Mass General Brigham
Wentworth-Douglass Hospital

Community Health Needs Assessment Implementation Strategy | 2022

Mass General Brigham
Wentworth-Douglass Hospital

Community Health Implementation Strategy 2022

Contents

Executive Summary

I. Introduction

- Wentworth-Douglass Hospital (WDH or the hospital) has a proud tradition of serving our community and providing significant resources towards community benefit and community health improvement activities. Over the next three years (2023-2025), the hospital plans to continue this commitment as we strive to better serve our community.
- This Community Health Implementation Strategy (CHIS) is a road map to address community-identified public health challenges identified through the hospital's Community Health Needs Assessment (CHNA). It identifies significant community health needs the hospital plans to address through various strategic initiatives; outlines actions the hospital intends to take, including programs and resources it plans to commit; identifies planned collaborations between the hospital and other organizations; and describes the anticipated impact of these actions.
- WDH reserves the right to amend this CHIS as circumstances warrant. Certain community health needs may become more pronounced during the next three years and merit enhancements to the described strategic initiatives. Alternatively, other organizations may decide to increase resources devoted to addressing one or more of the significant community health needs and as a result the hospital may amend its strategies and focus on other identified needs.

II. Reference to CHNA

- This document describes how WDH plans to address significant health needs found in the CHNA published by the hospital on September 30, 2022. The full report is available at www.wdhospital.org/wdh/about-wdh/giving-back.
- The 2022 CHNA and CHIS were undertaken by the hospital to assess and address significant community health needs and in accordance with Internal Revenue Service (IRS) regulations in Section 501(r) of the Internal Revenue Code.

III. About Wentworth-Douglass Hospital

- Wentworth-Douglass Hospital is a nationally recognized, not-for-profit charitable health care organization located in the Seacoast community of Dover, New Hampshire, with a 116-year history of compassionate care and innovation.
- Wentworth-Douglass is a family of over 400 providers, and 3,500 employees, including more than 500 nurses, and 200 volunteers dedicated to the health, safety, and well-being of residents and visitors to the Seacoast area of New Hampshire and Southern Maine. Wentworth-Douglass includes a 178-bed Magnet® Recognized hospital, urgent care and walk-in care facilities, testing centers, 36 Wentworth Health Partners primary care and specialty care provider practices, The Works Health and Fitness Center and the Wentworth-Douglass Foundation. In 2017, WDH joined the Massachusetts General Hospital family and Mass General Brigham system.
- Additional information on the hospital and its services is available at www.wdhospital.org/wdh.

IV. Definition of Community Served

- For the purposes of this report, WDH's community is defined as 26 ZIP Codes representing 24 towns across Rockingham, Strafford, and Carroll counties in New Hampshire and York County in Maine. The 24 towns are Barrington (NH), Berwick (ME), Dover (NH), Durham (NH), Eliot (ME), Farmington (NH), Kittery (ME), Kittery Point (ME), Lebanon (ME), Lee (NH), Madbury (NH), Middleton (NH), Milton (NH), Milton Mills (NH), Newington / Portsmouth (NH), Newmarket (NH), North Berwick (ME), Nottingham (NH), Rochester (NH), Rollinsford (NH), Somersworth (NH), South Berwick (ME), and Wakefield (NH).

V. Summary of Significant Community Health Needs

- The 2022 CHNA revealed the following top health needs in the hospital's service area (in alphabetical order):
    1. Access to Primary Care Services
    2. Access to Long Term Services & Supports
    3. Chronic Disease
    4. Financial Barriers to Care
    5. Mental Health
    6. Obesity and Physical Inactivity
    7. Oral Health
    8. Social Determinants of Health
    9. Substance Use Disorders

VI. Primary Focus

- The primary focus of this Implementation Strategy is to improve health outcomes in the communities served by the hospital. This includes aspects of both physical and mental health. It includes addressing health care disparities and supporting community and Mass General Brigham system initiatives designed to improve diversity, equity and inclusion. It also includes supporting mutually identified goals and strategies in alignment and partnership with the Strafford County Public Health Network.

