most commonly indicated partnerships among respondents were partnerships with organizations providing mental health services (73.3%) and crisis support services (66.7%).

Table 6. Partnerships to Address Mental Health

Please indicate what existing partnerships your organization has to help address mental health. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Partnerships with organizations that provide mental health services	73.3%	11
Partnerships with organizations that provide crisis support services	66.7%	10
Partnerships with organizations that provide substance misuse services	60.0%	9
Partnerships with organizations that provide behavioral health education	40.0%	6
Partnerships with local media outlets (newspaper/TV/social media)	20.0%	3
None	13.3%	2
Total Responses		**15**

Regarding barriers to participation in CHIP mental health efforts, 6 of 15 PHAC Executive Committee responses indicated their organization's limited or inconsistent funding for mental health efforts could impact participation. Additionally, three organizations responded that limited personnel and limited mission would impact their participation in CHIP efforts.

Goals, Objectives and Strategic Approach

GOAL	**Conduct a comprehensive analysis of the mental health system capacity in the GNPHR, including gaps/needs, identifying mental health resources, and indicating priority areas for improvement.**
OBJECTIVE	**1. Develop an exploratory committee of highly engaged stakeholders by December 2015.** **2. Complete a comprehensive report on the mental health system capacity in the GNPHR by December 2016**

Strategic Approach

- **Establish a committee to include representatives from the current workgroup and develop an action plan to recruit others**
- **Coordinate with the NH Bureau of Alcohol and Substance Misuse (BDAS) and Center for Excellence (CFEX) contractor to obtain template for use in asset identification and service gaps**

Summary

Stakeholders in support of mental health improvement come from a wide variety of backgrounds ranging from medical personnel, school professionals, support agency staff and individuals working to manage mental health in their families. Building on implementation efforts of the previous CHIP, the 2015 goals, objectives and strategies that call for comprehensive review and response in understanding the region's mental health system capacity are well rooted. Plans for the exploratory committee to include representation from the former mental health workgroup will help ensure the lessons learned over the past three years are included in future implementation efforts.

Priority Area 3: Substance Misuse

Background

Alcohol, tobacco and other drugs continue to be a problem in communities across the nation. The use, misuse and abuse of substances surpass the individual and impact all members of a community. Substance abuse has both short and long-term health and safety consequences, including cognitive impairment that affects activities such as driving and learning, delays to adolescent brain and social skill development, suicide risk, unwanted sexual activity, violence, injury, family and relationship problems, academic failure, low work place productivity, acute intoxication, crime, addiction and other outcomes, many of which are associated with significant personal and societal costs. Drug control spending has increased dramatically in the last decade. According to the National Drug Control Budget the 2013 Fiscal Year saw a spending of $23.8 billion for drug control up from $17 billion in 2003.[v] These numbers do not take into account drug related medical costs or loss of productivity due to substance abuse. According to the National Survey on Drug Use and Health, New Hampshire ranks as one of the highest states for substance abuse among New England states, and New England has a high substance abuse rate compared to the rest of the country.[vi]

According to the U.S. Drug Enforcement Administration, marijuana is the predominant drug of choice for New Hampshire, and is readily available in all parts of the State.[vii] This report also indicated that heroin and methamphetamine abuse and availability were increasing, particularly in the seacoast and western parts of the State. Abuse of alcohol or other drugs is a common cause of physical and mental health problems in older adults, especially older men. Rates of illicit drug abuse and dependence are lower in the older population than in younger people. However, substance misuse, such as inappropriate use of prescription and over-the-counter (non-prescription) medicines, is increasing.[viii] In New Hampshire, this is visible in the sharp increase of overdose deaths between 2012 and 2013 for males ages 50-59, increasing from zero deaths to eleven in just one year.[ix]

Most people who use drugs begin using as teenagers. Nationally, there were over 2.8 million new users of illicit drugs in 2012, or about 7,900 new users per day. Over half (55.1 %) were under 18 years of age when they first began using illicit drugs. Most (65.5%) of new illicit drug

users begin with marijuana followed by prescription pain relievers (17%) and inhalants (6.3%) which is most common among younger teens.[x] New Hampshire high school students were asked about drug use in the 2013 Youth Risk Behavioral Survey (YRBS) that was also completed in the Greater Nashua Public Health Region (GNPHR). Table 7 represents the results for substance related questions answered by high school students.[xi]

Table 7. Substance Abuse Indicators for High School Students, 2013

	Nashua	GNPHR	NH
Students used marijuana one or more times during past 30 days	26.2%	24.8%	24.2%
Students tried marijuana for the first time before age 13 years	7.8%	6.4%	7.0%
Students haven take prescription drug (such as OxiContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax) without a doctor's prescription one or more times during their life	18.6%	17.5%	16.6%
Students have taken a prescription drug (such as OxiContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax) without a doctor's prescription one or more times in the past 30 days	8.8%	8.1%	7.8%
Students used some form of cocaine, including powder, crack, or freebase, one or more times during their life	6.7%	6.0%	5.9%
Students sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life	8.4%	8.4%	8.3%
Students used heroin one or more times during their life	2.7%	2.8%	3.0%
Students used methamphetamines one or more times during their life	3.2%	3.4%	3.5%
Students used ecstasy one or more times during their life	8.1%	7.6%	7.0%
Students who were offered, sold, or given an illegal drug on school property by someone during the past 12 months	21.0%	19.3%	18.7%

Source: NH DHHS, 2013 YRBS

The Healthy People 2020 objective for high school students reporting use of marijuana in the past 30 days is to lower the rate from its current 6.7% (2008) to 6% by 2020.[xii] The current rate for the GNPHR is 24.8% which is far from the Healthy People 2020 goal. The communities of the GNPHR are working in coalitions focused on substance abuse prevention to lower the rates of use through education and projects to influence social norms regarding substance use.

When GNPHR students were asked about access to substances, 45.6% of students think it would be very easy for them to get some marijuana if they wanted to and 17.8% of students think it would be very easy for them to get a prescription drug without a doctor's prescription if they wanted to. When asked about perception of harm 22.7% of students think people are at great risk of harming themselves (physically or in other ways), if they smoke marijuana once or twice a week and 62.7% of students think people are at great risk of harming themselves (physically or in other ways), if they take a prescription drug without a prescription.[xiii]

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around substance misuse.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in substance misuse to improvement initiatives." Out of 15 respondents, 33.3% (n=5) indicated they did not have personnel with expertise in substance misuse. Another 33.3% (n=5) of respondents indicated having personnel with expertise and more than 6 hours of availability each month.

Of 15 PHAC Executive Committee respondents, a third of respondents indicated their organizations had formal educational curriculum available to address substance misuse (n=5). However, an additional one third of respondents indicated their organizations did not have any substance misuse programs available.

A few of the programs currently available that were identified in the survey were:

- Drug Free Communities grant program
- BDAS funded substance misuse program
- This is covered in Health classes
- Our district benefits from a federal safe and drug free schools grant
- Harbor Care Health and Wellness Center
- P.A.C.T. Program / Merrimack Safeguard

- Teens/young adults only. GAIN -- screening/assessment tool (EBP), Outpatient Counseling Challenge Program -- psychoeducational group
- Smart Moves, Smart Leaders

When asked to identify existing partnerships to address substance misuse, the most commonly indicated partnerships among respondents were partnerships with organizations providing mental health services (80.0%), followed by partnerships with local prevention coalitions and partnerships with organizations providing mental health services at 73.3% each.

Figure 4. Expertise in Substance Misuse

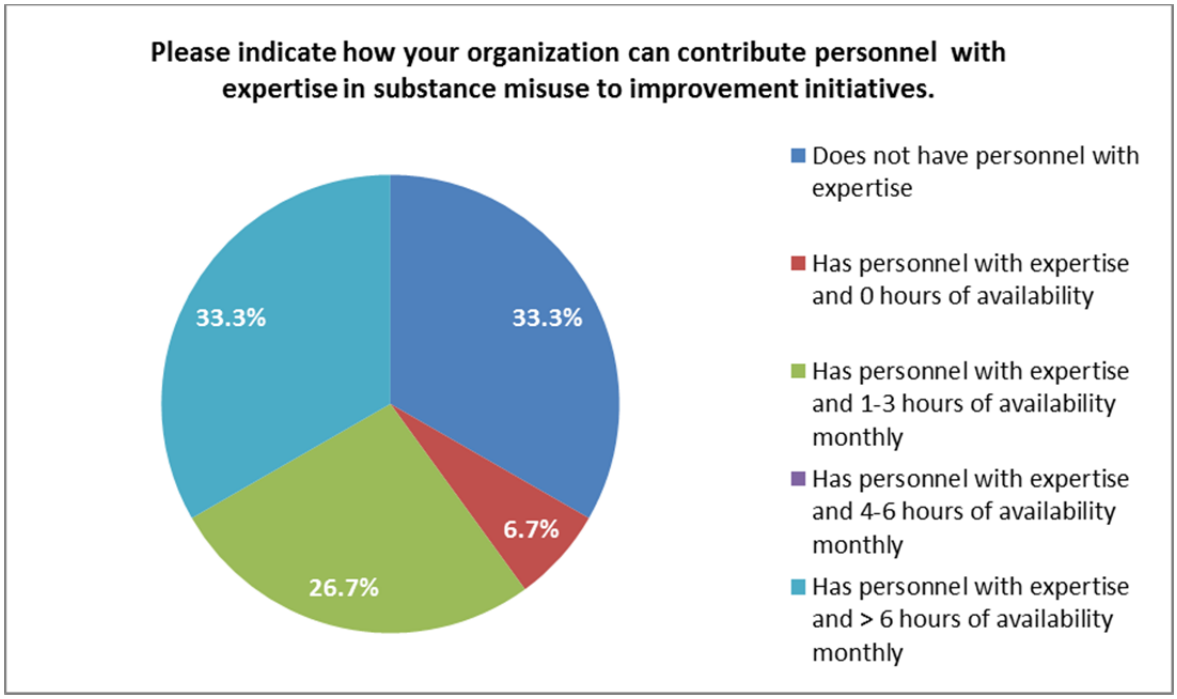


Table 8. Existing Programs in Substance Misuse

Please indicate what existing programs your organization has to address substance misuse. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
A formal educational curriculum	33.3%	5
None	33.3%	5
Other	26.7%	4
Treatment services	13.3%	2
For each area that your organization has a program, specify the name of the program.		8
Total Responses		15

Table 9. Existing Partnerships for Addressing Substance Misuse

Please indicate what existing partnerships your organization has to help address substance misuse. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Partnerships with organizations that provide substance misuse services	80.0%	12
Partnerships with local prevention coalitions	73.3%	11
Partnerships with organizations that provide mental health services	73.3%	11
Partnerships with organizations that provide crisis support services	46.7%	7
Partnerships with organizations that provide behavioral health education	46.7%	7
Partnerships with local media outlets (newspaper/TV/social media)	40.0%	6
None	6.7%	1
Total Responses		**15**

PHAC Executive Committee input from 15 survey respondents indicated limited/inconsistent funding as a barrier to participation in substance misuse related efforts (n=6). Time and limited mission were the next most commonly identified barriers with two votes each.

