PROPOSED TRANSACTION BETWEEN ELLIOT HEALTH SYSTEM AND SOUTHERN NEW HAMPSHIRE HEALTH SYSTEM, INC.

REPORT OF THE DIRECTOR OF CHARITABLE TRUSTS

March 5, 2018

NEW HAMPSHIRE
Department of Justice
Office of the Attorney General

Gordon J. MacDonald
Attorney General

Thomas J. Donovan
Director of Charitable Trusts

New Hampshire Department of Justice
33 Capitol Street
Concord, NH 03301

Introduction

The Charitable Trusts Unit received a notice and submission, filed November 3, 2018, pursuant to RSA 7:19-b, regarding the proposed transaction between Elliot Health System (EHS) and Southern New Hampshire Health System, Inc. (SNH) whereby a new entity, SolutionHealth (SH) will be created to serve as the sole member and supporting organization of EHS and SNH, thereby creating a regional health care system.

The transaction is described in a Combination Agreement by and between EHS and SNH dated October 30, 2017 and in a proposed Management Services Agreement. It will result in changes to the articles of agreement and bylaws of EHS and SNH to substitute SH as the sole member of the organizations, with directors elected in classes and with terms to provide initial equal representation from EHS and SNH. Over time, successor SH boards of directors will be comprised of representatives nominated by the boards of SH, EHS and SNH.

In addition to the November 3, 2017 submission, the Charitable Trusts Unit received from EHS and SNH responses dated December 20, 2017 and January 19, 2018 to the Charitable Trusts Unit's requests for additional information. Those responses have been supplemented by additional materials that provide further information. All of the documentation submitted will be referred to collectively as the "Notice". The Notice constitutes one of the requirements of RSA 7:19-b, II and III, which generally obligates the governing bodies of health care charitable trusts, including EHS and SNH, to satisfy certain minimum standards before they consummate an acquisition transaction.

The Charitable Trusts Unit has completed its review of the Notice. It has taken into consideration the public meetings and the media outreach conducted by the parties leading up to the submission of the Notice. The Director of Charitable Trusts and the Assistant Director of Charitable Trusts attended public meetings held in Nashua on January 10, 2018 and in Manchester on January 18, 2018. They also met with representatives of Mental Health Center of Greater Manchester, Greater Nashua Mental Health Center, Manchester Community Health Center, Lamprey Health Care, Harbor Homes, City of Manchester Health Department, the New Hampshire Community Behavioral Health Association, Network 4 Health, the Endowment for Health and the University of New Hampshire School of Law Health Law and Policy Program. The Charitable Trusts Unit posted on its web page the Notice and requested written comments regarding the proposed transaction. Finally, the Charitable Trusts Unit retained Katharine London of the University of Massachusetts Medical School Center for Health Law and Economics to assess EHS's and SNH's current provision of community benefits and the potential impacts to cost, quality and access from the proposed transaction.

Jurisdiction over the Transaction

Both EHS and SNH are New Hampshire voluntary corporations and charitable organizations registered with the Charitable Trusts Unit. Because each organization operates a New Hampshire-based community hospital, each is also a "health care charitable trust". RSA 7:19-b, I(d). The proposed transaction constitutes an "acquisition transaction" because the creation of SH to serve as sole member of EHS and SNH with substantial reserved powers creates a "transfer of control" within the meaning of RSA 7:19-b, I(a) – (c). Accordingly, the

transaction is subject to the provisions of RSA 7:19-b, II, III and IV which require specific due diligence and notice by EHS and SNH, followed by a review of the transaction by the Director of Charitable Trusts.

Review of Standards Required for Acquisition Transactions

The boards of directors of EHS and SNH must comply with their fiduciary duties in considering the proposed transaction. RSA 7:19-b, II sets forth in seven subparagraphs ((a) through (g)) the specific minimum standards that the boards must meet in order to approve an acquisition transaction. This report will address compliance with each of the standards but presented in a different manner than the statute and with reference to the applicable subparagraphs of RSA 7:19-b, II.

(b) Due Diligence

The Notice describes the process that EHS and SNH engaged in to consider the general health care marketplace and the specific negotiations that led to the Combination Agreement. In making their respective decisions, EHS and SNH relied separately upon the advice of health care and legal experts. Those experts made repeated presentations to the boards of directors with respect to market conditions and negotiations.

The Notice describes the plan for EHS and SNH to form SH and create a regional health care system in southern New Hampshire. The existing organizations believe that the transaction will "create opportunities for efficiencies, value and improvements in access and controlling costs for the communities they serve." Combination Agreement, Section 1.1. "The goal of the Combination is to create a truly regional health care system that will allow for greater coordination of care, implementation of best practices and collaborative regional planning, and elimination of inefficiencies, all of which will enhance regional access and improve the quality and control the cost of care for southern New Hampshire." Combination Agreement, Section 1.2(c).

The due diligence of the parties has not documented a likelihood of specific improvements in those measures, however. That lack of specificity is compounded by the absence of any Coordinated Activity Plans, which will not be instituted until after the closing pursuant to a process identified in Section 3 of the proposed Management Services Agreement to be executed by the parties at the closing. Combination Agreement, Section 2.3.2 and Exhibit F. In order for EHS, SNH and SH to achieve any of those improvements to access, quality and cost, they must reach agreement on one or more Coordinated Activity Plans.

The Charitable Trusts Unit's information requests to EHS and SNH sought further explanation of post-transaction plans. With limited exceptions, the responses contained no detailed answers as to how the transaction will make a meaningful difference. The responses confirmed that "the parties have not developed any plans regarding EHS or [SNH] as part of the [SH] regional health care system." The reason given is that … "the parties are specifically precluded from engaging in any activities that would violate antitrust laws…" Still, the parties explained in some detail two of their plans: SNH will join EHS's Epic-based electronic medical records system, and the parties will develop a population health-based model to deliver services.

In addition, while the parties plan to make substantial improvements to access, quality and cost through the implementation of Coordinated Activity Plans, the documents do not describe the metrics that will be used to measure the effectiveness of those improvements. Coupled with that, there is a paucity of readily accessible data in New Hampshire concerning the benefits achieved through hospital consolidations. This lack of information will be discussed further in the section on post-consolidation community benefits.

(c) Conflicts of Interest

In response to information requests 12 and 68, EHS and SNH confirmed that the proposed transaction will not result in any direct or indirect pecuniary benefit to any of the organizations' directors. See, RSA 7:19-a.

However, the governance structure of a health care system lends itself to structural conflicts of interest. In this transaction, EHS and SNH will nominate individuals for certain of the seats on the SH board of directors. Combination Agreement, Section 2.1.2(a). Both *ex officio* members and two other members of the SH board of directors may also serve as directors of either EHS or SNH. Combination Agreement, Section 2.1.2(a)(i). The bylaws of the three entities do not set out the process for the selection of future *ex officio* members of the SH board of directors. That omission will need to be addressed.

Accordingly, under the governance structure of the transaction, it is possible that a director of SH may also serve as a director of EHS or SNH. While there is no per se prohibition of director service on interlocking boards, the practice requires a heightened awareness by those directors to spot financial and/or mission conflicts as they arise and to analyze whether a proposed action will benefit an individual hospital, the system, neither or both. *See* Huberfeld, Tackling the 'Evils' of Interlocking Directorates in Healthcare Nonprofits, 85 Neb.L.Rev. 681 (2007); Hershey and Jarzab, Fiduciary Duties of Interlocking Directors within a Nonprofit Health System, 38 J. Health L. 449 (2005). This issue is discussed further, below, with respect to use of a corporate member.

(d), (e) and (f) Proceeds of Transaction

The transaction is between two New Hampshire voluntary corporations and a new voluntary corporation to be formed. EHS and SNH will retain their own assets, and there will be no proceeds as such from the transaction. *See* Combination Agreement, Section 2.2. Under the proposed Management Services Agreement, each organization will allocate payment for SH's general overhead and for any approved Coordinated Activity Plans in accordance with a formula. Management Services Agreement, Section 2.

With respect to the endowment assets of EHS and SNH, a majority of the SH board of directors may vote to change applicable investment policies, but not ownership of any restricted funds. SH Bylaws, Section 7(b)(xiii).

In response to information requests, EHS and SNH provided valuations of individual donor restricted funds. Upon a review of those materials, it became apparent that several of the EHS funds must have their values restated or the restrictions released pursuant to RSA 292-B:6. Follow-up action is required.

(g) Notice and Hearing

The Notice describes the outreach to the communities affected by the proposed transaction and the opportunity for individuals to provide input about the transaction to the boards of directors of the hospitals.

The Director of Charitable Trusts and the Assistant Director of Charitable Trusts attended public meetings in Nashua on January 10, 2018 and in Manchester on January 18, 2018 concerning the proposed transaction.

The transaction has received uniformly positive comments from Nashua and Manchester area community leaders and users of EHS and SNH. The news media's coverage of the transaction has largely been limited to reporting statements made at public meetings. Commercial payers and other providers of health care services have expressed concern about the effect on health care costs and access resulting from the establishment of a regional system in Southern New Hampshire.

Overall, the outreach and meetings have provided sufficient opportunities for the public to weigh in on the transaction.

(a), (b) and (e) Best Interests of the Organizations

The Notice lays out a number of challenges facing EHS and SNH: policy changes to the delivery of and payment for health care, an aging population in Southern New Hampshire, renewed emphasis on behavioral health (including to address the substance use disorder crisis), increased competition from other providers, and increasing consolidation in the health care industry.

EHS and SNH believe that they can address these challenges by coming together. They state that as a regional system they can develop population health outcome-based care, introduce unspecified specialized clinical programs, adopt a shared electronic medical records program, and create efficiencies of scale. They maintain that EHS and SNH have shared values and compatible missions, and each organization performs a similar role in its home city.

The hospitals retained a shared consulting firm that advised the boards of directors of EHS and SNH separately on the value of such a transaction. The organizations relied upon that firm's opinion in reaching their decisions. Any financial projections supplied by the consulting firm were not included in responses to information requests.

The ultimate success of EHS and SNH arising from their participation in the proposed regional system will depend upon their success in implementing Coordinated Activity Plans developed pursuant to the Management Service Agreement. With the exception of commitments to a combined electronic medical records system and population health outcome-based care, the nature and scope of those plans remains to be seen.

However, based on the limited materials offered, EHS and SNH have presented enough information to support their belief that the transaction is in their own institutional best interests.

(a), (b) and (e) Continuation of Charitable Purposes

(i) Entities as Charitable Organizations

EHS and SNH and their affiliated organizations are New Hampshire voluntary corporations as well as charitable organizations registered with the Charitable Trusts Unit. The Internal Revenue Service has determined all of the entities to be public charities classified under §501(c)(3) of the Internal Revenue Code. After the acquisition, these organizations will retain their separate status as charitable organizations. SH likewise will become a New Hampshire voluntary corporation, a charitable organization registered with the Charitable Trusts Unit and a public charity supporting organization classified under §501(c)(3) of the Internal Revenue Code.

(ii) Compatibility of Charitable Purposes

EHS has its origins in the 1881 legislative charter to create a hospital in Manchester. It currently operates a 296-bed acute care facility and employs or has contracts with more than 380 physicians and other providers. It provides inpatient behavioral health facilities and operates an outpatient surgery center. By revenue and patient volume, it is the larger of the two community hospitals in Manchester. EHS's charitable purpose expresses no specific religious orientation, although five of its directors are chosen from the membership of five Protestant churches in Manchester. EHS's healing orientation is based upon a standard health promotion and medical model.

SNH has its origins in the 1892 legislative charter to create a hospital in Nashua, originally named Nashua Memorial Hospital. It currently operates a 188-bed acute care facility and employs more than 360 physicians and other providers. It provides inpatient behavioral health facilities. By revenue and patient volume, it is the larger of the two community hospitals in Nashua. SNH's charitable purpose expresses no specific religious orientation. SNH's healing orientation is based upon a standard health promotion and medical model.

The current charitable purposes of EHS and SNH are compatible: the operation of a community hospital and the supply of health care services to their communities. Each organization maintains a core facility – a hospital – and each provides inpatient, outpatient and ancillary services in its communities. Their charitable purposes reveal no specific religious or healing orientation, i.e. they focus on health promotion and a medical model of care. The representation on EHS's board from five Protestant churches in Manchester may assure that certain values get expressed, but no specific outcome is presumed. The transaction will not change the EHS board representation from the churches.