VII. Planning Process and Methodology

- To develop this Implementation Strategy, the hospital reviewed the CHNA findings and applied the following criteria to determine the most appropriate needs for Wentworth-Douglass Hospital to address:
    - The extent to which the hospital has resources and competencies to address the need;
    - The impact that the hospital could have on the need;
    - The frequency with which stakeholders identified the need as a significant health priority; and
    - The extent of community support for the hospital to address the issue and potential for partnerships to address the issue.
- By applying these criteria, the hospital determined that it would address all of the significant community health needs identified in the CHNA.

Access to Primary Care Services

I. Explanation of Community Need Being Addressed

- Data show that the Rockingham and Strafford Counties in New Hampshire and York County in Maine have a higher-than-average ratio of population to primary care physicians. This indicates a significant need for investment in primary care services to improve access and reduce barriers to care. Access to primary care services was identified by interview participants as an area of concern and where existing services were unavailable or unable to meet the needs of the community.

II. Goal(s) for Addressing Need(s)

- Ensure access to primary care services.

a. Specific Objective(s) to Achieve the Goal(s)

- Increase the capacity of primary care services and improve navigation.

b. Strategies and Tactics

- Increase the capacity in Wentworth Health Partners primary care practices.
  - Expand access to primary care providers through additional recruitment and/or new service locations.
  - Redesign and enhance primary care recruitment process.
  - Implement new staffing strategies to improve and maintain provider support (partnering with community colleges, on the job educational opportunities, etc.).
- Reduce barriers to care through increased navigation and innovative solutions to improve access.
  - Maintain and/or expand service offerings for timely access to health care, including walk-in, urgent care and/or telehealth services.
  - Maintain and/or expand patient navigation services to support primary care patients.
  - Pilot one or more care redesign programs to increase primary care access.
  - Optimize provider capacity to ensure access for patients without primary care providers.

c. Community Collaborations

- Wentworth Health Partners
- Mass General Brigham
- Community colleges as appropriate
- Other community organizations as appropriate

III. Summary Table

Goal: Ensure access to primary care services.		
Objective: Increase the capacity of primary care services and improve navigation.		
	Strategy 1: **Increase the capacity in Wentworth Health Partners primary care practices.**	**Strategy 2:** **Reduce barriers to care through increased navigation and innovative solutions to improve access.**
Population(s):	Wentworth Health Partners patients Community residents	Wentworth Health Partners patients Community residents
Potential New Resources:	• Hospital Investment • Philanthropy	• Hospital Investment • Philanthropy
Current Initiatives:	• Provider recruitment • Additional practice location(s) • Care model redesign	• On-demand care (walk-in, virtual) • Urgent care • Patient navigation program • Care model redesign
Collaborations:	• Wentworth Health Partners • Mass General Brigham • Community colleges as appropriate • Other community organizations as appropriate	• Wentworth Health Partners • Mass General Brigham • Other community organizations as appropriate
Expected Outcomes:	• Improved access to care • Improved health of community residents • Increased care coordination	• Improved access to care • Improved health of community residents • Increased care coordination
Data Source(s):	• Program data • County Health Rankings	• Program data

Access to Long Term Services & Supports

I. Explanation of Community Need Being Addressed

- Data show that the number of persons aged 65 years and older in the community is projected to increase by nearly 18 percent between 2022 and 2027. Access to long term services and supports (including long term care, home health, skilled nursing, palliative care, and hospice care) was identified by interview participants as an area of concern and where existing services were unavailable or unable to meet the needs of the community.

II. Goal(s) for Addressing Need(s)

- Ensure access to long term services and supports.

a. Specific Objective(s) to Achieve the Goal(s)

- Increase the capacity of long term services and supports.

b. Strategies and Tactics

- Build organizational capacity to increase access to long term services and supports through internal programs and/or partnering with community organizations.
    - Maintain and/or expand supportive and palliative care services.
    - Maintain and/or expand care management services.
    - Maintain and/or expand home care and Hospital at Home services.
    - Provide educational offerings for patients related to advanced care planning.
    - Offer educational programming for staff to improve understanding of advanced care planning needs and available resources.
- Advocate for policies that support access to long term services and supports.
    - Educate state and regional level policy makers about the demand for long term services and supports, such as the need for skilled nursing, long term care, and hospice services.

c. Community Collaborations

- Wentworth Health Partners
- New Hampshire Hospital Association
- Mass General Brigham
- ServiceLink
- Local area hospitals
- Local home care organizations
- Local hospice organizations
- Local skilled nursing facilities
- Other community organizations as appropriate