Goals, Objectives and Strategic Approach

GOAL	**Decrease substance misuse in the GNPHR**
OBJECTIVE	**1. During 2016, increase opportunities for high school students to participate in positive programs that reduce substance misuse.**

Strategic Approach

- **Reconnecting Youth (RY). RY is resiliency programming for students ages 14-19. RY is a peer group approach to building life skills that helps build resiliency against risk factors and control early signs of substance abuse and emotional distress. The program targets youth who demonstrate poor school achievement and have a high potential for school dropout**

Summary

The regional network infrastructure for substance misuse prevention has undergone major changes in the past two years. The most notable change that has impacted the GNPHR is the move of the Substance Misuse Prevention (SMP) network (formerly Beyond Influence) from being housed under the Greater Nashua United Way to being organized within the City of Nashua Division of Public Health and Community Services. The Greater Nashua United Way provided guidance to the program for many years, resulting in the development of strong regional coalitions with clear leadership. The benefits of being organized under the public health department are; enhanced access to the public health network, access and collaboration with other public health initiatives, increased communication with the public health network.

Considering that the 2015 CHIP goals, objectives and strategies for substance misuse prevention reflect the same goals committed to in the 2015 SMP Strategic Plan, and considering that SMP leadership is established within DPHCS, this priority area is well positioned for early progress and streamlined implementation efforts.

The SMP network is committed to system development by supporting the local prevention coalitions that exist throughout the Greater Nashua Region. There are currently five coalitions in this region that focus on substance misuse prevention, each with a developed mission and identity that reflect their local collaboration. The Substance Misuse Leadership Team has been re-established and there is SMP representation on the regional Public Health Advisory Council (PHAC) Executive Committee.

Priority Area 4: Obesity and Weight Management

Background

Maintaining a healthy body weight through proper nutrition and regular physical activity can help decrease a person's risk of developing serious health conditions such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer.[xiv] These activities can have a positive impact on overall well-being through better management of existing health conditions and improved quality of life. A number of factors, such as access to healthy foods and safe places to engage in physical activity, affect a person's ability to eat a healthy diet, stay physically active, and achieve or maintain a healthy weight.[xv] Healthy People 2020 (HP2020) is a program of the US Department of Health and Human Services and the vision for Healthy People 2020 is, "A society in which all people live long, healthy lives". For three decades, Healthy People has set 10-year national objectives for improving the health of Americans.

The State of New Hampshire mirrors the national average with 26% of adults and 18% of children being obese. In comparison to the United States, New Hampshire has lower rates of obesity than other parts of the country, especially compared to the southeast and Midwest.[xvi] Obesity and overweight are associated with increased risk for several chronic diseases and conditions and have been on the forefront of prevention strategies over the past few years. Progress in obesity management and prevention are being made by developing programs, systems, and environmental initiatives that help make healthy choices available, affordable, and easy.[xvii]

The Healthy People 2020 goal is to reduce national obesity from 35.3% to 30.5% for adults ages 20 years and older. In NH, the New Hampshire State Health Improvement Plan has a goal to reduce it to 20% by 2020.[xviii] In the Greater Nashua Public Health Region (GNPHR), 26.6% (CI 23.1-30.1%) of adults over 18 years of age are obese and 63.7% (59.6-67.7%) are obese or overweight. In Nashua, 23.7% (CI 18.4-29%) of adults over 18 years of age are obese and 65.2% (CI 58.8-71.5%) are obese or overweight. According to these data, the GNPHR and Nashua meet the Healthy People 2020 goal but do not meet the SHIP 2020 goal.[xix]

Table 10. Weight by Geography, 2012

	Nashua	GNPHR	NH	HP2020 Goal	SHIP Goal (2020)
Obese	23.7% (CI 18.4-29%)	26.6% (CI 23.1-30.1%)	27.6% (CI 26.1-29.1%)	30.5%	20%
Overweight	41.5%*	37.1%*	34.8%*	N/A	N/A
Healthy Weight	31.7% (CI 25.6-37.9%)	34.6% (CI 30.6-38.6%)	36.2% (CI 34.5-37.8%)	N/A	N/A
*Source: NH DHHS; *=Confidence Intervals were not calculated*					

Childhood obesity increases the risk for several chronic diseases including type II diabetes, high blood pressure, liver disease and depression during childhood as well as adulthood. The problem of childhood obesity has increased significantly during recent years. The percentage of children ages 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 18% in 2012.[xx] The Healthy People 2020 goal aims to reduce the proportion of children ages 6 to 11 years old who are considered obese to 15.7% and the NH SHIP goal aims to reduce the proportion of children considered to be obese to 17.2% by 2015 and 16.2% by 2020.[xxi]

The City of Nashua 2013-2014 Third Grade Survey was conducted between September 2013 and March 2014 in conjunction with the New Hampshire Third Grade Healthy Smiles Healthy Growth Survey. Height and weight assessments for all participating third grade students indicated that 17.4% of students were obese, 17.5% were overweight, 63.3% were normal weight, and 1.7% of students were underweight. There were no statistically significant differences between BMI categories by sex. The City of Nashua has not met the Healthy People 2020 goal of reducing the proportion of 6 to 11 year olds that are considered obese to 15.7%.[xxii] The NH SHIP goal is to reduce the proportion of children considered obese from 18.1% to 17.2% by 2015 and Nashua is 0.2% away from reaching this goal but needs to continue efforts to reach the NH SHIP 2020 goal of 16.2%. Regional data for this health indicator is not available at this time.

Table 11. Overall (both males and females) age and gender, BMI categories, 2013

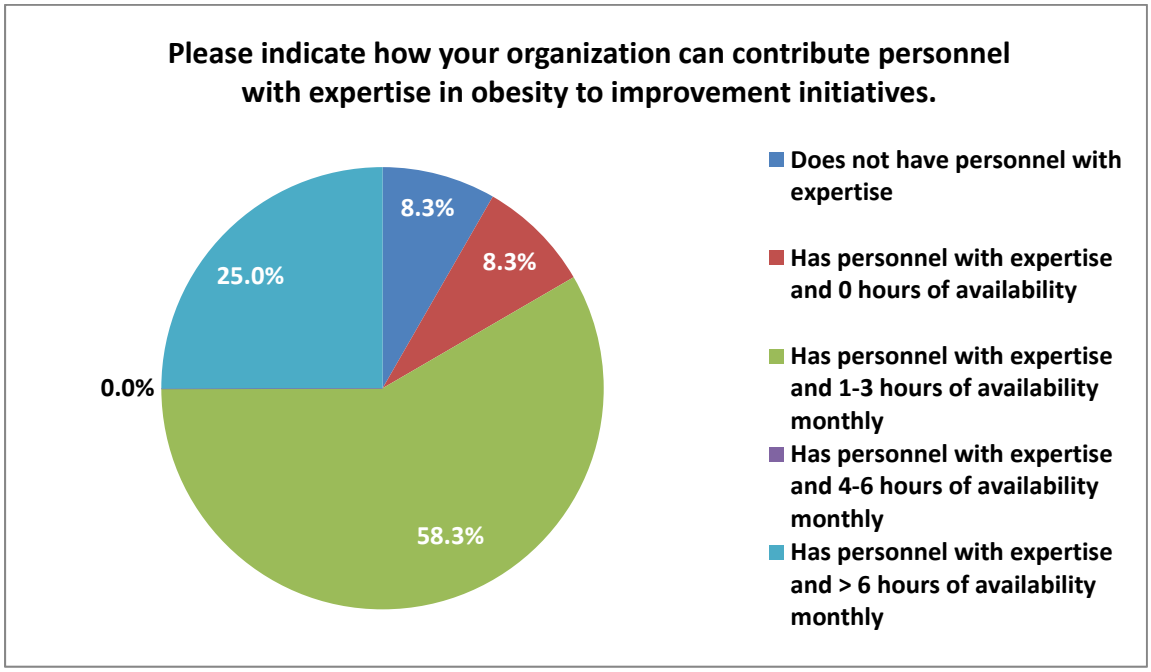
Variable	Students overall (n = 821)	
	No.	Proportion
Obese	143	17.4%
Overweight	144	17.5%
Normal weight	520	63.3%
Underweight	14	1.7%
Source: City of Nashua, Third Grade Survey; NH DHHS		

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around obesity.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in obesity to improvement initiatives." Nearly 60% of respondents (58.3%) indicated that they had personnel with expertise who were able to dedicate 1-3 hours each month to obesity improvement initiatives. One quarter of respondents indicated that they did not have personnel with expertise in obesity.

Figure 5. Expertise in Obesity Prevention



Approximately 40% of respondents indicated having physical activity/recreational programs or employee wellness initiatives within their organization (n=5). Following that, a third of organizations indicated having healthy eating/cooking programs or other programs available.

Table 12. Existing Programs in Obesity Prevention

Please indicate what existing programs your organization has to address obesity. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Physical activity or recreational programs	41.7%	5
An employee wellness initiative	41.7%	5
Healthy eating/cooking program	33.3%	4
Other (Please describe in the comment box below)	33.3%	4
A formal educational curriculum	25.0%	3
None	8.3%	1
For each area that your organization has a program, specify the name of the program.		9
Total Responses		12

PHAC Executive Committee survey respondents identified the following existing programs to address obesity:

- Amherst Street Elementary School program
- workgroup members, staff able to commit to community projects, grant opportunities
- Health Classes and physical education classes
- health education forums for community
- Can provide mapping and development / design of outreach materials focused on walking and biking.
- nutritionist on staff
- Lighten Up Nashua
- Many programs
- Harbor Care Health and Wellness Center

When asked to identify existing partnerships to address obesity, the most commonly indicated partnerships among respondents were partnerships with organizations that offer sports, physical and/or recreational activity (58.3%), followed by relationships with chefs, grocers, local farmers, restaurant owners and/or community gardeners and local media outlets at 41.7% each.