(iv) Participation of EHS and SNH in a System

As discussed above, the transaction contemplates that EHS and SNH will become a part of a regional system, SH. It is not the acquisition of one entity by the other. The participation by the organizations in a system does mean some expansion of their charitable purposes. Both EHS and SNH currently offer a collection of hospital, outpatient and ancillary services in various locations in Manchester, Nashua, and surrounding towns. EHS has locations in Hooksett, Goffstown, Allenstown, Londonderry, Raymond, Windham, Bedford and Amherst. SNH has locations in Merrimack, Amherst, Milford, Hudson, Pelham, and Pepperell, MA. EHS and SNH

separately do not constitute what is typically considered to be a health system representing multiple hospitals in an extensive geographic region.

Charitable organizations may expand their purposes without court oversight, with some limits, so long as it is not inconsistent with their prior purposes. *See generally Queen of Angels Hospital v. Younger*, 66 Cal. App. 359, 368 – 71 (Cal.App. 1977); Restatement of the Law of Charitable Organizations (Tent. Draft No. 1, 2016) §2.02, Comment (e) and Reporters' Note 17; §3.01(a), Comment (b) and (c); §3.04(a), Comment (b) and (c). There are limits, however, to the use of pre-affiliation assets for the support of the expanded mission. *See generally* Restatement of Charitable Organizations §3.01(b), Comment (e) (citing *Attorney General v. Hahnemann Hospital*, 494 N.E.2d 101, 1021 (Mass. 1987)).

The organizations recognize those limits in Section 2.2.4 of the Combination Agreement and in their respective bylaws. For instance, any transfer of assets of either EHS or SNH requires a separate vote of that organization's board of directors. If the transfer exceeds $2 million, the SH board of directors must also approve. Combination Agreement Exhibit C, SH Bylaws, Article IV, Section 7(b)(ix); Combination Agreement Exhibit E-1, EHS Amended Bylaws, Article V, Section B(8); Combination Agreement Exhibit E-2, SNH Amended Bylaws, Section 5.5(b)(viii). The addition or elimination of a clinical service program of EHS or SNH requires a separate vote of the organization's board of directors, except that changes involving programs with expenses exceeding $2 million per year also requires approval of the SH board of directors. The SH board, with a 75% majority vote, may override a negative vote by the EHS or SNH board concerning such a change. Combination Agreement, Exhibit C, SH Bylaws, Article IV, Section 7(b)(xx) and 7(c); Combination Agreement Exhibit E-1, EHS Amended Bylaws, Article V, Section B(18) and C; Combination Agreement Exhibit E-2, SNH Amended Bylaws, Section 5.5(b)(xviii) and 5.5(c).

Under this structure, neither the Combination Agreement nor the bylaws strictly prohibit nor do they define the outer limits of the transfer of pre-transaction assets or programs from one organization to another. Such protections often appear in hospital affiliation transactions. It will be up to the directors of EHS and SNH to determine in each instance whether a specific transfer of assets or a change to a clinical service will provide comparable benefits to their own organization as part of a system. While the SH board of directors holds a veto power over the selection of EHS and SNH nominated directors, a majority of the SH board itself is comprised of equal representatives from EHS and SNH. Therefore, the governance structure contains enough bottom-up protection such that the pre-transaction assets and clinical services of EHS and SNH will not be transferred without appropriate consideration of the interests of the transferring entity.

(v) Use of Corporate Member

The proposed transaction takes its form in contracts and governing documents. The articles of agreement of EHS and SNH will be amended to make SH the sole member of each. The membership rights of SH are documented in the amended by-laws of EHS and SNH. Those include the interlocking directorship seats, discussed in the Conflicts of Interest section above, and a number of reserved rights governing Major Matters, including SH's role in the approval of budgets, capital projects, clinical program changes and chief executive appointment and removal. Combination Agreement Exhibit C, SH Bylaws, Article IV, Section 7(b) and (c); Combination

Agreement Exhibit E-1, EHS Amended Bylaws, Article V, Section B and C; Combination Agreement Exhibit E-2, SNH Amended Bylaws, Section 5.5(b) and (c).

Moreover, absent consensus, SH can impose an operating and capital budget on EHS or SNH, or change a clinical program, with a 75 percent vote of the SNH board of directors. Further, SH will "oversee and provide management, administrative and support services with respect to the business, operations, activities… and affairs of [EHS and SNH]. Management Services Agreement, Section 1(a).

Corporate membership has now become the preferred method to structure hospital affiliations. This construct provides control while preserving pre-existing health insurance contracts, Medicare reimbursement rates and local identity. It may be designed to limit Attorney General oversight and avoid court approval. *See* Reiser, Decision-Makers without Duties: Defining the Duties of Parent Corporations Acting as Sole Corporate Members in Nonprofit Health Care Systems, 53 Rutgers L.Rev. 979, 988 - 91 (2001).

Simply stated, SH, as the sole member of EHS and SNH, will hold considerable power. The breadth of that power comes with responsibility over its exercise. Where another corporate entity exercises authority over a charitable organization by use of its controlling membership, the member owes a targeted fiduciary duty to act in the best interest of the organization, and not just in the interest of the member. N.H. Att'y Gen. Opinion, February 13, 2017. *See generally* RSA 7:19-a, IX (charitable organization transactions with member must be "fair" to organization); *Lifespan Corp. v. New England Medical Center*, 731 F.Supp.2d 232, 239 - 41 (D.R.I. 2010); Restatement of the Law of Charitable Organizations (Tent. Draft No. 1, 2016) §2.01, Comment (c); Hesse and Szabo, The Fiduciary Duty of a Charitable Corporation's Sole Corporate Member: New Law and New Questions, 7 Boston Health L.Rep., Winter 2012 at 4; Decision-Makers without Duties, 53 Rutgers L.Rev. at 1013 - 26.

SH's fiduciary duties pertain to its exercise of its authority over Major Matters as set forth in the bylaws of the three organizations. Because the controlling member exercises those powers through its board of directors, the corresponding fiduciary duties apply to the board of directors of SH.

Issues may arise when the corporate member exercises its power in a way that benefits one hospital at the expense of another. This situation is complicated further when a director of the corporate member also sits on the board of a member hospital. While recusal of a member or a director may occasionally be appropriate, at some point the practice would imperil the success of the system project. Tackling the 'Evils', 85 Neb.L.Rev. at 716 – 32. Upfront disclosure, clearer governance and other mission documents, identification of congruence versus conflicts of interest and attention to which hospital is taking what action may permit a member or director to observe fiduciary duties within a hospital system. Id.; s*ee also* Fiduciary Duties of Interlocking Directors, 38 J. Health L. at 449.

In this transaction, SH more likely will observe its fiduciary duties toward EHS and SNH as a practical matter because EHS and SNH together will select a majority of the directors of SH, and EHS and SNH each will select more than 25 percent of the SH board members. However, should additional hospital entities join SH, the EHS and SNH voting blocs may become diluted.

Should that occur, there will be a need for additional language in the bylaws of each organization to express the responsibility of SH in its exercise of reserved powers through its shared control over Major Matters.

The use of a corporate member with reserved powers over Major Matters does diminish the independent authority of EHS and SNH. That diminishment comes with a counterbalance because those co-fiduciaries share power. This transaction therefore does not create a simple delegation of power to SH. Given the current bylaw language, so long as no additional health care organizations join the SH system, the extent of SH's rights and powers as sole member are not objectionable. Any future transactions must include further documentation of the shared responsibility among entities.

Accordingly, the creation of a corporate member does not by itself cause a "hitch in the administrative machinery" for fulfillment of the charitable purpose of either EHS or SNH. A judicial decree of deviation is therefore not necessary. *See*, RSA 547:3-c; *Jacobs v. Bean*, 99 N.H. 239, 241 (1954). *See also In re Certain Scholarship Funds*, 133 N.H. 227, 240 (1990) (Brock, C.J., dissenting). Whether court approval is required in the context of a specific health care transaction depends on an interpretation of the common law and statutes applied to a complicated deal. *See,* RSA 7:19-b, VI(b). Again, based on the materials presented, the proposed transfer of control is not so great that a probate court decree of deviation is required.

(b) and (e) Best Interest of Community

(i) Current Community Needs and Community Benefits

The boards of directors of EHS and SNH are expected to determine whether the transaction is in the best interest of the community, as well as in the organization's best interest. The statute does not define "best interest", but it likely includes issues identified in the health needs assessment and addressed in the community benefits that the organizations measure and report to the Charitable Trusts Unit pursuant to RSA 7:32-c – 32-*l*. The past commitments by each organization toward community benefits may be an indicator of each organization's attitude toward future commitments.

EHS along with Catholic Medical Center participated in the Greater Manchester Community Needs Assessment, completed in 2016. It identified the five greatest health needs to be: substance misuse, mental health, poverty rates, support services and access to care. The needs assessment did not recommend specific programmatic and spending priorities. The 2016 Greater Manchester Health Improvement Plan, prepared by the Manchester Health Department with the participation of EHS and other organizations, proposed programming to address five identified priority areas: injuries and violence, asthma, diabetes, substance misuse and emergency preparedness.

EHS gets high marks for its work in the community to address mental health and substance use disorder. It operates a 12-bed adult inpatient unit and a 25-bed geriatric inpatient unit. Within those units it maintains 14 beds as a designated receiving facility for involuntary emergency admissions. It works with the Mental Health Center of Greater Manchester and Catholic Medical Center to address emergency behavioral health needs. EHS's emergency

department handles a large volume of substance use cases and is increasing its programming in that area.

EHS also gets high marks for its support of Manchester Community Health Center, the region's federally qualified health center (FQHC) that provides primary care for thousands of lower income persons. EHS has supported MCHC with $300,000 or more of annual cash support, plus electronic medical records integration, laboratory services and specialist referrals.

With respect to various hospital quality scores, EHS presents mixed results. Attached as Exhibit 1 is a Fact Sheet prepared by the University of Massachusetts Medical School Center for Health Law and Economics. It shows quality statistics for EHS reported by New Hampshire HealthCost Quality of Care Scores, New Hampshire Hospital Scorecard and the Center for Medicare and Medicaid Services Hospital Compare.

The historical monetary community benefits reported by EHS show that it provides uncompensated (charity) care at rates comparable to or higher than other New Hampshire hospitals. It reports a substantial volume of subsidized health services, which include large amounts of subsidies for primary and specialty care physician practices whose offices are located in medically underserved areas. The inclusion of physician practice subsidies as a community benefit requires better definition and more uniformity statewide. More recently, the cost of EHS' charity care decreased from $8,734,000 in fiscal year 2016 to $7,158,000 in fiscal year 2017.

As to EHS's outpatient prices for uninsured and privately insured patients, a partial review shows that the prices tend to be lower than the statewide median and lower than neighboring Catholic Medical Center. *See* Ex. 1, attached. However, those statistics lack reports on outpatient office visits.

SNH published its own community needs assessment in 2015. It identified three top priorities: mental health/substance abuse, access to and coordination of care, and obesity. The needs assessment included an action plan including goals for resource inputs, program outputs and outcomes. The plan included an increase in staffed behavioral health beds from 12 to 18, adding 7.1 employees to the behavioral health/substance abuse programs and 8.2 employees to bring in-house the ACCESS emergency behavioral health care system. With respect to access, it cited plans to open new intermediate care facilities in Amherst and Pepperell, and adding two employees to assist with Medicaid applications.

While SNH now does have 18 licensed behavioral health beds, only 12 are currently staffed. It has brought in-house the ACCESS emergency behavioral health system, which now employs 8 staff in positions previously outsourced to other providers. It has added a case coordinator for addiction in its emergency department and is in the process of expanding the capacity of the emergency department to deal with psychiatric crises.

With respect to addressing the access need, SNH cites its opening of two new intermediate care facilities. It states that it assists patients with Medicaid applications, but does not address expanded capacity in that regard. It also mentions free health screenings and health fairs, as well as its professional services agreement with Massachusetts General Hospital to bring specialty care services to Nashua. SNH does not mention support for any FQHC in the Nashua

area, and in fact in 2013 it ended its prior substantial annual cash contribution to Lamprey Health Care.

SNH ranks somewhat higher than EHS on hospital quality scores. Attached as Exhibit 2 is a Fact Sheet prepared by the University of Massachusetts Medical School Center for Health Law and Economics. It shows SNH quality statistics reported by New Hampshire HealthCost Quality of Care Scores, New Hampshire Hospital Scorecard and the Center for Medicare and Medicaid Services Hospital Compare.