III. Summary Table

Goal: Ensure access to long term services and supports.				
Objective: Increase the capacity of long term services and supports.				
		Strategy 1:		**Strategy 2:**
		Build organizational capacity to increase access to long term services and supports through internal programs and/or partnering with community organizations.		**Advocate for policies that support access to long-term services and supports.**
Population(s):		Patients with complex health and social needs		Patients with complex health and social needs

Potential New Resources:		• Hospital Investment • Philanthropy		• Hospital Investment
Current Initiatives:		• Supportive and Palliative Care • Care Management • Hospital at Home • Advanced Care Planning • Education		• Advocacy
Collaborations:		• Wentworth Health Partners • Mass General Brigham • Local skilled nursing facilities • Local home care organizations • Local hospice organizations • Other community organizations as appropriate		• ServiceLink • Local area hospitals • New Hampshire Hospital Association • Community and municipal agencies • Other community organizations as appropriate
Expected Outcomes:		• Improved access to care • Improved health of community residents • Increased care coordination • SDOHs addressed • Connection to support services		• Improved health of community residents • Increased care coordination
Data Source(s):		• Program data		• Program data

Chronic Disease

I. Explanation of Community Need Being Addressed

- Data show that cancer, asthma, diabetes, cardiometabolic disease, and other chronic diseases contribute to mortality in the community and impact quality of life. Chronic disease was identified by interview participants as an issue within the community, and one that worsened because of the COVID-19 pandemic due to deferred disease management.

II. Goal(s) for Addressing Need(s)

- Improve health outcomes for those with chronic disease.

a. Specific Objective(s) to Achieve the Goal(s)

- Ensure patients with chronic disease (diabetes, asthma, cancer, cardiometabolic disease, chronic obstructive pulmonary disorder, etc.) receive access to coordinated health and support services, assistance with social determinants, and other resources, to better manage their disease.

b. Strategies and Tactics

- Implement programs to support the health of patients with chronic disease.
  - Maintain and/or expand the Patient & Family Learning Center, including health coaching services.

- Maintain support groups for patients with chronic diseases, such as diabetes.
- Maintain participation in the Center for Disease Control's National Diabetes Prevention Program.
- Participate in the Strafford County Public Health Advisory Council and associated community awareness and prevention activities pertaining to chronic disease.
- Offer educational resources pertaining to chronic disease management, such as newsletters, articles, and educational sessions.
- Offer educational events and risk screenings at least once per year targeted at chronic disease awareness and prevention.
- Offer educational events and risk screenings at least once per year targeted at cancer screening and prevention.
- Implement targeted risk clinics in the Seacoast Cancer Center for needed services, such as a high-risk breast clinic.
- Maintain and/or expand access to ambulatory pharmacy services to optimize medication therapy management in patients with chronic disease (including but not limited to financial barriers, patient education, medication adherence, etc.).
- Participate in the American Lung Association's "Freedom From Smoking" program (at least quarterly) and adapt this program in partnership with local schools to address vaping.
- Offer educational programming and outreach focused on the risks of tobacco use (including vaping use).
- Maintain and/or expand physical activity programs at The Works Family Health and Fitness Center designed to support those with chronic disease (Cancer Recovery; cardiac rehabilitation; and WorksRx, an 8-week exercise program in which a health coach provides a safe exercise program based on medical history and contraindications).

c. Community Collaborations

- Wentworth Health Partners
- Wentworth-Douglass Outpatient Pharmacy
- The Works Family Health and Fitness Center
- Wentworth Homecare & Hospice
- Mass General Brigham
- New Hampshire Department of Public Health
- Community Partners
- Cornerstone VNA
- The Foundation for Healthy Communities
- Strafford County Public Health Network
- Local home care agencies
- Local long term care facilities