Table 13. Existing Partnerships

Please indicate what existing partnerships your organization has to help address obesity. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Existing partnerships with organizations that offer sports, physical and/or recreational activity	58.3%	7
Relationships with chefs, grocers, local farmers, restaurant owners and or community gardeners	41.7%	5
Partnerships with local media outlets (newspaper/TV/social media)	41.7%	5
Partnerships with food growers, distributors/retailers, convenience/grocery stores, supermarkets, restaurants.	25.0%	3
None	25.0%	3
Total Responses		12

50% of PHAC Executive Committee responded "none" when asked about the barriers or organizational limitations that would impact their participation in CHIP improvement strategies. Four out of 12 respondents indicated limited funding as a barrier and 2 respondents indicated limited time as a barrier.

Goals, Objectives and Strategic Approach

GOAL	**Reduce overweight and obesity in the GNPHR**
OBJECTIVE	**1. Reduce the percentage of overweight and obese adults in the GNPHR from 63.7% to 62% by December 2018** **2. Reduce the percentage of overweight and obese children in the GNPHR by 1% by December 2018**

Strategic Approach

- **Granite State Market Match. This program allows for individuals with Supplemental Nutrition Assistance Program (SNAP) benefits to purchase twice the value of produce at local farmer's markets. Implementation of this strategy will give more families with financial need the ability to access fresh fruit and vegetables and will generate increased economic activity for local vendors.**
- **Plan4Health Nashua. This initiative promotes transportation planning that includes consideration for pedestrians, bicyclists, motorists, and transit riders and can impact all ages and abilities.**
- **5-2-1-0. This educational campaign provides simple, easy to remember guidance around fruit and vegetable consumption, television and computer use, physical activity, and sweetened beverage elimination.**
- **Prescribe the Y. This program allows pediatricians to prescribe a YMCA membership to overweight and obese children at no cost to the family**

Summary

The combination of strategies that promote both healthy eating and active living supports the regional goals and objectives that target specific reductions in overweight and obesity rates in the region. As an issue highlighted by data in both the 2011 and 2014 CHAs, and included in the 2012 CHIP, there have been focused obesity prevention efforts in the Nashua region over the past several years. Noted successes in increasing access and use of trails and promoting opportunities for better access to healthy foods will contribute to ongoing efforts during the

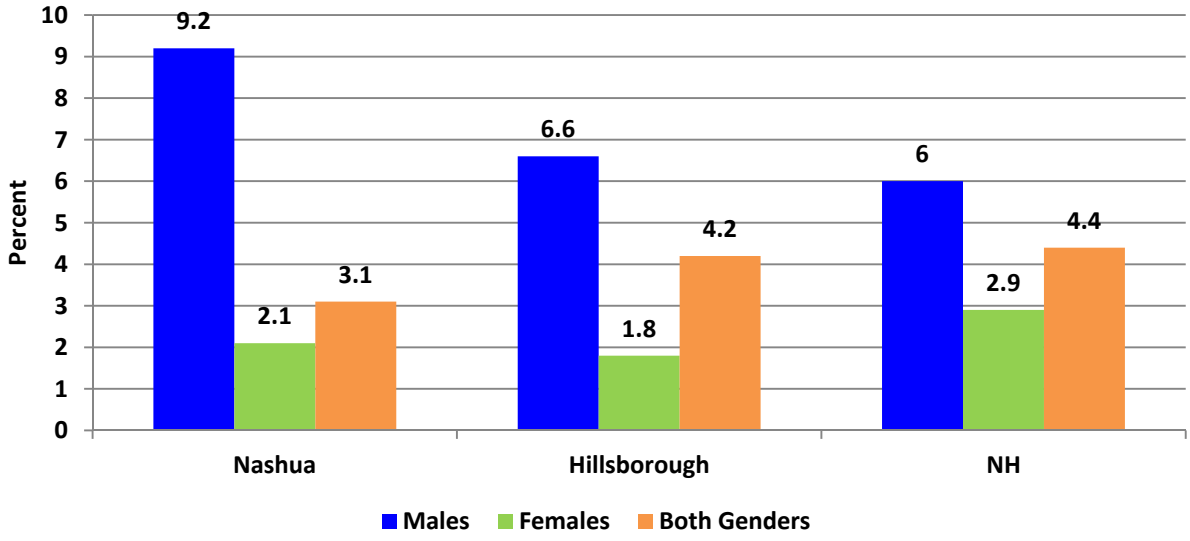
next 2015-2018 CHIP cycle. Leadership commitment by the YMCA of Greater Nashua, including provision of a workgroup facilitator, continues to assist in bringing strategies to the workplaces, food outlets, municipal organizations, schools, and health providers in the region. Connection with the NH HEAL community also supports obesity prevention efforts through collaborative efforts and statewide networking. The 2012 selection of Nashua as a "HEAL Community" gave Nashua an opportunity to move forward with a project to increase neighborhood access to healthy foods and exercise. By focusing on an initial goal to create a garden and increase trail use, the obesity prevention workgroup was able to experience an early, simple success that brought with it an increase in confidence that the community could achieve more by connecting with other sectors and initiatives. Community recognition reached the workgroup in the form of additional funding, additional interest in workgroup membership, presentation and publicity opportunities, invitations to participate in local obesity prevention events, awards for local schools celebrating their focus on healthy living, photos and mentions in city reports, and genuine connection with local residents who worked in the initial garden activities. Such community visibility sent a message that prevention efforts were appreciated and valued, and has continued to provide ongoing energy for future strategy implementation.

Priority Area 5: Heart Disease and Stroke

Background

The coronary arteries carry oxygen-rich blood to the heart muscle, thereby enabling it to perform its critical function of providing blood flow to nearly every tissue in the body. Coronary artery disease usually results from the building up of plaque which hardens and obstructs the blood flow. This process may occur silently for years before manifesting as chest pain (angina pectoris), shortness of breath or in the most severe cases, sudden cardiac death. In 2011, 8.3% (CI 4.1-12.4%) of adults over 65 years of age in the GNPHR had coronary heart disease (CHD)compared to 12% (CI 10.57-14.13%) in New Hampshire and Nashua (12% CI 4.8-19.6%). CHD in 2010 was significantly higher in Nashua males (9.2% CI4.4-12%) than in Nashua females (2% CI 0.4-3.8%) as seen in Figure 6. This gender gap is similar to that seen nationally.[xxiii]

Figure 6. Coronary Heart Disease by Gender and Geography, 2010



Source: NH DHHS, BRFSS

Modifiable risk factors for heart disease include smoking, hypertension, high cholesterol, physical inactivity, obesity, diabetes, unhealthy diet and chronic stress. Even as the overall death rate from heart disease has declined since the 1960's, it remains the number one killer nationally.[xxiv] Cardiovascular disease (CVD) is a broad term for a range of diseases affecting the

heart and blood vessels. It includes stroke, heart attack, hypertension and several other conditions. As such it is immensely costly. According to one estimate, "By 2030, 40.5% of the US population is projected to have some form of cardiovascular disease (CVD). Between 2010 and 2030, real total direct medical costs of CVD are projected to triple, from $273 billion to $818 billion (2008 dollar rate)."[xxv]

Every 34 seconds someone in the United States has a myocardial infarction (MI), commonly known as a heart attack, and every minute someone dies from a heart-related event.[xxvi] In 2009, heart attacks in New Hampshire accounted for 2,589 hospital discharges and 363 of those adults were Nashua residents. The age-adjusted rate of hospital discharges from heart attacks decreased slightly from 2000 to 2009 in Nashua, the GNPHR and NH. However, there is no statistically significant difference between Nashua, the GNPHR and NH with respect to hospitalizations for heart attack. Deaths from heart attacks are highest in adults over 85 years of age. From 2006 to 2010, there were 213 deaths from heart attacks in the GNPHR and 91 deaths were in adults over 85 years of age.[xxvii]

Stroke occurs when the blood supply to a part of the brain is interrupted. The majority of strokes are due to clot formation and obstruction of a blood vessel. Aneurysm, or other bleeding from a broken artery, is another frequent cause. Stroke is often related to poorly controlled high blood pressure, smoking, and diabetes. Stroke is a leading cause of long-term disability and people who survive an initial stroke may be left with permanent problems with their vision, motor function (weakness), speech and language problems, memory and balance. The controllable risk factors for stroke are very similar to those for coronary artery disease, and include hypertension, high cholesterol, smoking, alcohol use, physical inactivity, obesity and diabetes. Nationally, the estimated cost of stroke (direct and indirect costs) in 2010 was $53.9 billion.[xxviii]

Stroke data from New Hampshire and the GNPHR indicate there continues to be room for improvement in stroke prevention:

- From 2005-2010, the self-reported incidence of stroke did not have a statistically significant change; in 2010, 2.3% of men and 2% of women indicated that a health care professional had told them they had experienced a stroke.[xxix]
- From 2008 to 2012, there were 2,360 deaths from stroke in New Hampshire and there were 280 deaths from stroke in the GNPHR.[xxx]
- In 2012, the death rate from stroke was 33.3 per 100,000 in the GNPHR and 27.8 per 100,000 in Nashua.[xxx]

One of the Healthy People 2020 goals is to reduce the national stroke death rate to 34.8 per 100,000 and the NH SHIP goal is to reduce the rate for NH to 28 per 100,000 by 2020. As shown in Table 14, the death rate from stroke in Nashua already meets this goal, but the rate in the GNPHR has progress to make. The rate of death from stroke by gender is similar but it increases

as people age with the highest death rate in adults over 85 years of age. From 2008 to 2013, the death rate stayed consistently around 30 per 100,000 with minimal change over time.[xxx]

Table 14. Death Rate from Stroke, 2012

	Nashua	GNPHR	NH
Death rate from stroke (per 100,000)	27.8	33.3	29.0
Source: NH DHHS, BRFSS			