Historically, the monetary community benefits reported by SNH show that it provides uncompensated (charity) care at rates close to the average of New Hampshire hospitals. It does not include subsidies paid to primary or specialty care physicians as a community benefit. More recently, the cost of SNH's charity care increased from $2,851,261 in fiscal year 2016 to $3,326,903 in fiscal year 2017.

A partial review of SNH's prices for outpatient services show that its charges are above the statewide average for commercial insurers, but below that average for self-paying patients. *See* attached Ex. 2.

(ii) Post-Consolidation Community Benefits

There are three outcomes that are evaluated in any health care system: cost, quality and access. If the transaction improves these metrics, then the outcome will be in the best interest of the community. *See* Community Benefit and Market Changes in New Hampshire, New Hampshire Center for Public Policy Studies (2017). Here, EHS and SNH predict improvement in all three areas as a result of the transaction. But with the exception of commitments to implement electronic medical records and a population health model, there are no concrete plans to achieve improvements targeted to these metrics. This lack of specificity is described in the Due Diligence section, above.

The best indicator of the future should be the experience of past hospital affiliations. The available literature offers limited positive guidance, however. For instance, it does not show that recent hospital consolidations have improved quality. *See id.* at 20.

Significant numbers of patients from many southern New Hampshire towns obtain health care services offered both by EHS and SNH. This report assumes, however, that the EHS and SNH markets do not substantially overlap. Still, price increases may be associated with cross-market mergers where there is payer (commercial insurer) and employer overlap. *See* L. Dafny et al., The Price Effect of Cross-Market Hospital Mergers, National Bureau of Economic Research Working Paper No. 22106 (2016). There is considerable insurer and employer overlap between the Nashua and Manchester regions. New Hampshire Insurance Department, Final Report of the 2016 Health Care Premium and Claim Cost Drivers (2017); New Hampshire Department of Employment Security, Community Profiles by County (2018). This transaction will result in the largest physician network in the region and the consolidation of the two larger hospitals (by revenue) in the two largest cities in New Hampshire.

Currently, EHS and SNH are considered to be low to moderate cost health providers. *See* attached Ex. 1 and 2. Their communities may lose that benefit if those organizations can leverage their increased size to increase their commercial insurance rates.

Finally, there is evidence that greater competition increases the access component of population health initiatives. Less competition tends to decrease access to services. See, Community Benefit, NHCPPS at 17.

In sum, based on available evidence and literature, consolidation does not clearly improve the broader provision of community benefits, at least in cases where none of the hospitals is in financial distress. While EHS and SNH have presented a positive view of their future together, the Notice documents do not sufficiently commit to ongoing community benefits and to specific quality, cost and access achievements. That lack of documentation may be partially explained by antitrust law limitations placed on pre-transaction communications between the parties. SNH and EHS have no doubt each made financial projections, either prepared internally or by their consultants. Those projections, if realized, may enable the organizations to fund community benefit initiatives at a different level in the future. But EHS and SNH did not include that material in their responses to information requests. In the face of literature skeptical of hospital consolidations, and in the face of limited data provided to the Charitable Trusts Unit, EHS and SNH must expect to commit to more specific post-merger benefits.

This review is not alone in questioning the effect of consolidations on health care costs and access. The Consumer Protection and Antitrust Bureau has conducted its own antitrust review and analysis of this transaction pursuant to N.H. RSA 356, the Combinations and Monopolies Act. The Bureau has issued a no action letter at this time. In doing so, it identified areas of potential concern and reserved the right to take formal action in the future if necessary.

Conclusions and Determination

The Notice, the meetings, the outreach and the research indicate that EHS and SNH have complied with the minimum standards set forth in RSA 7:19-b, II for an acquisition transaction, but only if they are supplemented by the representations and conditions set forth below.

The information presented described how far-reaching changes are taking place in the delivery of and payment for health care. The Notice also described the process that the EHS and SNH boards of directors used to explore a transaction. In the end, the parties decided that they should jointly form a supporting organization, SH, which in turn would become the sole member of each organization. By doing so, EHS and SNH believe they can best meet future challenges and improve their delivery of health care.

Over 60 percent of nonprofit hospitals in New Hampshire have decided in recent years that their future lies in consolidation. The jury is still out on whether these transactions will in the end deliver net benefits to the communities served by these hospitals. Better data are needed to evaluate how access, quality and cost may change. For now, the literature remains skeptical that real improvements can be achieved. With respect to this transaction, the information supplied by EHS and SNH lacks the specificity needed to confirm that it is in the best interest of the

communities the organizations serve, an important standard that underpins RSA 7:19-b. However, this lack of specificity can be addressed if the organizations adhere to the representations and conditions listed below. With those representations and conditions in place, the best interest of the community standard is satisfied. EHS and SNH have met the other minimum standards of RSA 7:19-b.

Accordingly, the Director of Charitable Trusts will take **no further action** with respect to the transaction, subject to the following representations, conditions and guidance.

Representations

EHS and SNH each represent that the statements below will be true and correct with respect to such party as of the date of the closing of the transaction (the "Closing Date"):

(i) The transaction will comply with the terms of the Combination Agreement and the statements made in the Notice.

(ii) There are no conflicts of interest or pecuniary benefit transactions involving directors or officers of EHS or SNH or their affiliates contemplated as part of the transaction.

Conditions

EHS and SNH each assent to the following post-closing conditions:

(i) In connection with the closing of the transaction, the parties will add language to the bylaws of EHS, SNH and SH to describe the future selection process for the two *ex officio* directors of SH, one each to be selected by the boards of directors of EHS and SNH.

(ii) Within thirty days of the Closing Date, the parties will give notice to the Director of Charitable Trusts that the transaction contemplated by the Combination Agreement has closed.

(iii) For a period of five years from the Closing Date, the parties will notify the Director of Charitable Trusts should a dispute arise that requires dispute resolution pursuant to Article 8 of the Combination Agreement or Section 7 of the Management Services Agreement.

(iv) In furtherance of the goals of the Notice and the Combination Agreement, the parties have committed to undertaking certain planning and implementation activities around the subject matters identified below. Accordingly, within six months from the Closing Date, EHS, SNH and SH shall convene internal working groups to commence material deliberations on the following issues:

(a) Improvement of local access to one or more specialty health care services within the communities served by the parties;

(b) Implementation system-wide of a state-of-the-art electronic health care information and medical records system which, among other capabilities, will enable patients to receive ready access to their records and will facilitate timely transfer of their records directly to another provider of the patient's choice;

(c) Development of collaborative and coordinated initiatives to improve population health management for the patient populations served by the parties (including the formation of accountable care systems that may include other providers such as federally qualified health centers);

(d) Collaboration and coordination of EHS's and SNH's financial assistance and charitable care policies such that patients who are eligible under one organization's policy are also eligible for such services at the other organization; and

(e) Development of collaborative and coordinated initiatives intended to improve how the behavioral health needs of the communities served by EHS and SNH are met (including, but not limited to, implementation and maintenance of emergency room and inpatient psychiatric beds, consideration of best practices for primary care physicians involved in opioid prescribing, prescription drug monitoring, screenings for substance use and mental health disorders, and information on referral sources).

(v) EHS, SNH and SH shall submit written reports to the Charitable Trusts Unit on the status of the working groups described in paragraph (iv) above as follows:

(a) On the first, second and third anniversaries of the Closing Date, specify the status of improvements of local access to one or more specialty healthcare services, including numbers of patients using such services.

(b) On the first anniversary of the Closing Date, specify the status of implementation of a state-of-the-art, integrated electronic health care information and medical records system, which, among other capabilities, will enable patients to receive ready access to their records and will facilitate timely transfer of their records directly to another provider of the patient's choice. The report will include the status of the development of metrics to measure expected benefits from the integrated system

(c) On the first, second, third, and fourth anniversaries of the Closing Date, specify the status of coordinated population health management/accountable care initiatives, including processes for

identification of unmet clinical needs and the development of community specific metrics and analytics.

(d) On the first anniversary of the Closing Date, specify the status of collaboration and coordination of EHS's and SNH's financial assistance and charitable care policies such that patients who are eligible under one organization's policy are also eligible for such services at the other organization.

(e) On the first, second, third and fourth anniversary of the Closing Date, specify the status of improvements intended to meet the behavioral health needs of the communities served by EHS and SNH, including any changes since the Closing Date in staffing behavioral health. This report will include confirmation that EHS and SNH have implemented and are maintaining within their behavioral health units at least: six beds within each of their emergency departments in addition to 37 (at EHS) plus 18 (at SNH) inpatient behavioral health beds. If at any time before the fourth anniversary of the Closing Date EHS makes a unilateral decision to change its level of participation in the Manchester Psychiatric Emergency Services Response System, EHS shall submit to the Charitable Trusts Unit 90 days advance notice.

(vi) By the first anniversary of the Closing Date, EHS and SNH will create a plan for a common reporting system that will annually assess and report data to the Director of Charitable Trusts pertaining to access to, quality and cost of health care services, such plan and reporting system to be in a form reasonably acceptable to the Director of Charitable Trusts. The common reporting system will include data such as: assessments relating to the share of primary and secondary markets by type of care and payer category for inpatient and outpatient care; inpatient and total costs per case-mix adjusted [i.e. outpatient] charges; Medicare cost per beneficiary; additions/closures of services; numbers of primary care and specialist staff physicians; FQHC support - direct financial, value of other support, patient specialist referrals and hospital admissions; patient satisfaction rankings from Medicare Compare; inpatient core measure composite achievement; emergency care wait times; hospital acquired infections from CLABSI, CAUTI, SSI, MRSA and C. diff; and Hospital Compare readmission rates by category. EHS and SNH will thereafter submit the report to the Director of Charitable Trusts on the first, second, third and fourth anniversary of the Closing Date.

(vii) For a period of four years from the Closing Date, EHS and SNH will each maintain an annual ratio of community benefit spending to net patient service revenue that is equal to or greater than the ratio of community benefit spending to net patient service revenue reflected in EHS's and SNH's most recently filed

community benefit report. Should future circumstances beyond the control of either EHS or SNH make imprudent the maintenance of the current ratio, EHS and SNH will report the circumstances to the Director of Charitable Trusts. For a period of four years from the Closing Date, EHS will maintain or increase the current level of cash, laboratory, and specialist referral support for Manchester Community Health Center. For a period of four years from the Closing Date, SNH will provide direct financial support for community health facilities or services of other community providers within SNH's service area in the aggregate amount of $400,000. Such amount shall be in addition to SNH's current level of support for such providers. SNH shall have the flexibility to provide such support at such times and in such amounts at any time during such four-year period.

Guidance

(i) SH will act as a fiduciary toward EHS and SNH when exercising its rights concerning Major Matters and its reserved powers. N.H. Att'y Gen. Opinion, February 13, 2017.

This no further action report concerns the review of the Charitable Trusts Unit pursuant to RSA 7:19-b and does not implicate the jurisdiction of any other section of the New Hampshire Department of Justice which may also have a role in reviewing this proposed transaction, including the Consumer Protection and Antitrust Bureau.

EXHIBIT 1

Elliot Hospital Fact Sheet

Prepared for the New Hampshire Office of the Attorney General Charitable Trusts Unit

February 2018

Katharine London, Principal

Jeremy Tourish, Policy Analyst

University of Massachusetts Medical School

Center for Health Law and Economics

Summary

Overview: Elliot Hospital is a 296 bed, acute care facility located in Manchester, New Hampshire. The hospital provides emergency care along with clinical specialties including cardiovascular services, oncology services, and psychiatric services, among others. It also provides extensive community benefits, including over $19 million in subsidized health services, and over $8 million in charity care.

Quality: Elliot Hospital scores near or above the State average on 20 out of 30 NH HealthCost quality measures, but scores below the average on 10 quality measures. The hospital also receives a "below national level" patient experience score from the New Hampshire Hospital Scorecard. However, Medicare's Hospital Compare website gives the hospital four out of five stars for both its overall rating and for its score patient surveys.

Cost: Elliot Hospital received a "low cost" cost index rating by New Hampshire Hospital Compare. Elliot Hospital's outpatient prices were generally lower than the state median price for emergency services and for uninsured services. Elliot's prices for some privately insured outpatient procedures were higher than the state median. Elliot's outpatient prices were generally lower than neighboring Catholic Medical Center's prices.