- Local schools
- Other community organizations as appropriate

III. Summary Table

Goal: Improve health outcomes for those with chronic disease	
Objective: Ensure patients with chronic disease (diabetes, asthma, cancer, cardiometabolic disease, chronic obstructive pulmonary disorder, etc.) receive access to coordinated health and support services, assistance with social determinants, and other resources, to better manage their disease.	
	Strategy 1:
	Implement programs to support the health of patients with chronic disease.
Population(s):	Patients with diabetes, asthma, cardiometabolic disease, cancer, etc.
Potential New Resources:	• Hospital Investment • Philanthropy • State and Federal Funding
Current Initiatives:	• Patient & Family Learning Center • Health Coaching • Center for Disease Control's National Diabetes Prevention Program • American Lung Association's "Freedom From Smoking" program • Strafford County Public Health Network partnership • Education • Risk screenings • Support groups • High-risk breast clinic • Ambulatory pharmacy • Physical activity programs
Collaborations:	• Wentworth Health Partners • Wentworth-Douglass Outpatient Pharmacy • The Works Family Health and Fitness Center • Wentworth Homecare & Hospice • Mass General Brigham • New Hampshire Department of Public Health • Community Partners • Cornerstone VNA • The Foundation for Healthy Communities • Strafford County Public Health Network • Local home care agencies • Local long term care facilities • Local schools • Other community organizations as appropriate
Expected Outcomes:	• Decreased disease burden • Increased care coordination • Improved chronic disease management

		• Social Determinants of Health (SDOH) addressed • Connection to support services
Data Source(s):		Program data

Financial Barriers to Care

I. Explanation of Community Need Being Addressed

- Financial barriers to care frequently impact care delivery and patients' ability to access services. Financial barriers to care were identified by interview participants as an area of concern.

II. Goal(s) for Addressing Need(s)

- Ensure access to necessary health care services.

a. Specific Objective(s) to Achieve the Goal(s)

- Reduce financial barriers to care.

b. Strategies and Tactics

- Maintain financial assistance services and reduce barriers to care.
  - Provide financial assistance to individuals and families receiving services from Wentworth-Douglass Hospital and Wentworth Health Partners.
  - Maintain participation in Medicaid, although payments for services provided to Medicaid patients are traditionally less than the cost to provide these services.
  - Provide Marketplace and Medicaid (New Hampshire and Maine) enrollment assistance and educational resources to increase awareness of these programs.
  - Develop and implement educational offerings related to general insurance literacy, Medicare enrollment, and financial resource availability.
  - Advocate for reauthorization of New Hampshire's Medicaid expansion program.

c. Community Collaborations

- Wentworth Health Partners
- Mass General Brigham
- ServiceLink
- Meduit
- New Hampshire Hospital Association
- Other community organizations as appropriate

III. Summary Table

Goal: Ensure access to necessary health care services.		
Objective: Reduce financial barriers to care.		
		Strategy 1:
		Maintain financial assistance services and reduce barriers to care.
Population(s):		Patients who meet financial assistance policy requirements
Potential New Resources:		• Hospital investment
Current Initiatives:		• Financial assistance • Education • Advocacy
Collaborations:		• Wentworth Health Partners • Mass General Brigham • ServiceLink • Meduit • New Hampshire Hospital Association • Other community organizations as appropriate
Expected Outcomes:		• Improved access to care
Data Source(s):		• Program data

Mental Health and Substance Use Disorder

I. Explanation of Community Need Being Addressed

- Data show that the Rockingham and Strafford Counties in New Hampshire and York County in Maine have a higher than average ratio of population to mental health providers. Additionally, approximately 20 percent of adults report heavy drinking and approximately 10 percent of youth report using prescription drugs without a prescription or used differently. This indicates a significant need for investment in mental health care resources and substance use disorder treatment and prevention services to improve access and reduce barriers to care. Access to mental health and substance use disorder treatment and prevention services were identified by interview participants as areas of concern and where existing services were unavailable or unable to meet the needs of the community. In a survey of local residents, mental health counseling and substance misuse were highlighted as the top areas for hospitals to invest to improve the overall health of the community.

II. Goal(s) for Addressing Need(s)

- Ensure access to mental health and substance use disorder services and build equitable, accessible, respectful, and supportive communities and systems of care.

a. Specific Objective(s) to Achieve the Goal(s)

- Increase access to behavioral health resources and improve care coordination.