Resource and Asset Inventory and Gap Assessment Tools

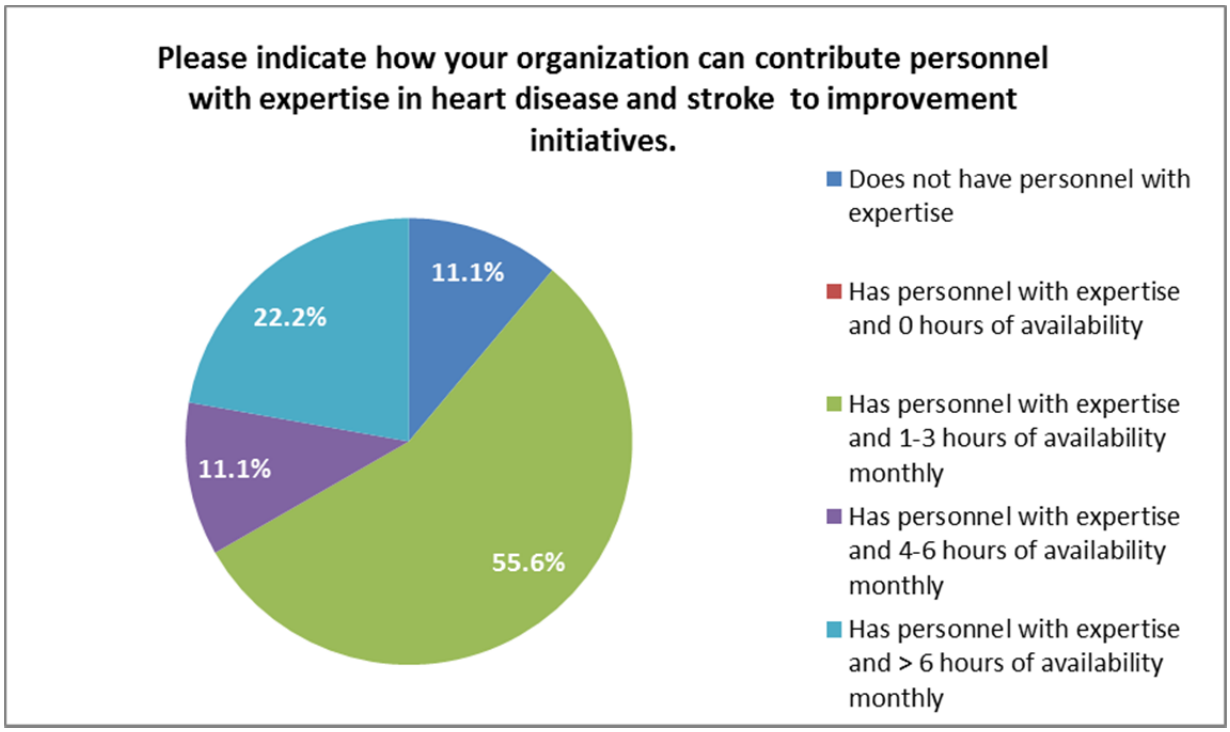
PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around heart disease and stroke.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in heart disease and stroke to improvement initiatives." Of the 9 organizations that indicated a willingness to participate in heart disease and stroke related initiatives, over half (n=5) indicated having personnel with expertise who were able to dedicate 1-3 hours each month to heart disease and stroke improvement initiatives and an additional one third of respondents indicated having personnel with expertise who are able to dedicate 4 or more hours monthly to heart disease and stroke improvement initiatives. Only 1 organization indicated that they did not have personnel with expertise.

Table 15. Existing Programs Addressing Heart Disease and Stroke

Please indicate what existing programs your organization has to address heart disease and stroke. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Programs for physical activity or recreation	33.3%	3
Programs for healthy eating/cooking	33.3%	3
Educational programs	33.3%	3
Programs that work with high risk groups (e.g. senior citizens)	33.3%	3
Programs providing CPR training offerings/Automated External Defibrillator Programs	22.2%	2
None	22.2%	2
Other (Please describe below in the comment box)	11.1%	1
For each area that your organization has a program, specify the name of the program.		3
Total Responses		9

Figure 6. Expertise in Heart Disease and Stroke



Of the 9 respondents indicating a willingness to participate in heart disease and stroke improvement initiatives, an equal number (n=3) indicated having programs for physical activity/recreation, healthy eating/cooking, educational programs and programs that work with high risk groups.

Programs specified:

- Senior supper, community medical school
- Million Hearts
- Harbor Care Health and Wellness Center

When asked to identify existing partnerships to address heart disease and stroke, the most commonly indicated partnerships among respondents were partnerships with organizations that offer sports, physical and/or recreational activity and relationships with organizations that provide heart disease and stroke resources (66.7%). Relationships with organizations that offer CPR trainings and free or low cost Automated External Defibrillators was the next most commonly indicated partnership at 55.6%.

Table 16. Existing Partnerships

Please indicate what existing partnerships your organization has to help address heart disease and stroke. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Partnerships with organizations that offer sports, physical and/or recreational activity	66.7%	6
Relationships with organizations that provide heart disease and stroke resources	66.7%	6
Relationships with organizations that offer CPR trainings and free or low cost Automated External Defibrillators	55.6%	5
Partnerships with organizations that promote heart healthy diets	44.4%	4
None	11.1%	1
Total Responses		9

When asked to list the organizational barriers or obstacles that would limit the ability for the organization to participate in community efforts to improve the incidence of heart disease and stroke, over half indicated that limited funds was a barrier (n=5). Limited personnel was the second most commonly indicated barrier with 2 responses. One third of respondents did not indicate a barrier to heart disease and stroke improvement efforts in their response (n-3).

Goals, Objectives and Strategic Approach

GOAL	**Provide chronic disease education and screening opportunities in the GNPHR to increase awareness and reduce rates of heart disease, stroke, and diabetes**
OBJECTIVE	**1. Increase the percentage of adults getting blood pressure screening at least every 2 years to 92% by 2018** **2. Reduce the percentage of adults with hypertension from 32% to 29% by December 2018** **3. Annually in the GNPHR, increase the number of outreach educational opportunities on the early signs of stroke** **4. Conduct outreach education events for pre diabetes utilizing pre-diabetes questionnaire, beginning with 8 events in 2016 and increasing to 16 events in 2018**

Strategic Approach

- **Million Hearts Campaign. This initiative is based on the ASTHO Million Hearts Project and includes focusing, coordinating, and enhancing cardiovascular disease prevention activities across the public and private sectors. Efforts include promoting self-monitoring or blood pressure tied with clinical support, promotion of awareness of high blood pressure among patients, and increased engagement of non-physician team members in hypertension management**

- **Diabetes Prevention Program (DPP). DPP is a pre-diabetes intervention program that uses community based support groups to develop lifestyle behavior change through diet and physical activity. The YUSA model is established in the GNPHR**

- **5-2-1-0. This educational campaign provides simple, easy to remember guidance around fruit and vegetable consumption, television and computer use, physical activity, and sweetened beverage elimination.**

Summary

The goals, objectives, and strategies that will bring systemic change to the GNPHR, by influencing chronic disease rates, are the same when considering either heart disease and stroke or diabetes. These health issues can be simultaneously improved through a coordinated

strategic approach that reaches select audiences affected by those chronic diseases. Implementation efficiencies can be realized when educational materials, outreach and promotion efforts provide population based information and awareness about positive lifestyle options. For this reason, community improvement efforts selected to reduce heart disease and stroke were also selected as the key strategies to reduce diabetes. As strategies that link blood pressure screening opportunities with both educational materials for self monitoring and ongoing health services are expanded, leveraged benefits will extend to other health improvement priorities. With a successful history of working together to develop environmental and system changes, the chronic disease workgroup has many established partnerships that will facilitate ongoing work to meet the objectives for reducing heart disease and stroke.

Priority Area 6: Diabetes

Background

Diabetes is a group of diseases marked by high levels of blood glucose resulting from problems in insulin production, insulin action, or both. Approximately 95% of diabetes is type II (formerly adult-onset) diabetes. The body initially becomes resistant to insulin and then later loses its ability to produce enough insulin. Diabetes is a major cause of stroke, heart disease and heart attacks. It also is a leading cause of blindness, non-traumatic amputations and kidney disease requiring dialysis. It can cause painful nerve damage, and lead to reduced circulation to the arms and legs. The development of diabetes is linked with obesity, smoking, high cholesterol, high blood pressure, lack of physical activity, poor diet and mental health problems.

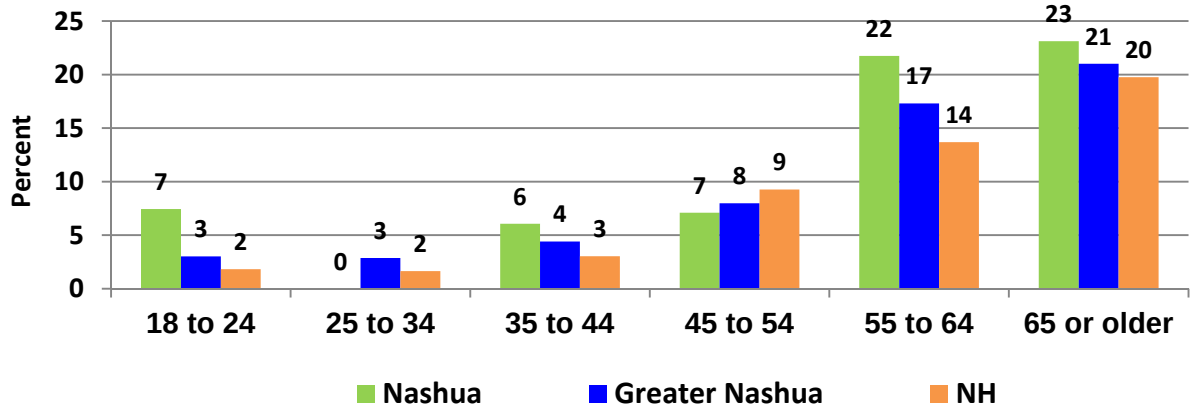
In 2010, diabetes was estimated to affect 25.8 million Americans or about 8.3%.[xxxi] In the same year in New Hampshire, that percentage was 7.1%.,[xxxii] while in Nashua, the prevalence was 9.9% (CI 0-21.64%) and in the Greater Nashua Region 9.5% (CI 0-8.88%).[xxxiii] In addition, up to 1 in 4 adults nationally do not know they have diabetes. Diabetes is more common:

- In people over 55 years of age,
- In Nashua residents compared to NH residents as a whole,
- In males under 55 compared to females under 55 (and then equally prevalent in men and women over 55).[xxxiv]

A marked association is seen with income: lower income Nashua residents have higher rates of diabetes. Income is a social determinant of health that can influence access to medications and quality healthcare.

In 2010, diabetes was estimated to affect 25.8 million Americans or about 8.3% of the population.