Population Health: The city of Manchester has significant health challenges in relation to other areas of the State. Some of these include higher than average incidence of:

- People with a disability under the age of 65;
- People under the age of 65 without health insurance;
- Adults who have asthma;
- Adults who have diabetes;
- Adults who are current smokers;
- Adults with a reported BMI or 30 or greater;
- Asthma related emergency room visits;
- Newly diagnosed chlamydia cases;
- Births to mothers between the ages of 15-19;
- Years of potential life lost before the age of 75;
- Adults reporting fair or poor health;
- People in poverty; and
- Daily density of fine particulate matter

In addition, the opioid death rate in Hillsborough County is 50% higher than in the State overall, and 4 times higher than the national rate.

Contents of This Report: This report provides the following information:

- a service profile of Elliot Hospital that includes quality, cost, and community benefit statistics
- the NH HealthCost quality measure scores for the hospital
- a comparison of population health measures for the city of Manchester, Hillsborough County, the State of New Hampshire, and the United States

Elliot Hospital Service Profile [i, ii]

General Hospital Information	
Type of Facility	Acute Care
Total Staffed Beds	296
Joint Commission Accreditation	Yes

Clinical Services Offered

- Emergency Services
- Cardiovascular Services
- Neurosciences
- Oncology Services
- Orthopedic Services
- Radiology/Nuclear Medicine/Imaging
- Psychiatric Services
- Surgery
- Substance Use Treatment
- Maternity Care

Charity Care and Other Community Benefits [iii]

The table below offers a snapshot of the charity care and other community benefits provided to the greater Manchester community by Elliot Hospital. All information derives from Elliot Hospital's FY 2016 Community Benefit Report.

Community Benefit Report (FY 2016)	Benefits Provided	Financial Benefit
	(1) Community Health	$165,737
	(2) Health Professions Education	$752,276
	(3) Subsidized Health Services	$19,663,773
	(4) Medical Research	$6,901
	(5) Financial Contributions	$783,852
	(6) Community Building	$107,620
	(7) Community Benefit Operations	$200,021
	(8) Charity Care	$8,344,812
	Total Community Benefits	$30,024,992

Quality Statistics Summary

The table below offers a view of Elliot Hospital's performance on quality of care scores from three different sources; NH HealthCost, New Hampshire Hospital Scorecard, and CMS Hospital Compare.

Source	*Measure*	*Score*
NH HealthCost Quality of Care Scores [iv]	Quality of Care Measures Worse Than Average	10 out of 30
	Quality of Care Measures Near Average	18 out of 30
	Quality of Care Measures Better Than Average	2 out of 30
New Hampshire Hospital Scorecard [v]	Patient Experience Score	Below national level
	Patient Safety Score	Not Reported
	Clinical Quality: Blood Clot (VTE) Care	Below national level
	Clinical Quality: Stroke Care	At or above state level
	Clinical Quality: Surgical Infection	At or above state level
CMS Hospital Compare [vi]	Overall Rating	4 out of 5 stars
	Patient Survey Rating	4 out of 5 stars

Cost Statistics Summary The table below provides Elliot Hospital's performance on a cost of care measure outlined by New Hampshire Hospital Scorecard.		
Source	*Measure*	*Score*
New Hampshire Hospital Scorecard [vii]	Cost Index Rating	Low cost

Elliot Hospital Financial and Utilization Statistics [viii]

The table below offers a multi-year financial comparison profile based on an analysis of CMS Hospital Form 2552-10 data for Elliot Hospital.

	2011	***2012***	***2013***	***2014***	***2015***	***Average annual change***
Reported Data						
Total Expenses	$284,957,875	$295,154,569	$299,002,299	$321,816,850	$331,057,870	4.0%
Total Hospital Discharges	12,201	11,690	11,665	12,008	11,777	-0.9%
Hospital Subprovider and Other Discharges	771	753	735	755	686	-2.8%
Total Hospital Days	53,256	50,436	51,377	54,857	52,709	-0.3%
Hospital Subprovider and Other Days	11,164	10,647	11,288	12,159	12,557	3.1%
Charity Care Costs (Uninsured Patients)	$3,339,958	$2,913,153	$3,801,745	$2,684,749	$6,720,193	25.3%
Charity Care Costs (Insured Patients)	$3,238,879	$3,250,559	$6,390,602	$4,327,830	$1,877,192	-10.5%
Total Unreimbursed & Uncompensated Care	$37,522,206	$37,094,614	$26,434,401	$27,577,531	$18,738,831	-12.5%
Total Inpatient Charges	$259,161,317	$269,670,586	$282,550,745	$300,620,081	$312,309,481	5.1%
Total Outpatient Charges	$440,815,144	$473,732,741	$491,658,030	$553,630,540	$600,588,869	9.1%
Net Patient Service Revenue	$313,736,012	$322,130,041	$345,576,782	$374,264,846	$394,699,284	6.5%
Calculated trends						
Adjusted Hospital Days (Inpt Days + Inpt Days*(Outpt Charges/ Inpt Charges))	143,841	139,037	140,777	155,883	154,071	1.8%
Total Expense per Adjusted Day (Total Expenses/Adj Hospital Days)	$1,981	$2,123	$2,124	$2,064	$2,149	2.1%
Net Patient Service Revenue per Adjusted Day (NPSR/Adj Hospital Days)	$2,181	$2,317	$2,455	$2,401	$2,562	4.4%

Elliot Hospital - Estimated Outpatient Visit Pricing

On average, Elliot Hospital's estimated outpatient prices were lower than the state median price for all uninsured services and all privately insured emergency services. Elliot's prices were lower than neighboring Catholic Medical Center's prices in all but one insurer-service grouping. Prices highlighted in green are lower than the state median, yellow are near the state median, and red are higher than the state median. Elliot does not bill for physician office visits.

Event Type	State	Elliot Hospital			Catholic Medical Center		
	Number of Events	*Number of Events*	*Hospital Price (weighted median)*	*Price if billed at the state median price*	*Number of Events*	*Hospital Price (weighted median)*	*Price if billed at the state median price*
Emergency Visits							
Anthem	4,200	284	$510	$631	146	$646	$630
Cigna	1,784	133	$442	$701	34	$493	$709
Harvard Pilgrim	3,701	235	$514	$605	83	$620	$559
Other Insurance	657	58	$616	$642	20	$703	$712
Uninsured	14,172	984	$361	$597	501	$806	$586
Office visits							
Anthem	210,899	0	NA	NA	9,366	$150	$155
Cigna	82,259	0	NA	NA	1,925	$145	$147
Harvard Pilgrim	194,372	0	NA	NA	5,076	$191	$162
Other Insurance	29,109	0	NA	NA	512	$172	$172
Uninsured	609,123	0	NA	NA	19,464	$182	$223
Outpatient tests and procedures							
Anthem	6,493	541	$3,748	$3,054	114	$4,760	$3,217
Cigna	2,866	206	$3,183	$3,184	41	$3,382	$3,771
Harvard Pilgrim	5,340	343	$3,409	$2,879	52	$4,642	$3,698
Other Insurance	797	47	$3,907	$2,935	8	$5,256	$3,037
Uninsured	18,487	1,378	$3,074	$3,564	317	$6,004	$3,951
Radiology							
Anthem	31,003	2,544	$706	$631	1,047	$800	$656
Cigna	10,892	1,177	$623	$685	261	$776	$732
Harvard Pilgrim	24,625	1,875	$667	$692	656	$623	$604
Other Insurance	3,807	295	$1,105	$775	58	$916	$646
Uninsured	84,958	7,043	$626	$833	2,517	$1,126	$810

Author's analysis of NH CHIS Group Medical Plans and Uninsured Claims only, FY2017 Q1. Authors calculated median price by insurer by service by hospital and by insurer by service for the state. Prices shown the hospitals own prices weighted by its service mix, compared to state median prices weighted by the hospital's service mix.

NH HealthCost Quality of Care Report [ix]

The table below shows NH HealthCost's quality report for Elliot Hospital. NH HealthCost scores Elliot Hospital on 30 quality measures and compares it to average scores for the State of New Hampshire.

Patient Experience		
"Always" quiet at night	Below the average	44% state average (57%)
"YES", patients would definitely recommend the hospital	Near the average	73% state average (74%)
Doctors "always" communicated well	Near the average	79% state average (81%)
Nurses "always" communicated well	Near the average	78% state average (81%)
Pain was "always" well controlled	Below the average	66% state average (72%)
Patients "always" received help as soon as they wanted	Below the average	61% state average (72%)
Patients who gave a rating of "9" or "10" (high)	Below the average	67% state average (73%)
Room was "always" clean	Below the average	70% state average (76%)
Staff "always" explained	Near the average	62% state average (67%)
Yes, staff "did" give patients this information	Near the average	46% state average (42%)
Stroke Care		
Anticoagulation Therapy for Atrial Fibrillation/Flutter	Near the average	100% national average (97%)

Antithrombotic Therapy By End of Hospital Day 2	Near the average	100% national average (98%)
Assessed for Rehabilitation	Near the average	99% national average (99%)
Discharged on Antithrombotic Therapy	Near the average	100% national average (99%)
Discharged on Statin Medication	Near the average	95% national average (98%)
Stroke Education	Near the average	97% national average (94%)
Venous Thromboembolism (VTE) Prophylaxis	Near the average	97% national average (97%)
Time and Effectiveness		
Admit Decision Time to ED Departure Time for Admitted Patients	Below the average	137 mins state average (109 mins)
Head CT Scan Results for Stroke Patients	Below the average	42% state average (71%)
Influenza Immunization	Near the average	95% state average (97%)
Initial antibiotic selection for CAP in immunocompetent patient	Near the average	95% state average (97%)
Median Time From ED Arrival to ED Departure for Admitted ED Patients	Below the average	328 mins state average (295 mins)
Median Time From ED Arrival to ED Departure for Discharged ED Patients	Below the average	192 mins state average (148 mins)
Median Time From ED Arrival to Provider Contact for ED Patients	Near	29 mins state average (28 mins)

	the average	
Median Time to Pain Management for Long Bone Fracture	Near the average	52 mins state average (54 mins)
Primary PCI Received Within 90 Minutes of Hospital Arrival	Below the average	79% state average (96%)
Venous Thromboembolism (VTE)		
Intensive Care Unit (ICU) VTE Prophylaxis	Near the average	98% national average (97%)
VTE Discharge Instructions	Better than average	100% national average (92%)
VTE Patients with Anticoagulation Overlap Therapy	Better than average	100% national average (94%)
VTE Prophylaxis	Near the average	98% national average (95%)

City, County, State, Country Comparison Profile [x, xi]

The table below offers a community health measure needs comparison profile based on analysis of data from multiple sources. Numbers in the Source column refer to citations in the endnotes. "NA" indicates that the measure was not available for the geographic area. X indicates that the Census Bureau deemed the item to be not applicable in the geographic area.

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
Population					
Population estimates, July 1, 2017, (V2017)	NA	NA	1,342,795	325,719,178	11
Population estimates, July 1, 2016, (V2016)	110,506	407,761	1,334,795	323,127,513	11
Population estimates base, April 1, 2010, (V2017)	NA	NA	1,316,460	308,758,105	11
Population estimates base, April 1, 2010, (V2016)	109,574	400,720	1,316,461	308,758,105	11
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	NA	NA	2.00%	5.50%	11
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	0.90%	1.80%	1.40%	4.70%	11
Population, Census, April 1, 2010	109,565	400,721	1,316,470	308,745,538	11
Age and Sex					
Persons under 5 years, percent, July 1, 2016, (V2016)	X	5.30%	4.80%	6.20%	11
Persons under 5 years, percent, April 1, 2010	6.70%	5.90%	5.30%	6.50%	11
Persons under 18 years, percent, July 1, 2016, (V2016)	X	21.00%	19.50%	22.80%	11
Persons under 18 years, percent, April 1, 2010	21.60%	23.50%	21.80%	24.00%	11
Persons 65 years and over, percent, July 1, 2016, (V2016)	X	14.80%	17.00%	15.20%	11
Persons 65 years and over, percent, April 1, 2010	11.80%	11.90%	13.50%	13.00%	11
Female persons, percent,	X	50.30%	50.50%	50.80%	11