b. Strategies and Tactics

- Build organizational capacity to increase access to behavioral health services and supports through internal programs and reduce barriers to care.
    - Maintain and/or expand mental health services through Wentworth Health Partners' integrated behavioral health practice and Great Bay Mental Health.
    - Maintain and/or expand substance use disorder treatment services through Wentworth Health Partners' integrated behavioral health practice, Great Bay Mental Health, and The Doorway.
    - Increase mental health provider coverage through the addition of one or more providers focused on behavioral health services for children, youth, and adolescents.
    - Increase mental health provider coverage through the addition of one or more geriatric health provider(s).
    - Continue to expand programs to meet a more complex patient population with higher acuity behavioral health needs.
    - Maintain and/or expand the Substance Use Resource Team (SURT) training to improve provider and clinicians' ability to care for patients with substance use disorder and reduce stigma.
- Support community coalitions and partnerships to advocate for policy, systems, and environmental changes to improve mental health and reduce stigma.
    - Explore opportunities to improve mental health in children / adolescents via community partnerships, such as collaboration with one or more local schools.
    - Participate in community-based efforts to improve access to mental health and substance use disorder treatment services, such as The Doorway.
    - Fund community grants (as appropriate) to support mental health programs.
    - Educate state and federal policy makers about mental health issues and the demand for inpatient and outpatient treatment services.
    - Offer educational programming for staff and providers to improve understanding of mental health needs and available resources.
    - As community services evolve, continue to expand programs and partnerships to meet a more complex patient population with higher acuity behavioral health needs.
    - Continue to participate in the Dover Mental Health Alliance and support the Zero Suicides Initiative within the Dover School system.

- Support community coalitions and partnerships to advocate for policy, systems, and environmental changes to reduce youth and adult substance use, prevent substance use-related deaths, and reduce stigma.
    - Maintain and/or expand substance use disorder screening, counseling, referral, treatment, and prevention services through Wentworth Health Partners' integrated behavioral health practice, Great Bay Mental Health, and The Doorway.
    - Participate in community-based efforts to improve access to mental health and substance use disorder treatment services, such as The Doorway, and address co-occurring disorders.
    - Fund community grants (as appropriate) to support community substance abuse prevention and treatment programs.
    - Explore opportunities to expand outpatient substance use disorder treatment and recovery options within the community (such as medication for opioid use disorder and/or mobile care access).
    - Educate state and federal policy makers, community members and other stakeholders about substance use disorders and the demand for treatment services.
    - Enhance participation in harm reduction education, programming, and activities.
    - Offer educational programming for staff and providers to improve understanding of substance use disorder and available resources.
    - Maintain tobacco cessation counseling services (including vaping use cessation).
    - Participate in the American Lung Association's "Freedom From Smoking" program (at least quarterly).
    - Offer educational programming and outreach focused on the risks of tobacco use (including vaping use).
    - Maintain and/or expand tobacco use screening and education in affiliated primary and specialty care offices.

c. Community Collaborations

- Wentworth Health Partners
- Mass General Brigham
- The Doorway
- Dover Youth 2 Youth
- Hope on Haven Hill
- SOS Recovery Community Organization
- Southeastern New Hampshire Alcohol & Drug Abuse Services
- NH Harm Reduction Coalition
- Triangle Club
- Seacoast Coordinated Response
- Seacoast Mental Health

- Community Partners
- Dover Mental Health Alliance
- Greater Seacoast Community Health
- Strafford County Public Heath Network
- New Hampshire Hospital Association
- Local emergency medical services
- Local law enforcement agencies
- Local schools
- Other community organizations as appropriate

III. Summary Table

Goal: Ensure access to mental health and substance use disorder services and build equitable, accessible, respectful, and supportive communities and systems of care.		
Objective: Increase access to behavioral health resources and improve care coordination.		
		Strategy 1:
		Build organizational capacity to increase access to behavioral health services and supports through internal programs and reduce barriers to care.
Population(s):		Community residents with behavioral health needs
Potential New Resources:		• Hospital investment • System investment • Philanthropy
Current Initiatives:		• Integrated behavioral health • Great Bay Mental Health • The Doorway • WDH crisis clinician team • Provider recruitment (focused on services for children, youth, adolescents) • Provider recruitment (focused on geriatric services) • Increase acuity through program development • Substance Use Resource Team (SURT)
Collaborations:		• Wentworth Health Partners • Mass General Brigham • The Doorway
Expected Outcomes:		• Improved access to care • Improved health of community residents • Increased care coordination
Data Source(s):		Program data County Health Rankings
		Strategy 2:
		Support community coalitions and partnerships to advocate for policy, systems, and environmental changes to improve mental health and reduce stigma.
Population(s):		Community residents with behavioral health needs
Potential New Resources:		• Hospital investment • System investment