Figure 7. Diabetes Prevalence by Age and Geography, 2011



Source: NH DHHS, BRFSS

Diabetes has tremendous economic costs which include both direct medical costs and those related to lost productivity. In 2012, the total cost to the US economy was estimated at $245 billion. Care for people with diagnosed diabetes consumes 1 in 5 health care dollars in the U.S., and more than half of that expenditure is attributable to diabetes.[xxxv] In 2007, diabetes indirectly accounted for 15 million work days absent, 120 million work days with reduced performance.[xxxvi] The hospitalization rate due to diabetes in Nashua is higher than in New Hampshire as a whole (Figure 10). Hospitalizations attributable to diabetes for ambulatory care sensitive conditions is also significantly higher for Nashua than the rest of the state (Figure 11). When you look at the GNPHR without Nashua, the rate for diabetes hospitalizations and diabetes hospitalizations for ambulatory care sensitive conditions is significantly lower than the state (Figure 10; 11).

Figure 8. Diabetes Hospitalizations, Age-Adjusted Rate, 2007

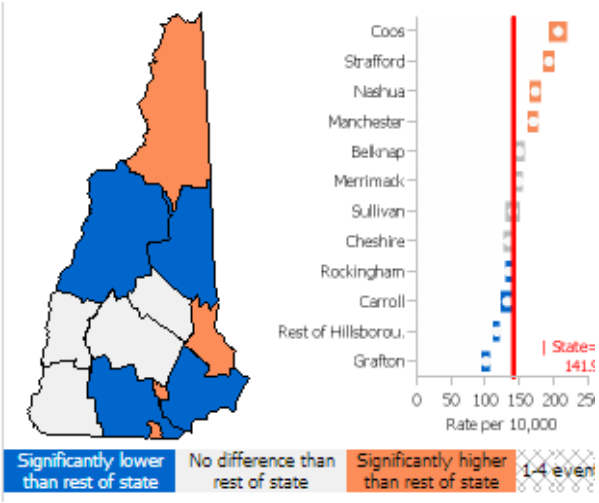
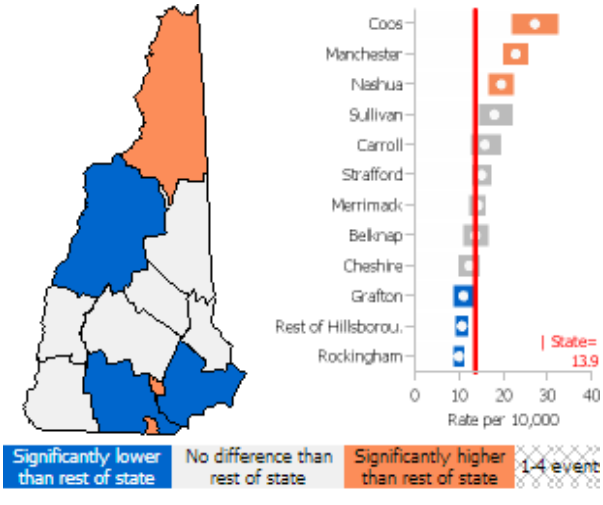


Figure 9. Diabetes Hospital Visits for Ambulatory Care Sensitive Conditions (Age-Adjusted Rate), Emergency Department, 2007



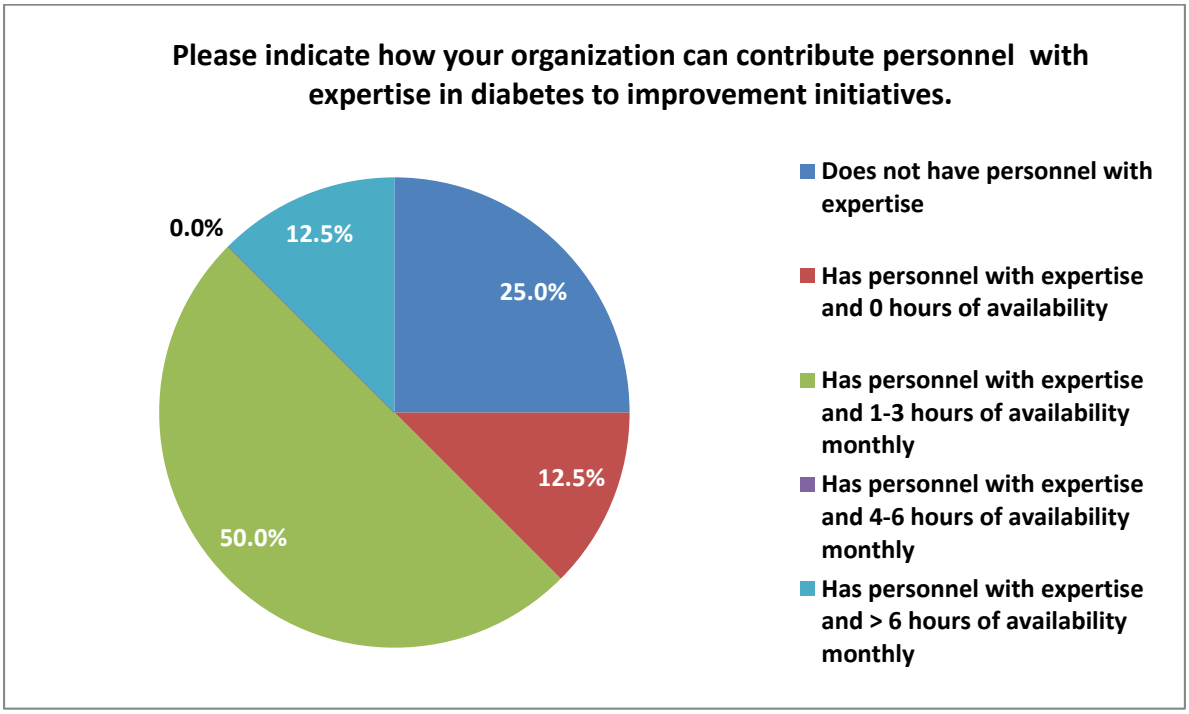
Source: NH DHHS, WISDOM

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around diabetes.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in diabetes to improvement initiatives." Half of respondents (n=4) reported having personnel with expertise that were able to dedicate 1-3 hours monthly to diabetes improvement initiatives.

Figure 10. Expertise in Diabetes



Of the 8 respondents who indicated willingness to participate in diabetes related initiatives, 5 organizations said they had either a formal diabetes management or employee wellness program. Other types of programs indicated by respondents were programs for physical activity/recreation and healthy eating/cooking programs (3 respondents each).

Table 17. Existing Programs in Diabetes

Please indicate what existing programs your organization has to address diabetes. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
A formal diabetes management program	62.5%	5
Programs for employee wellness	62.5%	5
Programs for physical activity or recreation	37.5%	3
Programs for healthy eating/cooking program	37.5%	3
A formal pre-diabetes education program	25.0%	2
None	12.5%	1
Other	0.0%	0
For each area that your organization has a program, specify the name of the program.		1
Total Responses		8

Programs specified:

- Harbor Care Health and Wellness Center

When asked to identify existing partnerships to address diabetes, the most commonly indicated partnerships among respondents were connections with established diabetes prevention organizations at 75%, followed by partnerships with exercise programs at 62.5%.

Table 18. Existing Partnerships in Diabetes

Please indicate what existing partnerships your organization has to help address diabetes. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Connections with established diabetes prevention organizations	75.0%	6
Partnerships with exercise programs	62.5%	5
Partnerships with nutritionists	37.5%	3
None	12.5%	1
Total Responses		8

Organizational barriers to participating in diabetes improvement efforts were indicated by 8 of the PHAC Executive Committee survey respondents. Limited funding, limited staff, limited resources and “none” were each indicated an equal number of times (n=2).

Goals, Objectives and Strategic Approach

NOTE: 2015-2018 goals, objectives and strategies for addressing diabetes are the same as those listed for addressing heart disease and stroke.

GOAL	**Provide chronic disease education and screening opportunities in the GNPHR to increase awareness and reduce rates of heart disease, stroke, and diabetes.**
OBJECTIVE	**1. Increase the percentage of adults getting blood pressure screening at least every 2 years to 92% by 2018** **2. Reduce the percentage of adults with hypertension from 32% to 29% by December 2018** **3. Annually, increase the number of outreach educational opportunities in the GNPHR on the early signs of stroke** **4. Conduct outreach education events for pre diabetes utilizing pre-diabetes questionnaire, beginning with 8 events in 2016 and increasing to 16 events in 2018**

Strategic Approach

- **Million Hearts Campaign. This initiative is based on the ASTHO Million Hearts Project and includes focusing, coordinating, and enhancing cardiovascular disease prevention activities across the public and private sectors. Efforts include promoting self-monitoring or blood pressure tied with clinical support, promotion of awareness of high blood pressure among patients, and increased engagement of non-physician team members in hypertension management**

- **Diabetes Prevention Program (DPP). DPP is a pre-diabetes intervention program that uses community based support groups to develop lifestyle behavior change through diet and physical activity. The YUSA model is established in the GNPHR**

- **5-2-1-0. This educational campaign provides simple, easy to remember guidance around fruit and vegetable consumption, television and computer use, physical activity, and sweetened beverage riddance.**

Summary

As the Greater Nashua PHAC expanded the health priority of obesity prevention to also include chronic diseases of heart disease and stroke and diabetes, they also reviewed past experience and leadership, including the resources available through Greater Nashua YMCA. The Greater Nashua YMCA has worked with its national organization to gain programming support for the Y-USA Diabetes Prevention Program (DPP) model. The DPP model includes a whole person assessment that looks at lifestyle, dietary, and medical influences to examine the factors that can be considered for change. Trained DPP facilitators work within a classroom setting to provide participants with increased understanding of the healthy eating and active living practices that can prevent diabetes, as well as the chronic diseases of obesity and heart disease and stroke.

Locally, the YMCA has both the physical facilities and trained personnel to provide the coordinated DPP education that emphasizes lifestyle practices to prevent diabetes. Working with PHAC partners, they are leading efforts to establish DPP as a system wide model for the region, and to organize regular DPP availability in multi sector settings. The flexibility of program location was one of the considerations in adopting this strategy, and the opportunity to locate DPP classes in workplace environments makes the strategy easily available to a broad population. Efforts to expand the DPP with established PHAC partners are being promoted in combination with other workgroup strategies to reduce chronic disease.

Find out more about the YMCA of Greater Nashua's Diabetes Prevention Program at http://www.nmymca.org/.

Priority Area 7: Access to Health Care

Background

Access is a broad term referring to the ability of individuals or groups to obtain needed medical services. Access can center on individual concerns such as affordability, lack of health insurance and difficulty navigating a health care system or on system's issues such as limited health care facilities, lack of public transportation or insufficient interpreter services. The overarching goal for "Access to Services" for Healthy People 2020 is to improve access to comprehensive, quality health care services.[xxxvii] The ability for individuals to easily access health care services has a direct correlation to the prevention, diagnosis and treatment of health conditions.