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
July 1, 2016, (V2016)					
Female persons, percent, April 1, 2010	50.40%	50.50%	50.70%	50.80%	11
Race and Hispanic Origin					
White alone, percent, July 1, 2016, (V2016)(a)	X	91.00%	93.80%	76.90%	11
Black or African American alone, percent, July 1, 2016, (V2016)(a)	X	2.70%	1.50%	13.30%	11
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016)(a)	X	0.30%	0.30%	1.30%	11
Asian alone, percent, July 1, 2016, (V2016)(a)	X	4.00%	2.70%	5.70%	11
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016)(a)	X	0.10%	0.10%	0.20%	11
Two or More Races, percent, July 1, 2016, (V2016)	X	1.90%	1.70%	2.60%	11
Hispanic or Latino, percent, July 1, 2016, (V2016)(b)	X	6.50%	3.50%	17.80%	11
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	X	85.50%	90.80%	61.30%	11
Families & Living Arrangements					
Households, 2012-2016	45,258	156,114	521,373	117,716,237	11
Persons per household, 2012-2016	2.37	2.54	2.47	264.00%	11
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	80.00%	85.50%	85.90%	85.20%	11
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	19.80%	12.80%	7.90%	21.10%	11
Education					
High school graduate or higher, percent of persons age 25 years+, 2012-2016	87.40%	91.60%	92.60%	87.00%	11
Bachelor's degree or higher, percent of persons age 25	28.00%	36.30%	35.50%	30.30%	11

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
years+, 2012-2016					
Health					
Percent of people with a disability, under age 65 years	10.60%	7.80%	8.70%	8.60%	11
Percent of people without health insurance, under age 65 years	13.40%	7.90%	7.10%	10.10%	11
Percent of Adults Who Currently Have Asthma, Ages 18 and older	18.9% [xii]	11.1% [xiii]	11% [xiv]	7.6% [xv]	12,13,14, 15
Proportion of Adults with Asthma whose Asthma is Not Well Controlled	54.8% [xvi]	NA	48.6% [xvii]	64.8% [xviii]	16,17,18
Number of ER visits due to asthma per 10,000 adults	79.9 [xix]	49.5 [xx]	51.0 [xxi]	NA	19,20,21
Percent of Adults Who Have Diabetes, Ages 18 and older	13.1% [xxii]	8.1% [xxiii]	9.2 [xxiv]	9.4% [xxv]	22,23,24, 25
Number of diabetes related hospitalizations per 10,000 adults	168.8 [xxvi]	NA	145 [xxvii]	515 [xxviii]	26,27,28
Number of opioid related deaths per 100,000 people	NA	48.2 [xxix]	31.3 [xxx]	10.4 [xxxi]	29,30,31
Number of opioid related ER visits per 100,000 people	NA	NA	NA	177.7 [xxxii]	32
Number of deaths among residents under age 75 per 100,000 (age-adjusted)	NA	300	290	NA	10
Number of deaths among children under age 18 per 100,000	NA	40	40	NA	10
Number of all infant deaths (within 1 year), per 1,000 live births	4.9 [xxxiii]	4	5	6 [xxxiv]	33,10,34
Percentage of adults reporting 14 or more days of poor physical health per month	NA	9%	10%	NA	10
Percentage of adults reporting 14 or more days of poor mental health per month	NA	10%	12%	9.4%[xxxv]	10,35

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
Number of persons living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 people	NA	151	104	303.5[xxxvi]	10,36
Health Behaviors					
Percentage of adults who are current smokers	26.9%[xxxvii]	15%	16%	15.5%[xxxviii]	37,10,38
Percentage of adults that report a BMI of 30 or more	32%[xxxix]	29%	28%	37.7%[xl]	39,10,40
Food environment index [0 (worst) to 10 (best)]	NA	8.5	8.4	NA	10
Percentage of adults age 20 and over reporting no leisure-time physical activity	NA	20%	20%	NA	10
Percentage of population with adequate access to locations for physical activity	NA	92%	84%	NA	10
Percentage of adults reporting binge or heavy drinking	21.2% [xli]	20%	18%	26.9% [xlii]	41,10,42
Percentage of driving deaths with alcohol involvement	NA	30%	31%	29%[xliii]	10,43
Number of newly diagnosed chlamydia cases per 100,000 people	631.7 [xliv]	356.8 [xlv]	302.5 [xlvi]	497.3 [xlvii]	44,45,46, 47
Number of births per 1,000 female population ages 15-19	36.2 [xlviii]	17.0	15.0	22.3 [xlix]	48,10,49
Percentage of population who lack adequate access to food	NA	10%	11%	12.3% [l]	10,50
Percentage of population who are low-income and do not live close to a grocery store	NA	3%	4%	6.2% [li]	10,51
Number of motor vehicle crash deaths per 100,000 population	NA	7	8	11.6 [lii]	10,52

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
Percentage of adults who report fewer than 7 hours of sleep on average	NA	34%	32%	35.2% [liii]	10,53
Clinical Care					
Ratio of population to primary care physicians	NA	1,160:1	1,060:1	~1,475:1 [liv]	10,54
Ratio of population to dentists	NA	1,310:1	1,410:1	NA	10
Ratio of population to mental health providers	NA	410:1	390:1	NA	10
Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	NA	49	45	57.8[lv]	10,55
Percentage of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	NA	91%	90%	88.4% [lvi]	10,56
Percentage of female Medicare enrollees ages 67-69 that receive mammography screening	NA	71%	71%	NA	10
Average per capita health care costs	NA	$8,664	$8,362	$10,348 [lvii]	10,57
Quality of Life					
Years of potential life lost before age 75 per 100,000 population (age-adjusted)	6,860 [lviii]	5,600	5,500	6,593.1 [lix]	58,10,59
Percentage of adults reporting fair or poor health (age-adjusted)	17.7% [lx]	11%	11%	NA	60,10
Percentage of live births with low birth weight (< 2500 grams)	NA	7%	7%	8.07% [lxi]	10,61
Income & Poverty					
Median household income (in 2016 dollars), 2012-2016	$54,899	$73,189	$68,485	$55,322	11
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$28,721	$36,012	$35,264	$29,829	11
Persons in poverty, percent	14.60%	8.00%	7.30%	12.70%	11
Geography					
Population per square mile,	3,310.00	457.4	147	87.4	11

Measure	Manchester	Hillsborough County	New Hampshire	United States	Source
2010					
Land area in square miles, 2010	33.1	876.14	8,952.65	3,531,905.43	11
Physical Environment					
Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	15 [lxii]	8.3	7.8	8 [lxiii]	62,10,63
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	20.07% [lxiv]	16%	16%	19.05% [lxv]	64,10,65

Citations

[i] Elliott Health System: About Us. http://elliothospital.org/website/about-us-awards.php. Accessed January 19, 2018.

[ii] ProPublica Nonprofit Explorer: Elliot Hospital of the City of Manchester. https://projects.propublica.org/nonprofits/organizations/20232673. Accessed on January 19, 2018.

[iii] Elliot Health System Community Benefit Report, 2016. Available at http://elliothospital.org/website/downloads/CBR_newsletter2016.pdf. Accessed on January 26, 2018.

[iv] NH HealthCost: Elliot Hospital. https://nhhealthcost.nh.gov/provider/elliot-hospital?cost_type=medical. Accessed on January 11, 2018.

[v] New Hampshire Hospital Scorecard: New Hampshire Hospital Ratings. https://www.nhpghscorecard.org/hospitalratings. Accessed on January 11, 2018.

[vi] Medicare Hospital Compare: Elliot Hospital. https://www.medicare.gov/hospitalcompare/profile.html#profTab=0&ID=300012&loc=03103&lat=42.9561485&lng=-71.4418101&name=ELLIOT%20HOSPITAL&Distn=2.4. Accessed on January 11, 2018.

[vii] New Hampshire Hospital Scorecard: New Hampshire Hospital Ratings. https://www.nhpghscorecard.org/hospitalratings. Accessed on January 11, 2018.

[viii] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for Elliot Hospital for FY2011 - FY2015.

- Total expenses, Wksht A, Col 7, line 118 (excludes non-reimbursable)
- Total hospital discharges , Wksht S-3, Col 15, row 14
- Hospital subprovider and other discharges, Wksht s-3, Col 15, line 27
- Total hospital days , Wksht S-3, Col 8, row 14
- Hospital subprovider and other days, Wksht s-3, Col 8, line 27
- Charity Care Costs, uninsured patients, Wksht s-10, Col 1, line 23
- Charity Care Costs, insured patients, Wksht s-10, Col 2, line 23
- Total unreimbursed and uncompensated care, Wksht s-10, col 1, line 31
- Total inpatient charges, Wksht C Part I, Col 6, line 202
- Total outpatient charges, Wkst C, Part I, Col 7, line 202
- Net Patient Service Revenue, Wksht G-3, Col 1, line 3

[ix] NH HealthCost: Elliot Hospital Profile: https://nhhealthcost.nh.gov/provider/elliot-hospital?cost_type=medical#quality. Accessed on January 17, 2018.

[x] Robert Wood Johnson Foundation: County Health Rankings & Roadmaps – Manchester NH Profile. http://www.countyhealthrankings.org/app/new-hampshire/2017/rankings/hillsborough/county/factors/overall/snapshot. Accessed on January 12, 2018.

[xi] United States Census Bureau: Quick Facts. https://www.census.gov/quickfacts/fact/table/US,NH,hillsboroughcountynewhampshire,manchestercitynewhampshire/PST045216. Accessed on January 19, 2018.

[xii] Greater Manchester, New Hampshire: Health Improvement Plan (2016). Available at https://www.manchesternh.gov/portals/2/departments/health/gmanchip.pdf. Accessed on January 23, 2018.

[xiii] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.

[xiv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.

[xv] Centers for Disease Control and Prevention, National Center for Health Statistics: Asthma. Available at https://www.cdc.gov/nchs/fastats/asthma.htm. Accessed on January 23, 2018.

[xvi] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[xvii] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[xviii] Centers for Disease Control and Prevention, National Center for Health Statistics: Asthma. Available at https://www.cdc.gov/nchs/fastats/asthma.htm. Accessed on January 23, 2018.
[xix] Greater Manchester, New Hampshire: Health Improvement Plan (2016). Available at https://www.manchesternh.gov/portals/2/departments/health/gmanchip.pdf. Accessed on January 23, 2018.
[xx] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[xxi] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[xxii] Greater Manchester, New Hampshire: Health Improvement Plan (2016). Available at https://www.manchesternh.gov/portals/2/departments/health/gmanchip.pdf. Accessed on January 23, 2018.
[xxiii] New Hampshire Department of Health and Human Services, Division of Public Health Services: Diabetes in New Hampshire – Issue Brief – July 2010. Available at https://www.dhhs.nh.gov/data/documents/brief10.pdf. Accessed on January 23, 2018.
[xxiv] New Hampshire Department of Health and Human Services: Diabetes . Available at https://www.dhhs.nh.gov/dphs/cdpc/diabetes/index.htm. Accessed on January 23, 2018.
[xxv] Centers for Disease Control and Prevention: National Diabetes Statistics Report, 2017. Available at https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed on January 23, 2018.
[xxvi] Greater Manchester, New Hampshire: Health Improvement Plan (2016). Available at https://www.manchesternh.gov/portals/2/departments/health/gmanchip.pdf. Accessed on January 23, 2018.
[xxvii] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire Coordinated Strategic Plan for Chronic Disease Prevention and Health Promotion (2013). Available at https://www.dhhs.nh.gov/dphs/cdpc/documents/cd-strategic-plan.pdf. Accessed on January 23, 2018.
[xxviii] Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP): Emergency Department Visits for Adults with Diabetes (2010). Available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb167.jsp. Accessed on January 23, 2018.
[xxix] New Hampshire Information and Analysis Center: New Hampshire Drug Monitoring Report, May 2017. https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-2017.pdf. Accessed on January 19, 2018.
[xxx] Kaiser Family Foundation: Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on January 19, 2018.
[xxxi] Centers for Disease Control and Prevention: Drug Overdose Mortality by State. https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-2017.pdf. Accessed on January 19, 2018.
[xxxii] Agency for Healthcare Research and Quality: Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-2014. Available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp. Accessed on January 24, 2018.
[xxxiii] City of Manchester Health Department: The Greater Manchester Health Needs Assessment, June 2013. Available at https://www.catholicmedicalcenter.org/uploads/2013%20CHNA%20FINAL%207-10-13.pdf. Accessed on January 24, 2018.

[xxxiv] Kaiser Family Foundation: Infant Mortality Rate (Deaths per 1,000 Live Births). Available at https://www.kff.org/other/state-indicator/infant-death-rate/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on January 24, 2018.

[xxxv] Centers for Disease Control and Prevention: Burden of Mental Illness. Available at https://www.cdc.gov/mentalhealth/basics/burden.htm. Accessed on January 24, 2018.

[xxxvi] Centers for Disease Control and Prevention: HIV in the United States by Geography. Available at https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html. Accessed on January 25, 2018.