	• Philanthropy
Current Initiatives:	• Community partnerships • Community grants • Education • Advocacy • Increase acuity through program development • Zero Suicides Initiative
Collaborations:	• Wentworth Health Partners • Mass General Brigham • The Doorway • Seacoast Mental Health • Community Partners • Dover Mental Health Alliance • Greater Seacoast Community Health • Strafford County Public Health Network • Local emergency medical services • Local law enforcement agencies • Local schools • Other community organizations as appropriate
Expected Outcomes:	• Improved access to care • Improved health of community residents • Increased care coordination
Data Source(s):	Program data Local and state reports Youth Risk Behavioral Risk Survey
	Strategy 3:
	Support community coalitions and partnerships to advocate for policy, systems, and environmental changes to reduce youth and adult substance use, prevent substance use-related deaths, and reduce stigma.
Population(s):	Community residents with behavioral health needs
Potential New Resources:	• Hospital investment • System investment • Philanthropy
Current Initiatives:	• The Doorway • Community partnerships • Community grants • Outpatient program expansion • Education • Advocacy • Harm reduction • American Lung Association's "Freedom From Smoking" program
Collaborations:	• Wentworth Health Partners • Mass General Brigham • The Doorway

		• Dover Youth 2 Youth • Hope on Haven Hill • SOS Recovery Community Organization • Southeastern New Hampshire Alcohol & Drug Abuse Services • NH Harm Reduction Coalition • Triangle Club • Seacoast Coordinated Response • Strafford County Public Health Network • Local emergency medical services • Local law enforcement agencies • Other community organizations as appropriate
Expected Outcomes:		• Improved access to care • Improved health of community residents • Increased care coordination
Data Source(s):		Program data Local and state reports Youth Risk Behavioral Risk Survey

Obesity and Physical Inactivity

I. Explanation of Community Need Being Addressed

- Diet and body weight are related to health status. Healthy diets, healthy body weight, and regular physical activity can improve the health and quality of life for individuals within the community. As identified in the CHNA, approximately 35 percent of community members are overweight and approximately 30 percent are obese. Additionally, many adults and youth within the community reported low levels of regular physical activity.

II. Goal(s) for Addressing Need(s)

- Reduce diet related health conditions and encourage healthy lifestyles inclusive of healthy nutrition and active living.

a. Specific Objective(s) to Achieve the Goal(s)

- Increase healthy eating habits and active living by increasing opportunities for physical activity, access to nutrition, and weight management support services.

b. Strategies and Tactics

- Support policy, system, programs, and environmental changes to increase access to affordable, healthy foods and physical activity in communities.
    - Explore opportunities to enhance nutrition, physical activity, and weight management service offerings via community partnerships, such as collaboration with one or more local schools.

- Increase educational offerings related to nutrition and physical activity.
- Participate in local health fairs to promote healthy behaviors and physical activity.
- Maintain and/or expand wellness-focused programs for children and youth at The Works Family Health and Fitness Center (summer camp, nature trail, after school programs, etc.).
- Maintain and/or expand physical activity programs at The Works Family Health and Fitness Center (Running Works program, etc.).
- Maintain and/or expand nutritional counseling and dietitian services.
- Maintain and/or expand the Patient & Family Learning Center, including health coaching services and promotion of Diabetes Prevention Program.
- Participate in the Strafford County Public Health Advisory Council and associated community awareness and prevention activities pertaining to obesity and physical activity.

- Increase the capacity of the Center for Weight Management and Bariatric Surgery and reduce barriers to care.
  - Maintain and/or expand weight management and bariatric surgery services.
  - Maintain and/or expand HealthCare at The Works Family Health and Fitness Center (a 12-week health coaching program with lectures on topics such as nutrition, stress management, behavior change, hormones, exercise, and more).
  - Increase educational programs and offerings related to obesity**.**

c. Community Collaborations

- Wentworth Health Partners
- The Works Family Health and Fitness Center
- The Foundation for Healthy Communities
- Strafford County Public Health Network
- Mass General Brigham
- Recreational centers / programs and youth programs
- Local senior centers and community centers
- Other community organizations as appropriate