From 2002 to 2012, the percent of adults with Medicaid and no insurance increased while the percent of adults with private insurance decreased. The percent of adults aged 18 to 44 with private insurance coverage declined from 68% in 2002 to 61% in 2012 and the percent on Medicaid coverage increased from 7% to 11%.[xxxviii] As a state, New Hampshire has more residents that are covered by health insurance than most states in the southern and western parts of the country but New Hampshire residents with less education, lower incomes and are unemployed are more likely to lack a health care plan. Nationally, 14.9% of all residents and 8.1% of children lack a health care plan compared to 10.5% of all residents and 4.5% of children in New Hampshire. According to the 2008-2012 American Community Survey, 10.8% of residents in Nashua do not have health insurance and 3.2% of children under 18 years of age in Nashua do not have health insurance.[xxxix]

When looking at the GNPHR by census tract, the percent of all residents that are uninsured varies from 2.4% to 23.7%, with the highest percentages in downtown Nashua (Figure 2.2). For children under 18 years of age, the percent of uninsured by census tract varies from 0.0% to 10.8% in the GNPHR. Census tracts with the highest percent of uninsured children were in Nashua, Merrimack and Lyndeborough.[xxxix] The GNPHR and Nashua do not meet the Healthy People 2020 objective of total healthcare coverage (Table 12).[xxxvii]

Table 19. Percent of Population with Insurance by Geography, 2008-2012

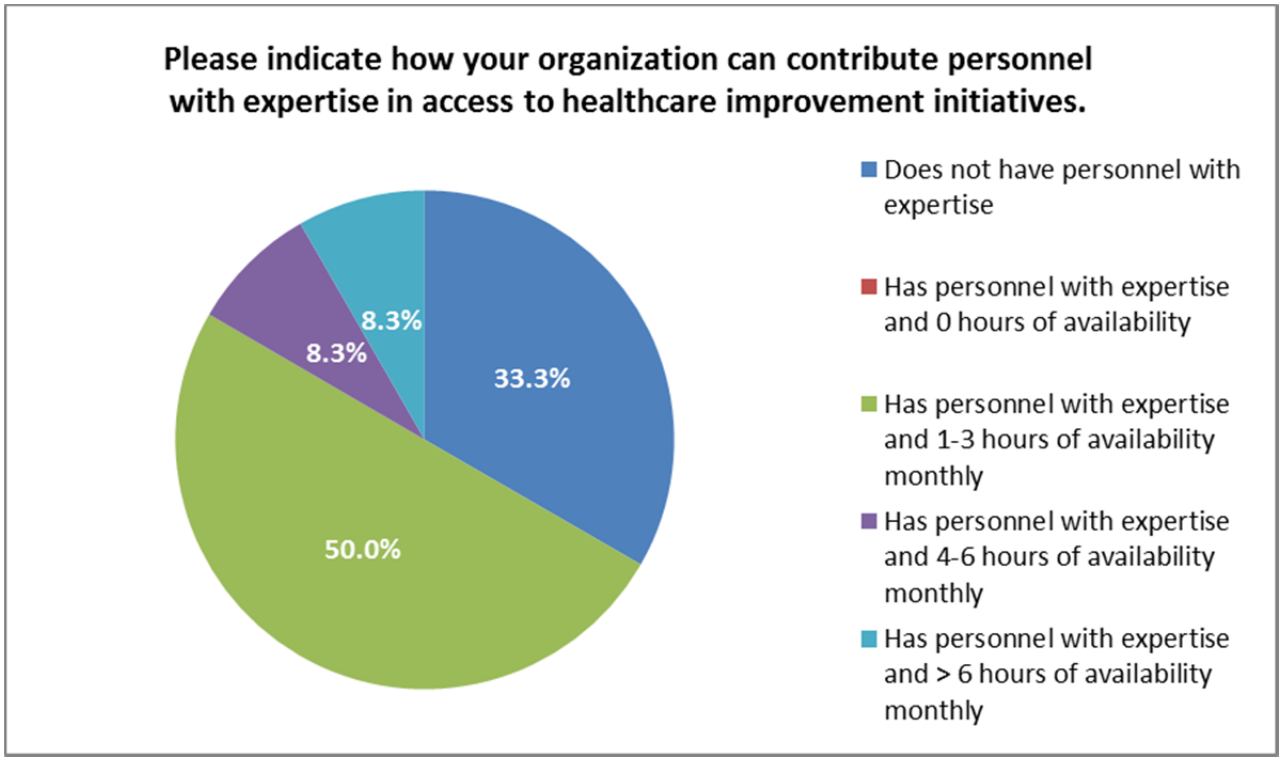
	Nashua	Hillsborough County	NH	US	Healthy People 2020 Goal
Percent Population Insured	89.2%	90.1%	89.5%	85.1%	100%
Source: American Community Survey, 2008-2012					

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around access to health care.

The chart below shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in Access to Health Care improvement initiatives." Half of respondents (n=6) reported having personnel with expertise that were able to dedicate 1-3 hours monthly to access to healthcare initiatives. 4 out of 12 respondents indicated that they did not have personnel with expertise in access to health care.

Figure 11. Expertise in Access to Healthcare Improvement Initiatives



Of the 12 respondents who indicated willingness to participate in access to healthcare related initiatives, half (n=6) indicated having no existing programs within their organization to address the issue. Of those who did, 41.7% (n=5) indicated having interpretation services and 33.3% indicated having either Healthcare Marketplace/NH Health Protection Program or programs providing information and referral to mental health resources.

Table 20. Existing Programs in Improving Access to Health Care

Please indicate what existing programs your organization has to address access to healthcare. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
None	50.0%	6
Programs that provide interpretation services	41.7%	5
Programs that provide assistance with the Healthcare Marketplace or the NH Health Protection Program	33.3%	4
Programs that provide information and referral to mental health resources	33.3%	4
Programs that provide free/reduced health services	25.0%	3
Programs that provide information and referral to oral health resources	25.0%	3
Other	8.3%	1
For each area that your organization has a program, specify the name of the program.		4
Total Responses		**12**

When asked to identify existing partnerships to address access to healthcare, 75% of respondents indicated relationships with organizations that provide free/low cost mental health services. Following that, 66.7% of respondents indicated relationships with organizations that provide free/low cost preventive screenings as well as with organizations that provide free/low cost oral health care services.

Access is a broad term referring to the ability of individuals or groups to obtain needed medical services.

- ***Healthy People 2020***

Table 21. Existing Partnerships

Please indicate what existing partnerships your organization has to help address access to healthcare. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Relationships with organizations that provide free/low cost mental health services	75.0%	9
Relationships with organizations that provide free/low cost preventative screenings	66.7%	8
Relationships with organizations that provide free/low cost oral health care services	66.7%	8
Relationships with medical interpreters/language line	50.0%	6
Relationships with organizations that work with individuals that have difficulty accessing healthcare	50.0%	6
None	16.7%	2
Total Responses		12

Of the 12 PHAC Executive Member respondents who provided input to the question, "Please list any barriers or obstacles specific to your organization that would limit its ability to participate in access to healthcare related efforts," one third indicated that limited funding was a barrier to participating in access to healthcare related efforts (n=4). The second most commonly indicated barrier to participation was limited personnel with 2 responses. Four respondents did not indicate a barrier in their response.

Goals, Objectives and Strategic Approach

GOAL	Enhance access to quality, comprehensive healthcare services in the GNPHR
OBJECTIVE	1. In a collaborative process, collect data to identify populations experiencing barriers to healthcare services and the causes for lack of access and availability of healthcare services in the GNPHR by 12/2016 2. Increase the percent of adults (89.2% in 2012) and children (96.8% in 2012) with health insurance to 100% in the GNPHR by 12/2020 3. Increase the percent of pregnant women in the GNPHR receiving prenatal care in the first trimester from 76% to 79% by August 2018 4. Increase the percent of people who receive screening for colorectal, lung, cervical and breast cancer based on the most recent USPSTF guidelines, with an emphasis on disparate populations, by August 2018

Strategic Approach

- **Data Collection**
- **"My Health. My Care" video series. Expanding use of this video series to audiences with low health literacy increases awareness and understanding about how to obtain, understand, and use health insurance.**
- **Establish Pre-Natal task force to identify strategies that support the pre-natal care objective**
- **Establish Cancer Screening task force to identify strategies that support the cancer screening objective**

Summary

Access to health care is another health topic that has carried over from the 2012 CHIP as a priority area for 2015-2018 improvement. The current goals, objectives, and strategies build on the successful collaborative work of the Access to Health Care work group, which has been successful in engaging the key health providers for the region in work to improve health access

and affordability. Dartmouth Hitchcock-Nashua, Southern NH Health System, St. Joseph Hospital, Lamprey Health Care, and the Partnership for Successful Living's Harbor Care Clinic have all invested personnel that have contribute to implementation efforts and have developed a history for partnering on major initiatives. The ongoing support and expanded use of "My Health. My Care", a video series which was developed in 2015 after receiving a National Networks of Libraries of Medicine grant award for improving health literacy, provides sustainability for an established and successful initiative. Leadership structuring for a prenatal task force and a cancer screening task force is underway and detailed work plans are under development.

Access the My Health. My Care. materials at www.nashuanh.gov.