[xxxvii] City of Manchester Health Department: The Greater Manchester Community Health Needs Assessment, June 2013. Available at https://www.catholicmedicalcenter.org/uploads/2013%20CHNA%20FINAL%207-10-13.pdf. Accessed on January 25, 2018.

[xxxviii] Centers for Disease Control and Prevention: Current Cigarette Smoking Among Adults — United States, 2016. Available at https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a1.htm#T1_down. Accessed on January 25, 2018.

[xxxix] City of Manchester Health Department: The Greater Manchester Health Needs Assessment, 2016. Available at http://elliothospital.org/website/downloads/QualitativeNeedsAssessment.pdf. Accessed on January 26, 2018.

[xl] U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Diabetes, Diabetes, and Kidney Diseases: Overweight & Obesity Statistics. Available at https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity. Accessed on January 25, 2018.

[xli] Manchester Department of Health: Manchester Needs Assessment, 2009. Available at http://www.manchesternh.gov/portals/2/departments/health/2009CNAHealthyLife.pdf. Accessed on January 26, 2018.

[xlii] Substance Abuse and Mental Health Services Administration (SAMHSA). 2015 National Survey on Drug Use and Health (NSDUH). Table 2.41B—Alcohol Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2014 and 2015. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab2-41b. Accessed on January 26, 2018.

[xliii] Department of Transportation (US), National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts 2014 data: alcohol-impaired driving. Washington, DC: NHTSA; 2015. Available at URL: http://www-nrd.nhtsa.dot.gov/Pubs/812231.pdf. Accessed on January 26, 2018.

[xliv] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire STD/HIV Surveillance Program 5 Year Data Summary Report 2012-2016. Available at https://www.dhhs.nh.gov/data/documents/std-hiv-aids-2012-16.pdf. Accessed on January 26, 2018.

[xlv] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire STD/HIV Surveillance Program 5 Year Data Summary Report 2012-2016. Available at https://www.dhhs.nh.gov/data/documents/std-hiv-aids-2012-16.pdf. Accessed on January 26, 2018.

[xlvi] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire STD/HIV Surveillance Program 5 Year Data Summary Report 2012-2016. Available at https://www.dhhs.nh.gov/data/documents/std-hiv-aids-2012-16.pdf. Accessed on January 26, 2018.

[xlvii] Centers for Disease Control and Prevention: 2016 Sexually Transmitted Diseases Surveillance, Chlamydia. Available at https://www.cdc.gov/std/stats16/chlamydia.htm. Accessed on January 26, 2018.

[xlviii] NewHampshire.com: NH's teen pregnancy still lowest nationwide. Available at http://www.newhampshire.com/apps/pbcs.dll/article?AID=%2F20140831%2FNEWHAMPSHIRE02%2F140839942%2F1001%2Fnewhampshire0b. Accessed on January 26, 2018.

[xlix] Centers for Disease Control and Prevention (CDC), National Vital Statistics Reports (NVSR), Vol. 66, No. 1: Births: Final Data for 2015, January 5, 2017. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf. Accessed on January 26, 2018.

[l] United States Department of Agriculture, Economic Research Service: Food Security Status of U.S. Households in 2016. Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx. Accessed on January 26, 2018.
[li] United States Department of Agriculture, Economic Research Service: Food Access Research Atlas. Available at https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/. Accessed on January 29, 2018.
[lii] Insurance Institute for Highway Safety, Highway Loss Data Institute: General Statistics (2016). Available at http://www.iihs.org/iihs/topics/t/general-statistics/fatalityfacts/state-by-state-overview. Accessed on January 29, 2018.
[liii] Centers for Disease Control and Prevention: Data and Statistics, Short Sleep Duration Among US Adults. Available at https://www.cdc.gov/sleep/data_statistics.html. Accessed on January 29, 2018.
[liv] Petterson SM, Liaw WR, Phillips RL, Rabin DL, Meyers DS, Bazemore AW. Projecting US Primary Care Physician Workforce Needs: 2010-2025. Annals of Family Medicine. 2012;10(6):503-509. doi:10.1370/afm.1431.
[lv] National Committee for Quality Assurance: Proposed Changes to Existing Measures for HEDIS1® 2018 - Inpatient Hospital Utilization (IHU) and Hospitalization for Potentially Preventable Complications (HPC). Available at https://www.ncqa.org/Portals/0/PublicComment/HEDIS-Ad-Hoc/3.%20Inpatient%20Hospital%20Utilization.pdf?ver=2017-07-13-092457-143. Accessed on January 29, 2018.
[lvi] Ayanian JZ et al. Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare. Health Affairs. 2013; 32(7). doi.org/10.1377/hlthaff.2012.0773.
[lvii] Centers for Medicare and Medicaid Services: NHE Fact Sheet. Available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html. Accessed on January 29, 2018.
[lviii] City of Manchester Health Department: The Greater Manchester Community Health Needs Assessment, June 2013. Available at https://www.catholicmedicalcenter.org/uploads/2013%20CHNA%20FINAL%207-10-13.pdf. Accessed on January 29, 2018.
[lix] Centers for Disease Control and Prevention: Health, United States, 2014 (Table 19). Available at https://www.cdc.gov/nchs/data/hus/2014/019.pdf. Accessed on January 29, 2018.
[lx] City of Manchester Health Department: The Greater Manchester Community Health Needs Assessment, June 2013. Available at https://www.catholicmedicalcenter.org/uploads/2013%20CHNA%20FINAL%207-10-13.pdf. Accessed on January 29, 2018.
[lxi] Centers for Disease Control and Prevention, National Center for Health Statistics: Birthweight and Gestation. Available at https://www.cdc.gov/nchs/fastats/birthweight.htm. Accessed on January 29, 2018.
[lxii] Indiana Department of Environmental Management: The States' View of the Air. Available at https://www.in.gov/idem/airquality/pages/states_view/files/report_2017_state_ct.pdf. Accessed on January 29, 2018.
[lxiii] The World Bank: PM2.5 air pollution, mean annual exposure (micrograms per cubic meter). Available at https://data.worldbank.org/indicator/EN.ATM.PM25.MC.M3. Accessed on January 29, 2018.
[lxiv] U.S. Department of Housing and Urban Development, Office of Policy Development and Research (PD&R): CHAS Data Query Tool. Available at https://www.huduser.gov/portal/datasets/cp/CHAS/data_querytool_chas.html. Accessed on January 29, 2018.
[lxv] U.S. Department of Housing and Urban Development, Office of Policy Development and Research (PD&R): CHAS Data Query Tool. Available at https://www.huduser.gov/portal/datasets/cp/CHAS/data_querytool_chas.html. Accessed on January 29, 2018.

EXHIBIT 2

Southern New Hampshire Medical Center Fact Sheet

Prepared for the New Hampshire Office of the Attorney General Charitable Trusts Unit

February 2018

Katharine London, Principal

Jeremy Tourish, Policy Analyst

University of Massachusetts Medical School

Center for Health Law and Economics

Summary

Overview: Southern New Hampshire Medical Center is a 188 bed, acute care facility located in Nashua, New Hampshire. The hospital provides emergency care along with clinical specialties including cardiovascular services, obstetric services, and pediatric services, among others. It also provides extensive community benefits, including over $1.5 million in subsidized health services, and over $3 million in charity care.

Quality: Southern New Hampshire Medical Center scores near or above the State average on 16 out of 19 NH HealthCost quality measures, but scores below the average on 3 quality measures. New Hampshire Hospital Scorecard rated the hospital as at or above the national level but below the state average for both Patient Experience and Patient Safety. Medicare's Hospital Compare website gives the hospital four out of five stars for both its overall rating and its score based on patient surveys.

Cost: Southern New Hampshire Medical Center received a "low cost" cost index rating by New Hampshire Hospital Compare. On average, Southern New Hampshire's estimated outpatient prices for all uninsured services were lower than the state median price and lower than neighboring St. Joseph's price. For two-thirds of private insurer-service groupings, SNH's prices were higher than the state median price and higher than St. Joseph's price

Population Health: The city of Nashua's population characteristics and health statistics are similar to state and national averages in many ways. The city has a few health challenges that exceed those in other areas of the State. Some of these include higher than average incidence of:

- People under the age of 65 without health insurance
- Adults reporting no leisure-time physical activity
- Years of potential life lost before age 75
- People in poverty

In addition, the opioid death rate in Hillsborough County is 50% higher than the State overall, and 4 times higher than the national rate.

Contents of This Report: This report provides the following information:

- a service profile of Southern New Hampshire Medical Center that includes quality, cost, and community benefit statistics
- the NH HealthCost quality measure scores for the hospital
- a comparison of population health measures for the city of Nashua, Hillsborough County, the State of New Hampshire, and the United States

Southern New Hampshire Medical Center Service Profile [lxv, lxv]

General Hospital Information	
Type of Facility	Acute Care
Total Staffed Beds	188
Joint Commission Accreditation	Yes

Clinical Services Offered

- Emergency Services
- Cardiovascular services
- Obstetric services
- Pediatric services
- Mammography services
- Lab services
- Maternity services
- Palliative care
- Gastroenterology services

Charity Care and Other Community Benefits [lxv]

The table below offers a snapshot of the charity care and other community benefits provided to the greater Nashua community by Southern New Hampshire Medical Center. All information derives from Southern New Hampshire Medical Center's FY 2017 Community Benefit Report.

Community Benefit Report (FY 2017)	Benefits Provided	Financial Benefit
	(1) Community Health Services	$160,294
	(2) Health Professions Education	$3,430,470
	(3) Subsidized Health Services	$1,604,924
	(4) Medical Research	$0
	(5) Financial Contributions	$723,271
	(6) Community Building Activities	$192,008
	(7) Community Benefit Operations	$5,137
	(8) Charity Care	$3,326,024
	Total Community Benefits	$9,442,128

Quality Statistics Summary

The table below offers a view of Southern New Hampshire Medical Center's performance on quality of care scores from three different sources; NH HealthCost, New Hampshire Hospital Scorecard, and CMS Hospital Compare.

Source	*Measure*	*Score*
NH HealthCost Quality of Care Scores [lxv]	Quality of Care Measures Worse Than Average	3 out of 19
	Quality of Care Measures Near Average	14 out of 19
	Quality of Care Measures Better Than Average	2 out of 19
New Hampshire Hospital Scorecard [lxv]	Patient Experience Score	At or above national level but below state level
	Patient Safety Score	At or above national level but below state level
	Clinical Quality: Blood Clot (VTE) Care	At or above state level
	Clinical Quality: Stroke Care	At or above state level
	Clinical Quality: Surgical Infection	At or above state level
CMS Hospital Compare [lxv]	Overall Rating	4 out of 5 stars
	Patient Survey Rating	4 out of 5 stars

Cost Statistics Summary The table below provides Southern New Hampshire Medical Center's performance on a cost of care measure outlined by New Hampshire Hospital Scorecard.		
Source	*Measure*	*Score*
New Hampshire Hospital Scorecard [lxv]	Cost Index Rating	Low cost

Southern New Hampshire Medical Center Financial and Utilization Statistics [lxv]

The table below offers a multi-year financial comparison profile based on an analysis of CMS Hospital Form 2552-10 data for Southern New Hampshire Medical Center.

	2011	***2012***	***2013***	***2014***	***2015***	***Average annual change***
Reported Data						
Total Expenses	$165,929,011	$157,857,899	$157,054,403	$161,898,815	$164,939,013	-0.1%
Total Hospital Discharges	7,602	7,065	6,875	6,941	7,158	-1.5%
Hospital Subprovider and Other Discharges	723	513	507	481	N/A	*-11.2%*
Total Hospital Days	33,996	31,208	30,566	30,624	32,020	-1.5%
Hospital Subprovider and Other Days	4,571	3,127	3,426	3,363	3,625	-5.2%
Charity Care Costs (Uninsured Patients)	$6,606,932	$5,445,046	$5,161,135	$3,281,663	$2,004,177	-17.4%
Charity Care Costs (Insured Patients)	$323,368	$246,886	$271,410	$755,300	$715,076	30.3%
Total Unreimbursed & Uncompensated Care	$22,435,518	$19,751,166	$19,779,878	$17,790,247	$12,450,254	-11.1%
Total Inpatient Charges	$168,982,940	$163,658,846	$178,217,216	$184,283,941	$194,252,871	3.7%
Total Outpatient Charges	$244,552,612	$255,268,441	$274,795,223	$290,365,101	$302,056,317	5.9%
Net Patient Service Revenue	$185,617,012	$186,987,473	$192,289,277	$195,913,095	$201,474,016	2.1%
Calculated trends						
Adjusted Hospital Days (Inpt Days + Inpt Days*(Outpt Charges/ Inpt Charges))	83,195	79,885	77,696	78,876	81,810	-0.4%
Total Expense per Adjusted Day (Total Expenses/Adj Hospital Days)	$1,994	$1,976	$2,021	$2,053	$2,016	0.3%
Net Patient Service Revenue per Adjusted Day (NPSR/Adj Hospital Days)	$2,231	$2,341	$2,475	$2,484	$2,463	2.6%

Southern New Hampshire - Estimated Outpatient Visit Pricing

On average, Southern New Hampshire's estimated outpatient prices for all uninsured services were lower than the state median price and lower than neighboring St. Joseph's price. For two-thirds of private insurer-service groupings, SNH's prices were higher than the state median price and higher than St. Joseph's price. Prices highlighted in green are lower than the state median, yellow are near the state median, and red are higher than the state median.