III. Summary Table

Goal: Reduce diet related health conditions and encourage healthy lifestyles inclusive of healthy nutrition and active living.		
Objective: Increase healthy eating habits and active living by increasing opportunities for physical activity, access to nutrition, and weight management support services.		
	Strategy 1:	**Strategy 2:**
	Support policy, system, programs, and environmental changes to increase access to affordable, healthy foods and physical activity in communities.	**Increase the capacity of the Center for Weight Management and Bariatric Surgery and reduce barriers to care.**
Population(s):	Community residents	Community residents with weight management needs
Potential New Resources:	• Hospital Investment • Philanthropy	• Hospital Investments • Philanthropy
Current Initiatives:	• Community partnerships • Educational offerings • Nutritional counseling • Wellness-focused programs for children and youth at The Works Family Health and Fitness Center • Patient & Family Learning Center • Health Coaching	• Center for Weight Management and Bariatric Surgery • Educational offerings • Patient & Family Learning Center • Health Coaching
Collaborations:	• Wentworth Health Partners • The Works Family Health and Fitness Center • The Foundation for Healthy Communities • Recreational centers / programs and youth programs • Strafford County Public Health Network • Mass General Brigham • Other community organizations as appropriate	• Wentworth Health Partners • The Works Family Health and Fitness Center • The Foundation for Healthy Communities • Recreational centers / programs and youth programs • Strafford County Public Health Network • Mass General Brigham • Other community organizations as appropriate
Expected Outcomes:	• Increased healthy eating • Increased physical activity	• Decreased disease burden • Increased care coordination
Data Source(s):	Program data County Health Rankings Behavioral Risk Factor Surveillance System Youth Risk Behavior Survey	Program data County Health Rankings Behavioral Risk Factor Surveillance System Youth Risk Behavior Survey

Oral Health

I. Explanation of Community Need Being Addressed

- Oral health is central to overall health and well-being. Data show that Rockingham and Strafford Counties in New Hampshire and York County in Maine have a higher than average ratio of population to dentists. This indicates a need for continued investment in oral health services to improve access and reduce barriers to care. Access to oral health services was identified by interview participants as an area of concern and where existing services were unavailable or unable to meet the needs of the community.

II. Goal(s) for Addressing Need(s)

- Ensure access to oral health care services.

a. Specific Objective(s) to Achieve the Goal(s)

- Increase access to oral health care providers.

b. Strategies and Tactics

- Build organizational capacity to increase access to oral health services through internal programs and/or partnering with community organizations.
    - Maintain support for the Wentworth Community Dental Center.
    - Provide educational offerings related to dental health.
    - Increase oral health provider coverage through the addition of one or more dentist(s) and the addition of one or more hygienist(s).
    - Explore potential opportunities for collaboration with one or more dental school(s) or community programs to increase access locally.

c. Community Collaborations

- Wentworth Community Dental Center
- Wentworth Health Partners
- Wentworth-Douglass Foundation
- Mass General Brigham
- Strafford County Public Health Network
- Schools
- Other community organizations as appropriate

III. Summary Table

Goal: Ensure access to oral health care services.		
Objective: Increase access to oral health care providers.		
		Strategy 1:
		Build organizational capacity to increase access to oral health services through internal programs and/or partnering with community organizations.
Population(s):		Wentworth Community Dental Center patients

		Community residents
Potential New Resources:		• Hospital Investment • Philanthropy
Current Initiatives:		• Wentworth Community Dental Center • Education • Program expansion *(potential)* • Partnership(s) with dental school(s) or community partnerships *(potential)*
Collaborations:		• Wentworth Community Dental Center • Wentworth Health Partners • Wentworth-Douglass Foundation • Mass General Brigham • Strafford County Public Health Network • Schools • Other community organizations as appropriate
Expected Outcomes:		• Improved health of community residents • Decreased dental disease
Data Source(s):		• Program data

Social Determinants of Health

I. Explanation of Community Need Being Addressed

- Social determinants of health are social, economic, physical, and other conditions that affect a wide range of health outcomes. Quality of life is affected by access to resources, including housing, education, public safety, and healthy food. Low-income census tracts and food deserts exist within the local community, and more than 10 percent of households experience severe housing problems. Basic needs insecurity, including access to food, transportation, and affordable housing, was identified by interview participants as an area of concern. Interview participants indicated these needs increased during the COVID-19 pandemic.