Priority Area 8: Public Health Emergency Preparedness

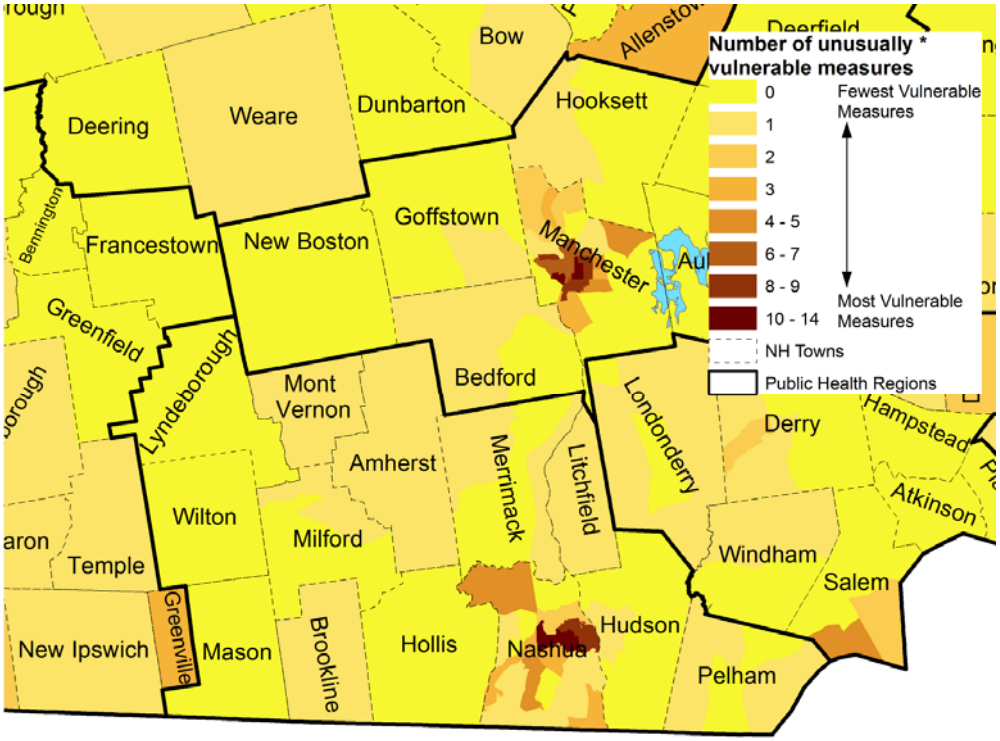
Background

A disaster is any natural or manmade incident, including terrorism that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale and/or government functions.[xl] Disasters can have devastating economic, health, and social consequences for affected communities and their residents. Almost all emergencies impact the public's health in some way. Flooding may lead to the development of mold, which may cause an asthma attack. A falling tree could take down power lines to the home of a person who is energy dependent because they need to use oxygen for a health condition. A child is exposed to influenza at school and within a couple of weeks the whole family has come down with respiratory illness. These and other types of emergencies – weather events, chemical exposures and communicable disease outbreaks – occur in our community on a regular basis, and our region has sufficient services in place to respond to them.

The City of Nashua, Division of Public Health and Community Services works with the Greater Nashua Public Health Region to prepare for, respond to and recover from disasters. Since 2011, New Hampshire has had 10 events that received federal declarations: 7 Major Disaster Declarations and 3 Emergency Declarations.[xli] Federal declarations are designations that identify the magnitude of an emergency, with Emergency Declarations indicating events where federal assistance is needed to supplement state and local efforts and Major Disaster declarations to indicate catastrophes requiring an even higher level of emergency response for which a broad level of federal assistance is available. Vulnerability to hazards is influenced by many factors, including poverty, lack of access to transportation, age, income, the strength of social networks, and neighborhood characteristics, which may weaken a community's ability to prevent human suffering and financial loss in the event of disaster. These factors are

collectively known as social vulnerability. Within the Greater Nashua Public Health Region, there are areas where higher social vulnerability requires increased support during an emergency response. Figure 12 shows social vulnerability variation within the region.

Figure 12. Social Vulnerability Measures, GNPHR



Effective planning includes accommodations for the needs of individuals whose physical or cognitive disabilities make it difficult for them to respond to an emergency and they may need help with evacuations and sheltering. Although terminology continues to evolve, the New Hampshire State Functional Needs Committee has proposed the collective term, "functional" to describe populations that under usual circumstances are able to function on their own or with support systems. Individuals with needs that extend beyond those of the general population are described as "functional needs populations." These include individuals with disabilities, those who have limited English language skills, and people who are at fixed facilities such as long term care facilities or hospitals. Planning for the evacuation, emergency sheltering, communication, and transportation of the functional needs population requires understanding where the individuals are located and what resources will be required to ensure the services they need are available and accessible.

In Nashua, according to the 2010 Census, 11.8% of children age 5-15 years, 10.9% of individuals ages 6-64 years, and 41.5% of those 65 years and older have a disability. In this group, 10% have a cognitive difficulty, 2% have a vision difficulty and 1% have a vision difficulty or self-care difficulty. For Nashua adults over the age of 65, 20% have hearing difficulty, 10% have vision difficulty, 8% have cognitive difficulty, 6% have self-care difficulty, 21% have ambulatory difficulty and 12% have difficulty living independently.[xlii]

Resource and Asset Inventory and Gap Assessment Tools

PHAC Executive Committee members who completed the *2015-2018 CHIP Goals and Objectives Survey* identified the personnel resources and existing programs, or other assets that would help support improvement initiatives around access to emergency preparedness

The following chart shows consolidated answers for the question "Please indicate how your organization can contribute personnel with expertise in Emergency Preparedness to improvement initiatives." 12 organizations indicated a willingness to participate in public health emergency preparedness improvement efforts. Of those, nearly 60% (n=7) of respondents indicated having personnel with expertise who were able to dedicate 1-3 hours monthly to public health emergency preparedness improvement initiatives. An additional 33.3% (n=4) were able to dedicate over 4 hours of time monthly.

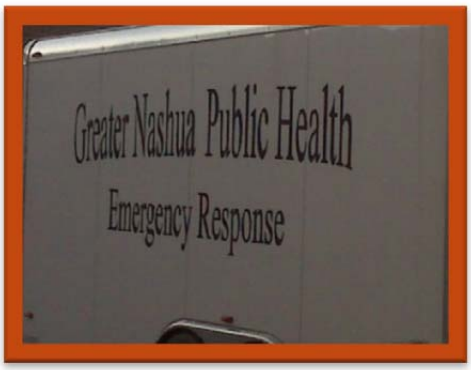
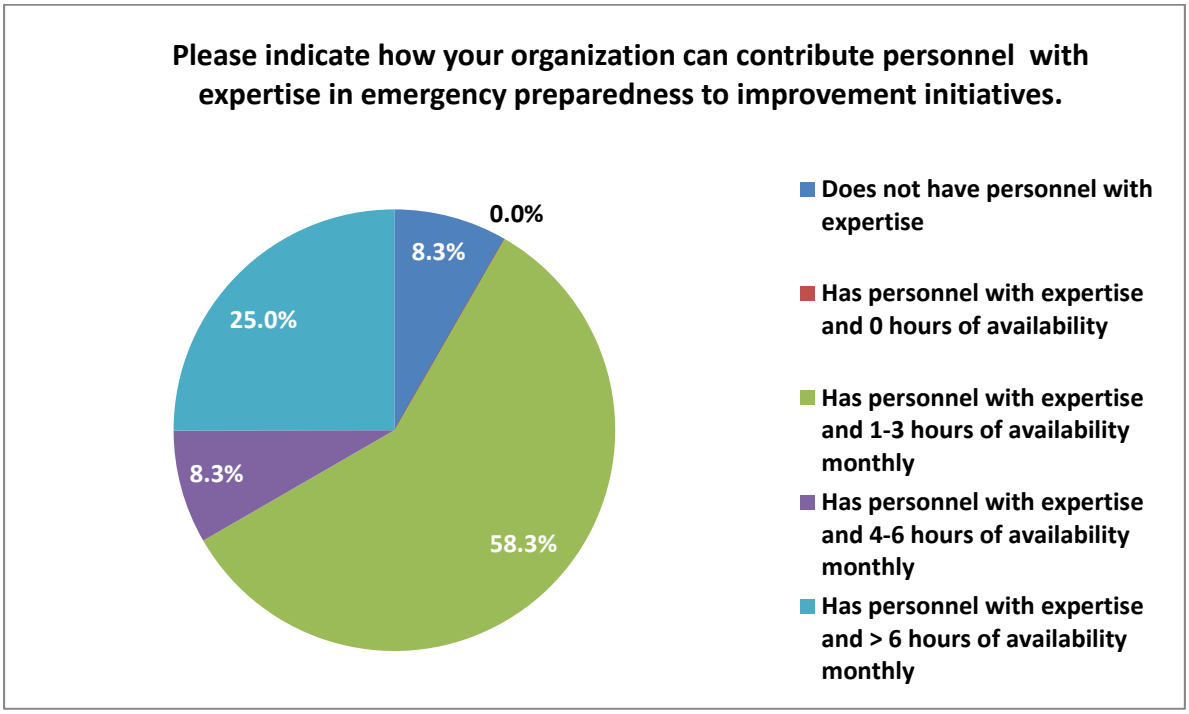


Figure 13. Expertise in Emergency Preparedness



The majority of respondents who were willing to participate in public health emergency preparedness efforts have existing programs to address the health priority. Out of the 12 respondents, 66.7% (n=8) indicated having training programs for emergency response volunteers within their facilities. Half of the respondents indicated having programs available to educate the general community about disaster response.

Table 22. Existing Programs for Emergency Preparedness

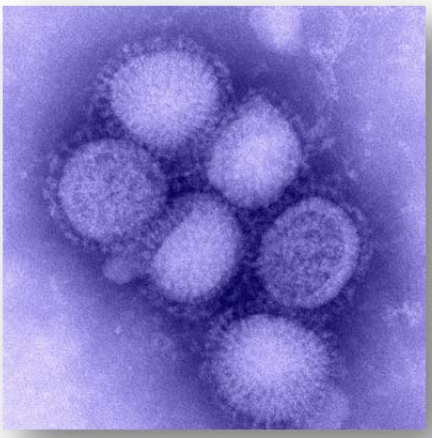
Please indicate what existing programs your organization has to address emergency preparedness. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Programs that provide training for emergency response volunteers	66.7%	8
Programs that educate the general community about disaster response	50.0%	6
Programs that provide resources during emergencies	41.7%	5
None	25.0%	3
Other	8.3%	1
For each area that your organization has a program, specify the name of the program below.		5
Total Responses		12

When asked to identify existing partnerships to address public health emergency preparedness, the vast majority of respondents indicated having existing partnerships with emergency responders (91.7%). The second most commonly indicated partnerships among respondents were those with local media outlets (newspaper/TV/social media) at 66.7%.