Event Type	State	SNH Medical Center			St. Joseph Hospital		
	Number of Events	*Number of Events*	*Hospital Price (weighted median)*	*Price if billed at the state median price*	*Number of Events*	*Hospital Price (weighted median)*	*Price if billed at the state median price*
Emergency Visits							
Anthem	4,200	207	$620	$646	148	$436	$512
Cigna	1,784	75	$729	$709	81	$660	$607
Harvard Pilgrim	3,701	212	$680	$617	184	$421	$515
Other Insurance	657	78	$674	$665	72	$709	$516
Uninsured	14,172	899	$305	$605	672	$496	$556
Office visits							
Anthem	210,899	5	$196	$194	41	$204	$186
Cigna	82,259	165	$183	$145	923	$139	$162
Harvard Pilgrim	194,372	357	$213	$155	2,212	$202	$188
Other Insurance	29,109	40	$202	$174	506	$176	$195
Uninsured	609,123	630	$73	$216	3,776	$168	$246
Outpatient tests and procedures							
Anthem	6,493	162	$3,741	$3,079	137	$3,159	$2,393
Cigna	2,866	53	$4,661	$3,875	52	$4,354	$3,366
Harvard Pilgrim	5,340	165	$3,124	$3,202	99	$3,796	$4,047
Other Insurance	797	39	$3,697	$3,320	19	$3,136	$3,877
Uninsured	18,487	512	$1,903	$3,869	385	$4,382	$3,917
Radiology							
Anthem	31,003	1,539	$668	$579	1,287	$627	$600
Cigna	10,892	650	$637	$546	506	$576	$612
Harvard Pilgrim	24,625	1,834	$430	$597	1,452	$318	$585
Other Insurance	3,807	393	$637	$691	269	$859	$761
Uninsured	84,958	5,414	$328	$754	4,178	$634	$772

Author's analysis of NH CHIS Group Medical Plans and Uninsured Claims only, FY2017 Q1. Authors calculated median price by insurer by service by hospital and by insurer by service for the state. Prices shown the hospitals

own prices weighted by its service mix, compared to state median prices weighted by the hospital's service mix.

NH HealthCost Quality of Care Report [lxv]

The table below shows NH HealthCost's quality report for Southern New Hampshire Medical Center. NH HealthCost scores Southern New Hampshire Medical Center on 19 quality measures and compares it to average scores for the State of New Hampshire.

Patient Experience		
Area Around Room was Always Quiet at Night	Near the average	56% state average (57%)
Best Hospital Experience	Near the average	72% state average (73%)
Doctors Always Communicated Well	Near the average	79% state average (81%)
Help was Always Received	Near the average	68% state average (72%)
Hospital Recommended	Near the average	76% state average (74%)
Hospital Staff Provided Discharge Information	Near the average	41% state average (42%)
Nurses Always Communicated Well	Near the average	80% state average (81%)
Pain was Always Well Controlled	Near the average	71% state average (72%)
Room was Always Clean	Below the average	69% state average (76%)
Timely and Effective Care		
Mothers with Elective Delivery		1%

	Near the average	state average (3%)
Patients Given PCI (to Open Blocked Vessels) Within 90 Minutes of Arrival	Near the average	97% state average (96%)
Patients with Stroke Symptoms Who Received Head CT Scan at Arrival	Better than average	100% state average (71%)
Pneumonia Patients Received Initial Antibiotic Selection for Community Acquired Pneumonia	Near the average	100% state average (97%)
Received Influenza (Flu) Shot	Near the average	97% state average (97%)
Time Spent Before Receiving Pain Treatment for Long Bone Fracture	Below the average	80 mins state average (54 mins)
Time Spent in Emergency Department After Being Admitted Before Getting to Room	Near the average	113 mins state average (109 mins)
Time Spent in the Emergency Department Before Being Admitted	Better than average	283 mins state average (295 mins)
Time Spent in the Emergency Department Before Being Discharged	Below the average	162 mins state average (148 mins)
Time Spent in the Emergency Department Before Seeing Healthcare Provider	Near the average	30 mins state average (28 mins)

City, County, State, Country Comparison Profile [lxv, lxv]

The table below offers a community health measure needs comparison profile based on analysis of data from multiple sources. Numbers in the Source column refer to citations in the endnotes. "NA" indicates that the measure was not available for the geographic area. X indicates that the Census Bureau deemed the item to be not applicable in the geographic area.

Measure	Nashua	Hillsborough County	New Hampshire	United States	Source
Population					
Population estimates, July 1, 2017, (V2017)	NA	NA	1,342,795	325,719,178	11
Population estimates, July 1, 2016, (V2016)	87,882	407,761	1,334,795	323,127,513	11
Population estimates base, April 1, 2010, (V2017)	NA	NA	1,316,460	308,758,105	11
Population estimates base, April 1, 2010, (V2016)	86,492	400,720	1,316,461	308,758,105	11
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	NA	NA	2.00%	5.50%	11
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	1.6%	1.80%	1.40%	4.70%	11
Population, Census, April 1, 2010	86,494	400,721	1,316,470	308,745,538	11
Age and Sex					
Persons under 5 years, percent, July 1, 2016, (V2016)	X	5.30%	4.80%	6.20%	11
Persons under 5 years, percent, April 1, 2010	6.30%	5.90%	5.30%	6.50%	11
Persons under 18 years, percent, July 1, 2016, (V2016)	X	21.00%	19.50%	22.80%	11
Persons under 18 years, percent, April 1, 2010	21.10%	23.50%	21.80%	24.00%	11
Persons 65 years and over, percent, July 1, 2016, (V2016)	X	14.80%	17.00%	15.20%	11
Persons 65 years and over, percent, April 1, 2010	12.70%	11.90%	13.50%	13.00%	11

Female persons, percent, July 1, 2016, (V2016)	X	50.30%	50.50%	50.80%	11
Female persons, percent, April 1, 2010	50.70%	50.50%	50.70%	50.80%	11
Race and Hispanic Origin					
White alone, percent, July 1, 2016, (V2016)(a)	X	91.00%	93.80%	76.90%	11
Black or African American alone, percent, July 1, 2016, (V2016)(a)	X	2.70%	1.50%	13.30%	11
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016)(a)	X	0.30%	0.30%	1.30%	11
Asian alone, percent, July 1, 2016, (V2016)(a)	X	4.00%	2.70%	5.70%	11
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016)(a)	X	0.10%	0.10%	0.20%	11
Two or More Races, percent, July 1, 2016, (V2016)	X	1.90%	1.70%	2.60%	11
Hispanic or Latino, percent, July 1, 2016, (V2016)(b)	X	6.50%	3.50%	17.80%	11
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	X	85.50%	90.80%	61.30%	11
Families & Living Arrangements					
Households, 2012-2016	34,889	156,114	521,373	117,716,237	11
Persons per household, 2012-2016	2.45	2.54	2.47	264.00%	11
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	81.30%	85.50%	85.90%	85.20%	11
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	20.00%	12.80%	7.90%	21.10%	11
Education					
High school graduate or higher, percent of persons age 25 years+, 2012-2016	90.40%	91.60%	92.60%	87.00%	11
Bachelor's degree or higher, percent of persons age 25 years+, 2012-2016	34.90%	36.30%	35.50%	30.30%	11
Health					

Percent of people with a disability, under age 65 years	8.60%	7.80%	8.70%	8.60%	11
Percent of people without health insurance, under age 65 years	11.10%	7.90%	7.10%	10.10%	11
Percent of Adults Who Currently Have Asthma, Ages 18 and older	10.9% [lxv]	11.1% [lxv]	11% [lxv]	7.6% [lxv]	12,13,14, 15
Proportion of Adults with Asthma whose Asthma is Not Well Controlled	21.8% [lxv]	NA	48.6% [lxv]	64.8% [lxv]	16,17,18
Number of ER visits due to asthma per 10,000 adults	58.0 [lxv]	49.5 [lxv]	51.0 [lxv]	NA	19,20,21
Percent of Adults Who Have Diabetes, Ages 18 and older	10.2% [lxv]	8.1% [lxv]	9.2 [lxv]	9.4% [lxv]	22,23,24, 25
Number of diabetes related hospitalizations per 10,000 adults	15.3 [lxv]	NA	145 [lxv]	515 [lxv]	26,27,28
Number of opioid related deaths per 100,000 people	NA	48.2 [lxv]	31.3 [lxv]	10.4 [lxv]	29,30,31
Number of opioid related ER visits per 100,000 people	NA	NA	NA	177.7 [lxv]	32
Number of deaths among residents under age 75 per 100,000 (age-adjusted)	NA	300	290	NA	10
Number of deaths among children under age 18 per 100,000	NA	40	40	NA	10
Number of all infant deaths (within 1 year), per 1,000 live births	NA	4	5	6 [lxv]	10,33
Percentage of adults reporting 14 or more days of poor physical health per month	NA	9%	10%	NA	10
Percentage of adults reporting 14 or more days of poor mental health per month	NA	10%	12%	9.4%[lxv]	10,34
Number of persons living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 people	NA	151	104	303.5[lxv]	10,35

Health Behaviors					
Percentage of adults who are current smokers	18.4% [lxv]	15%	16%	15.5%[lxv]	36,10,37
Percentage of adults that report a BMI of 30 or more	27% [lxv]	29%	28%	37.7%[lxv]	38,10,39
Food environment index [0 (worst) to 10 (best)]	NA	8.5	8.4	NA	10
Percentage of adults age 20 and over reporting no leisure-time physical activity	24.8% [lxv]	20%	20%	NA	40,10
Percentage of population with adequate access to locations for physical activity	NA	92%	84%	NA	10
Percentage of adults reporting binge or heavy drinking	18.9% [lxv]	20%	18%	26.9% [lxv]	41,10,42
Percentage of driving deaths with alcohol involvement	NA	30%	31%	29%[lxv]	10,43
Number of newly diagnosed chlamydia cases per 100,000 people	262.3 [lxv]	356.8 [lxv]	302.5 [lxv]	497.3 [lxv]	44,45,46, 47
Number of births per 1,000 female population ages 15-19	19 [lxv]	17.0	15.0	22.3 [lxv]	48,10,49
Percentage of population who lack adequate access to food	NA	10%	11%	12.3% [lxv]	10,50
Percentage of population who are low-income and do not live close to a grocery store	NA	3%	4%	6.2% [lxv]	10,51
Number of motor vehicle crash deaths per 100,000 population	NA	7	8	11.6 [lxv]	10,52
Percentage of adults who report fewer than 7 hours of sleep on average	NA	34%	32%	35.2% [lxv]	10,53
Clinical Care					
Ratio of population to primary care physicians	NA	1,160:1	1,060:1	~1,475:1 [lxv]	10,54
Ratio of population to dentists	NA	1,310:1	1,410:1	NA	10
Ratio of population to mental health providers	NA	410:1	390:1	NA	10

Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	NA	49	45	57.8[lxv]	10,55
Percentage of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	NA	91%	90%	88.4% [lxv]	10,56
Percentage of female Medicare enrollees ages 67-69 that receive mammography screening	NA	71%	71%	NA	10
Average per capita health care costs	NA	$8,664	$8,362	$10,348 [lxv]	10,57
Quality of Life					
Years of potential life lost before age 75 per 100,000 population (age-adjusted)	5,830 [lxv]	5,600	5,500	6,593.1 [lxv]	58,10,59
Percentage of adults reporting fair or poor health (age-adjusted)	NA	11%	11%	NA	10
Percentage of live births with low birth weight (< 2500 grams)	6.7% [lxv]	7%	7%	8.07% [lxv]	60,10,61
Income & Poverty					
Median household income (in 2016 dollars), 2012-2016	$68,944	$73,189	$68,485	$55,322	11
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$33,896	$36,012	$35,264	$29,829	11
Persons in poverty, percent	11.0%	8.00%	7.30%	12.70%	11
Geography					
Population per square mile, 2010	2,803.70	457.4	147	87.4	11
Land area in square miles, 2010	30.85	876.14	8,952.65	3,531,905.43	11
Physical Environment					
Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	8 [lxv]	8.3	7.8	8 [lxv]	62,10,63

Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	18.3% [lxv]	16%	16%	19.05% [lxv]	64,10,65

Citations

Southern New Hampshire Health: About Us. https://www.snhhealth.org/about-us. Accessed January 30, 2018.
[lxv] ProPublica Nonprofit Explorer: Southern New Hampshire Medical Center. https://projects.propublica.org/nonprofits/organizations/20483054. Accessed on January 30, 2018.
[lxv] Southern New Hampshire Medical Center and Foundation Medical Partners Community Benefit Report, 2017. Available at https://www.snhhealth.org/SNHH/media/Documents/SNHHS-2017-State-of-NH-Community-Benefits-Report.pdf. Accessed on January 30, 2018.
[lxv] NH HealthCost: Southern New Hampshire Medical Center Profile https://nhhealthcost.nh.gov/provider/southern-nh-medical-center?cost_type=medical#quality. Accessed on January 30, 2018.
[lxv] New Hampshire Hospital Scorecard: New Hampshire Hospital Ratings. https://www.nhpghscorecard.org/hospitalratings. Accessed on January 30, 2018.
[lxv] Medicare Hospital Compare: Southern NH Medical Center. https://www.medicare.gov/hospitalcompare/profile.html#profTab=0&ID=300020&Distn=0.8&dist=25&loc=03060&lat=42.7470311&lng=-71.4596201. Accessed on January 30, 2018.
[lxv] New Hampshire Hospital Scorecard: New Hampshire Hospital Ratings. https://www.nhpghscorecard.org/hospitalratings. Accessed on January 30, 2018.
[lxv] Data retrieved from CMS Hospital Form 2552-10 Cost Reports for Southern New Hampshire Medical Center for FY2011 - FY2015

- Total expenses, Wksht A, Col 7, line 118 (excludes non-reimbursable)
- Total hospital discharges , Wksht S-3, Col 15, row 14
- Hospital subprovider and other discharges, Wksht s-3, Col 15, line 27
- Total hospital days , Wksht S-3, Col 8, row 14
- Hospital subprovider and other days, Wksht s-3, Col 8, line 27
- Charity Care Costs, uninsured patients, Wksht s-10, Col 1, line 23
- Charity Care Costs, insured patients, Wksht s-10, Col 2, line 23
- Total unreimbursed and uncompensated care, Wksht s-10, col 1, line 31
- Total inpatient charges, Wksht C Part I, Col 6, line 202
- Total outpatient charges, Wkst C, Part I, Col 7, line 202
- Net Patient Service Revenue, Wksht G-3, Col 1, line 3

[lxv] NH HealthCost: Southern New Hampshire Medical Center Profile https://nhhealthcost.nh.gov/provider/southern-nh-medical-center?cost_type=medical#quality. Accessed on January 30, 2018.
[lxv] Robert Wood Johnson Foundation: County Health Rankings & Roadmaps – Hillsborough County, NH Profile. http://www.countyhealthrankings.org/app/new-hampshire/2017/rankings/hillsborough/county/factors/overall/snapshot. Accessed on January 12, 2018.

[lxv] United States Census Bureau: Quick Facts. https://www.census.gov/quickfacts/fact/table/US,NH,hillsboroughcountynewhampshire,nashuacitynewhampshire/PST045216. Accessed on January 30, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] Centers for Disease Control and Prevention, National Center for Health Statistics: Asthma. Available at https://www.cdc.gov/nchs/fastats/asthma.htm. Accessed on January 23, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] Centers for Disease Control and Prevention, National Center for Health Statistics: Asthma. Available at https://www.cdc.gov/nchs/fastats/asthma.htm. Accessed on January 23, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Asthmas Burden Report, Update (2014). https://www.dhhs.nh.gov/dphs/cdpc/asthma/documents/asthma-burden-2014.pdf. Accessed on January 22, 2018.
[lxv] Greater Manchester, New Hampshire: Health Improvement Plan (2016). Available at https://www.manchesternh.gov/portals/2/departments/health/gmanchip.pdf. Accessed on January 23, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: Diabetes in New Hampshire – Issue Brief – July 2010. Available at https://www.dhhs.nh.gov/data/documents/brief10.pdf. Accessed on January 23, 2018.
[lxv] New Hampshire Department of Health and Human Services: Diabetes . Available at https://www.dhhs.nh.gov/dphs/cdpc/diabetes/index.htm. Accessed on January 23, 2018.
[lxv] Centers for Disease Control and Prevention: National Diabetes Statistics Report, 2017. Available at https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed on January 23, 2018.
[lxv] Nashua Community Health Assessment. Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2526. Accessed on January 30, 2018.
[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire Coordinated Strategic Plan for Chronic Disease Prevention and Health Promotion (2013). Available at https://www.dhhs.nh.gov/dphs/cdpc/documents/cd-strategic-plan.pdf. Accessed on January 23, 2018.
[lxv] Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP): Emergency Department Visits for Adults with Diabetes (2010). Available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb167.jsp. Accessed on January 23, 2018.
[lxv] New Hampshire Information and Analysis Center: New Hampshire Drug Monitoring Report, May 2017. https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-2017.pdf. Accessed on January 19, 2018.

[lxv] Kaiser Family Foundation: Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on January 19, 2018.

[lxv] Centers for Disease Control and Prevention: Drug Overdose Mortality by State. https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-2017.pdf. Accessed on January 19, 2018.

[lxv] Agency for Healthcare Research and Quality: Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-2014. Available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.jsp. Accessed on January 24, 2018.

[lxv] Kaiser Family Foundation: Infant Mortality Rate (Deaths per 1,000 Live Births). Available at https://www.kff.org/other/state-indicator/infant-death-rate/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-hampshire%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on January 24, 2018.

[lxv] Centers for Disease Control and Prevention: Burden of Mental Illness. Available at https://www.cdc.gov/mentalhealth/basics/burden.htm. Accessed on January 24, 2018.

[lxv] Centers for Disease Control and Prevention: HIV in the United States by Geography. Available at https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html. Accessed on January 25, 2018.

[lxv] Greater Nashua Community Health Assessment (2014). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2490. Accessed on January 31, 2018.

[lxv] Centers for Disease Control and Prevention: Current Cigarette Smoking Among Adults — United States, 2016. Available at https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a1.htm#T1_down. Accessed on January 25, 2018.

[lxv] Nashua Division of Public Health and Community Services: Greater Nashua Community Health Assessment, 2017. Available at https://www.nashuanh.gov/DocumentCenter/View/11383. Accessed on January 31, 2018.

[lxv] U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Diabetes, Diabetes, and Kidney Diseases: Overweight & Obesity Statistics. Available at https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity. Accessed on January 25, 2018.

[lxv] Greater Nashua Community Health Assessment (2014). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2488. Accessed on January 31, 2018.

[lxv] Nashua Community Health Assessment. Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2529. Accessed on January 31, 2018.

[lxv] Substance Abuse and Mental Health Services Administration (SAMHSA). 2015 National Survey on Drug Use and Health (NSDUH). Table 2.41B—Alcohol Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2014 and 2015. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab2-41b. Accessed on January 26, 2018.

[lxv] Department of Transportation (US), National Highway Traffic Safety Administration (NHTSA). Traffic Safety Facts 2014 data: alcohol-impaired driving. Washington, DC: NHTSA; 2015. Available at URL: http://www-nrd.nhtsa.dot.gov/Pubs/812231.pdf. Accessed on January 26, 2018.

[lxv] Greater Nashua Community Health Assessment (2014). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2489. Accessed on January 31, 2018.

[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire STD/HIV Surveillance Program 5 Year Data Summary Report 2012-2016. Available at https://www.dhhs.nh.gov/data/documents/std-hiv-aids-2012-16.pdf. Accessed on January 26, 2018.

[lxv] New Hampshire Department of Health and Human Services, Division of Public Health Services: New Hampshire STD/HIV Surveillance Program 5 Year Data Summary Report 2012-2016. Available at https://www.dhhs.nh.gov/data/documents/std-hiv-aids-2012-16.pdf. Accessed on January 26, 2018.

[lxv] Centers for Disease Control and Prevention: 2016 Sexually Transmitted Diseases Surveillance, Chlamydia. Available at https://www.cdc.gov/std/stats16/chlamydia.htm. Accessed on January 26, 2018.
[lxv] Greater Nashua Community Health Assessment (2014). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2485. Accessed on January 31, 2018.
[lxv] Centers for Disease Control and Prevention (CDC), National Vital Statistics Reports (NVSR), Vol. 66, No. 1: Births: Final Data for 2015, January 5, 2017. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf. Accessed on January 26, 2018.
[lxv] United States Department of Agriculture, Economic Research Service: Food Security Status of U.S. Households in 2016. Available at https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx. Accessed on January 26, 2018.
[lxv] United States Department of Agriculture, Economic Research Service: Food Access Research Atlas. Available at https://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/. Accessed on January 29, 2018.
[lxv] Insurance Institute for Highway Safety, Highway Loss Data Institute: General Statistics (2016). Available at http://www.iihs.org/iihs/topics/t/general-statistics/fatalityfacts/state-by-state-overview. Accessed on January 29, 2018.
[lxv] Centers for Disease Control and Prevention: Data and Statistics, Short Sleep Duration Among US Adults. Available at https://www.cdc.gov/sleep/data_statistics.html. Accessed on January 29, 2018.
[lxv] Petterson SM, Liaw WR, Phillips RL, Rabin DL, Meyers DS, Bazemore AW. Projecting US Primary Care Physician Workforce Needs: 2010-2025. Annals of Family Medicine. 2012;10(6):503-509. doi:10.1370/afm.1431.
[lxv] National Committee for Quality Assurance: Proposed Changes to Existing Measures for HEDIS1® 2018 - Inpatient Hospital Utilization (IHU) and Hospitalization for Potentially Preventable Complications (HPC). Available at https://www.ncqa.org/Portals/0/PublicComment/HEDIS-Ad-Hoc/3.%20Inpatient%20Hospital%20Utilization.pdf?ver=2017-07-13-092457-143. Accessed on January 29, 2018.
[lxv] Ayanian JZ et al. Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare. Health Affairs. 2013; 32(7). doi.org/10.1377/hlthaff.2012.0773.
[lxv] Centers for Medicare and Medicaid Services: NHE Fact Sheet. Available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html. Accessed on January 29, 2018.
[lxv] New Hampshire Center for Public Policy Studies: Changing Leverage Points, Nashua and the Community Health Improvement Plan (2013). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2553. Accessed on January 31, 2018.
[lxv] Centers for Disease Control and Prevention: Health, United States, 2014 (Table 19). Available at https://www.cdc.gov/nchs/data/hus/2014/019.pdf. Accessed on January 29, 2018.
[lxv] Greater Nashua Community Health Assessment (2014). Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2485. Accessed on January 31, 2018.
[lxv] Centers for Disease Control and Prevention, National Center for Health Statistics: Birthweight and Gestation. Available at https://www.cdc.gov/nchs/fastats/birthweight.htm. Accessed on January 29, 2018.
[lxv] City of Nashua, Division of Public Health and Community Services: Community Health Assessment. Available at https://www.nashuanh.gov/DocumentCenter/Home/View/2527. Accessed on January 31, 2018.
[lxv] The World Bank: PM2.5 air pollution, mean annual exposure (micrograms per cubic meter). Available at https://data.worldbank.org/indicator/EN.ATM.PM25.MC.M3. Accessed on January 29, 2018.
[lxv] U.S. Department of Housing and Urban Development, Office of Policy Development and Research (PD&R): CHAS Data Query Tool. Available at https://www.huduser.gov/portal/datasets/cp/CHAS/data_querytool_chas.html. Accessed on January 29, 2018.
[lxv] U.S. Department of Housing and Urban Development, Office of Policy Development and Research (PD&R): CHAS Data Query Tool. Available at https://www.huduser.gov/portal/datasets/cp/CHAS/data_querytool_chas.html. Accessed on January 29, 2018.