II. Goal(s) for Addressing Need(s)

- Address social determinants of health to improve the health and well-being of patients and community members.

a. Specific Objective(s) to Achieve the Goal(s)

- Collaborate with and convene community organizations to address social determinants of health.
- Advocate for policies and make investments that increase and preserve access to transportation.
- Advocate for policies and make investments that increase and preserve affordable housing.

b. Strategies and Tactics

- Direct resources and support policies that promote screening for social determinants of health and increase access to basic needs, such as food access.
    - Maintain and/or expand social work services at Wentworth-Douglass Hospital and Wentworth Health Partners
    - Participate in a pilot program with the Foundation for Healthy Communities to screen patients for social determinants of health and ensure referrals to appropriate community partners.
    - Participate in the Strafford County Public Health Advisory Council and associated activities pertaining to social determinants of health.
    - Fund community grants (as appropriate) to support access to basic needs
- Direct resources and support policies that promote and increase availability of transportation services.
    - Provide transportation assistance to qualifying patients through the Care Van transportation service (in accordance with program guidelines)
    - Explore opportunities to expand transportation services in collaboration with community partners
    - Fund community grants (as appropriate) to support access to transportation
- Direct resources and support policies that promote community development, increase affordable housing, and address the needs of members of the community without access to stable shelter.
    - Educate community members and stakeholders about unmet basic needs in the community, including affordable housing
    - Participate in community-based efforts to improve access to basic needs
    - Fund community grants (as appropriate) to support access to basic needs

c. Community Collaborations

- Wentworth Health Partners
- Mass General Brigham
- Alliance for Community Transportation
- Community Action Partnership of Strafford County
- Strafford County Public Health Network
- Dover Chamber of Commerce
- Portsmouth Chamber of Commerce
- New England Council
- Local agencies which support affordable housing programs or services for those with housing instability
- Other area hospitals/health systems
- Other community organizations as appropriate

III. Summary Table

Goal: Address social determinants of health to improve the health and well-being of patients and community members.	
Objective: Collaborate with and convene community organizations to address social determinants of health.	
	Strategy 1:
	Direct resources and support policies that promote screening for social determinants of health and increase access to basic needs, such as food access.
Population(s):	Community residents
Potential New Resources:	• Hospital investment • System investment • Philanthropy
Current Initiatives:	• Community partnerships • Social work services • Screening pilot with Foundation for Healthy Communities • Community grant funding
Collaborations:	• Wentworth Health Partners • Mass General Brigham • Strafford County Public Health Network • Community Action Partnership of Strafford County • Other area hospitals/health systems • Other community organizations as appropriate
Expected Outcomes:	• SDOHs addressed • Connection to support services
Data Source(s):	Program data County Health Rankings
Objective: Advocate for policies and make investments that increase and preserve access to transportation.	
	Strategy 2:
	Direct resources and support policies that promote and increase availability of transportation services.
Population(s):	Community residents and patients with barriers to transportation
Potential New Resources:	• Hospital investment • Philanthropy • State and federal funding
Current Initiatives:	• Care Van patient transportation program • Community partnerships • Community grant funding
Collaborations:	• Wentworth-Douglass Care Van • Alliance for Community Transportation • Other area hospitals/health systems • Other community organizations as appropriate
Expected Outcomes:	• Increased access to transportation • Policies that support access to public transportation

Data Source(s):		Program data Local and state reports
Objective: Advocate for policies and make investments that increase and preserve affordable housing.		
		Strategy 3:
		Direct resources and support policies that promote community development, increase affordable housing, and address the needs of members of the community without access to stable shelter.
Population(s):		Those experiencing housing instability or homelessness
Potential New Resources:		• Hospital Investments • Philanthropy • Grants
Current Initiatives:		• Community grant funding • Education • Advocacy
Collaborations:		• Local agencies which support affordable housing programs or services for those with housing instability • Other area hospitals/health systems • Dover Chamber of Commerce • Portsmouth Chamber of Commerce • New England Council • Other community organizations as appropriate
Expected Outcomes:		• Increased access to affordable housing • Decreased number of unsheltered individuals and families • Policies that support safe and affordable housing
Data Source(s):		Local and state reports

Substance Use Disorders

- Please refer to the section labeled “Mental Health and Substance Use Disorders”.

Planned Commitment of Resources

- Planned commitment of resources includes support for many activities, such as program maintenance or expansion, increased educational offerings, and community grant funding to community partners.

Evaluation Plan

- Wentworth-Douglass Hospital will assess the impact of the above initiatives annually and as part of the Community Health Needs Assessment it will conduct in 2025.