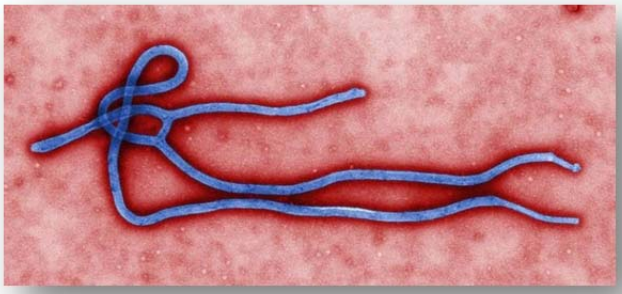
Table 23. Existing Partnerships for Emergency Preparedness

Please indicate what existing partnerships your organization has to help address emergency preparedness. Check all that apply.		
Answer Options	**Response Percent**	**Response Count**
Partnerships with emergency responders	91.7%	11
Partnerships with local media outlets (newspaper/TV/social media)	66.7%	8
Memorandums of understanding (MOUs) with vendors and other organizations in the region	33.3%	4
None	8.3%	1
Total Responses		**12**

Out of 12 PHAC Executive Committee respondents who listed obstacles or barriers to their organization's ability to participate in public health emergency preparedness efforts, four did not indicate any barriers. Of those who did, four respondents indicated limited funding, two respondents indicated limited time and two respondents indicated limited personnel.



H1N1 Influenza



Ebola Virus Disease

Goals, Objectives and Strategic Approach

GOAL	**To increase the capacity of the Greater Nashua Public Health Advisory Council/Public Health Network Services to prepare for, respond to and recover from public health incidents.**
OBJECTIVE	**1. Conduct two exercises annually to evaluate the ability of the GNPHR to prepare for, respond to and recover from public health incidents** **2. Conduct two trainings annually to educate the GNPHR on how to prepare for, respond to and recover from public health incidents** **3. Increase the proportion of public health emergency preparedness partner organizations that engaged in a significant public health emergency planning, exercising or training activity from 80% in 2014 to 85% in 2018**

Strategic Approach

- **The Greater Nashua Public Health Network Services will maintain detailed plans and documentation for the drills, exercises and reporting related to collaborative implementation of the All Hazards Emergency Operation Plan.**
- **The Greater Nashua Public Health Network Services will maintain a Trainings and Exercise plan to document planned trainings over a two year period.**

Summary

Vulnerability to hazards is influenced by many factors which may weaken a community's ability to prevent human suffering and financial loss in the event of disaster. Aligning regional CHIP priorities with established Public Health Network Services (PHNS) goals, objectives and strategies permits the region to strengthen social vulnerability factors, deepen social networks, and work collaboratively to ensure the region is safely positioned for unexpected disasters. Ongoing funding through the PHNS system is key to the continued successful integration of Public Health Emergency Preparedness in the 2015-2018 CHIP.

Next Steps

A published Community Health Improvement Plan provides a guideline for the collaborative work of implementing strategies over the three year improvement cycle outlined in the plan. Next steps will include the more detailed work of creating the work plans that will support the strategies, and engaging community partners in leading those efforts. By aligning with NH's SHIP improvement goals, the GNPHR can now anticipate the benefit of support from related state agencies as well as from other health regions with similarly aligned priorities. For all implementation efforts, the close engagement of the Greater Nashua Public Health Advisory Council ensures that mutually agreed upon strategies will move forward with community commitment and support. Current plans include regular meetings of stakeholders to review progress, along with agreement from workgroup facilitators to maintain ongoing communication and reporting to measure that progress. As Greater Nashua continues its journey towards a healthier Nashua region, the PHAC will remain closely engaged in the collaborative work that will bring changes in the policies, systems and environments impacting public health and well-being.

Figure 14. Community Health Improvement Process

Resources and Tools

A benefit of coordinating community health improvement planning through the Public Health Network system is the additional connection achieved among NH's thirteen networks. By sharing similar resources, technical expertise, template materials and planning guides, all regions have an opportunity to improve efficiencies by considering established models and planning tools. The State of NH DHHS has provided the following detailed list of federal registries, resources, and contacts that are useful to improvement plan development, planning, and implementation.

Federal Registries:

- The Guide to Community Preventive Services: The Community Guide
  http://www.thecommunityguide.org/index.html
- Healthy People 2020
  https://www.healthypeople.gov/2020/tools-and-resources/Federal-Prevention-Initiatives+
- Health Communities Program: U.S. Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/

Websites

- Cochrane Collaboration
  http://www.cochrane.org/
- PolicyLink
  http://www.policylink.org/
- CDC Best Practice Guidelines
  http://www.cdc.gov/chronicdisease/resources/guidelines.html

Developing a Vision and Mission

- The Eight Word Mission Statement
  http://www.ssireview.org/blog/entry/the_eight_word_mission_statement

Community Health Improvement Plan Tools and Resources

- Mobilizing for Action through Planning and Partnerships (MAPP)
  http://www.naccho.org/topics/infrastructure/mapp/
- Protocol for Assessing Community Excellence in Environmental (PACE EH)
  http://www.naccho.org/topics/environmental/PACE-EH/
- Health Healthy People 2020 – MAP-IT
  http://healthypeople.gov/2020/implement/MapIt.aspx
- The Institute of Medicine's Community Health Improvement Process (CHIP)
  http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/chip/main

Prioritization Tools and Resources

- Appendix E: NH State Health Improvement Plan
  http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf
- Importance and Changeability: SAMHSA
  http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework/plan/1

Resource and Asset Inventory and Gap Assessment Tools

- County Health Rankings and Roadmaps
  http://www.countyhealthrankings.org/roadmaps/action-center/assess-needs-resources
- Community Toolbox
  http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/develop-a-plan/main
  http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

Strategy Selection Tools

- State Health Improvement Plan
  http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf
- Substance Misuse Prevention
  Collective Action-Collective Impact
- National Prevention Strategies
  http://www.surgeongeneral.gov/initiatives/prevention/strategy
- NH SHIP Implementation Cross-Walk: Links to Statewide Plans - *See Table Below*

	RELATED STATE-LEVEL PLAN	WEB LINK	DATE CREATED	EXPECTED REVISION	LEAD ENTITY FOR THE PLAN	LEAD PROGRAM
TOBACCO	NH Comprehensive Cancer Plan	http://www.nhcancerplan.org/images/downloads/nhcancerplanbook.pdf	2010	2014	NH CCC	Comprehensive Cancer Control Program
OBESITY & DIABETES	NH HEAL Action Plan	http://www.healnh.org/images/pdffiles/HEALactionPlan.pdf	2008	2014	HEAL NH	Chronic Disease Prevention and Management, Healthy Eating and Physical Activity Section
	NH Action Plan for Diabetes	http://www.dhhs.state.nh.us/dphs/cdpc/diabetes/documents/action-plan.pdf	2006		DPHS	Chronic Disease Prevention and Management, Diabetes Section
HEART DISEASE AND STROKE	NH Heart Disease and Stroke Prevention, 2015-2020 Action Plan (This plan is in draft, if you would like a copy, please contact Lia Baroody at: lbaroody@dhhs.state.nh.us)		2015		DPHS	Heart Disease and Stroke Prevention Program
TEEN PREGNANCY	Supporting New Hampshire Youth Moving toward a Healthier Future	http://www.dhhs.state.nh.us/dphs/bchs/mch/documents/adolescenthealth.pdf	2005	2013	DPHS	Family Planning Program Manager
PRETERM BIRTH	No Current Plan					Maternal and Child Health Section

	RELATED STATE-LEVEL PLAN	WEB LINK	DATE CREATED	EXPECTED REVISION	LEAD ENTITY FOR THE PLAN	LEAD PROGRAM
AUTISM	NH Commission on Autism Spectrum Disorder Findings and Recommendations	http://iod.unh.edu/pdf/NHCommissionOnASD_FinalReport.pdf	2008		Autism Commission	Maternal and Child Health Section
ORAL HEALTH	NH Oral Health Plan: A Framework for Action	http://nhoralhealth.org/blog/wp-content/uploads/2009/11/FrameworkforAction.pdf	2003	2014	Oral Health Coalition	Oral Health Program
IMMUNIZATION	No Current Plan					Immunization Program
HAI	State of New Hampshire Healthcare-Associated Infections Plan	http://www.cdc.gov/HAI/pdfs/stateplans/nh.pdf	2009	2014	DPHS, HAI Technical Advisory Workgroup	HAI Program
FOOD PROTECTION	Emergency Action Plan forRetail Food Establishments	http://www.dhhs.state.nh.us/dphs/fp/documents/emergency.pdf	2007		DPHS	Food Protection Section
CANCER PREVENTION	NH Comprehensive Cancer Plan	http://www.nhcancerplan.org/images/downloads/nhcancerplanbook.pdf	2010	2014	NH Comprehensive Cancer Collaboration	Comprehensive Cancer Control Program
ASTHMA	NH State Asthma Plan	http://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/state-plan.pdf	2009	2014	DPHS	Healthy Homes Program
INJURY PREVENTION	NH Injury Prevention Strategic Plan	In progress. Will be available on the Injury Prevention Program webpage, http://www.dhhs.state.nh.us/dphs/bchs/mch/injury.htm	2013	2017	Injury Prevention Advisory Council	Injury Prevention Program

	RELATED STATE-LEVEL PLAN	WEB LINK	DATE CREATED	EXPECTED REVISION	LEAD ENTITY FOR THE PLAN	LEAD PROGRAM
	NH Suicide Prevention Plan	http://www.dhhs.state.nh.us/dphs/bchs/mch/documents/state-suicide-prevention-plan-2013.pdf	2013	2015	Suicide Prevention Council	Injury Prevention Program
	NH Strategic Highway Safety Plan	www.nhdtz.com/news-events/download/information/21	2013	2015	Department of Transportation, Driving Towards Zero Coalition	Injury Prevention Program
SUBSTANCE MISUSE	Collective Action/Collective Impact	http://www.dhhs.state.nh.us/dcbcs/bdas/documents/collectiveaction.PDF	2013	2018	Governor's Commission, Bureau of Drug and Alcohol Services	DHHS Prevention Services, Bureau of Drug and Alcohol Services
EMERGENCY PREPAREDNESS	Public Health Emergency Preparedness and Response Plan	Plan unavailable online. To contact the Community Health Development section, visit: http://www.dhhs.nh.gov/dphs/bchs/cphd/contact.htm	2008		Advisory Council on Emergency Preparedness and Security Advisory Board Subcommittee	Community Health Development Section, Bureau of Infectious Disease Control
COORDINATED CHRONIC DISEASE	Coordinated Chronic Disease Strategic Plan	http://www.dhhs.nh.gov/dphs/cdpc/index.htm	2013			
BEHAVIORAL HEALTH	Addressing the Critical Mental Health Needs of NH's CitizensA Strategy for Restoration	http://www.dhhs.state.nh.us/dcbcs/bbh/documents/restoration.pdf			NH DHHS, NH Hospital, Bureau of Behavioral Health, the Community Behavioral Health Association	Bureau of Behavioral Health

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