South Central New Hampshire

Community Health Improvement Plan

2016

with support from the

South Central Regional Public Health Network

WORKING TO IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES OF SOUTH CENTRAL NEW HAMPSHIRE

SOUTH CENTRAL NH
PUBLIC HEALTH NETWORK
The healthiest and safest communities in New Hampshire!

EXECUTIVE SUMMARY

The South Central Regional Public Health Network (PHN) is pleased to present its first Community Health Improvement Plan (CHIP). This plan represents a collective vision for the transformation of public health across the 10 communities in the South Central Region of New Hampshire. Its purpose is to build an integrated public health system that is capable of seamless collaborations among all healthcare providers and public safety personnel and to support constructive engagement of patients, families, and communities. Through this integrated system, all people will have equitable access to timely, comprehensive, cost-effective, high-quality, and compassionate care.

Public health is the practice of preventing disease and promoting good health within groups of people – from small communities to entire countries. Public Health is YOUR health. It embodies everything from clean air to safe food and water, as well as access to healthcare and safe communities.

Through public health planning and prevention initiatives, people get sick less frequently, children grow to become healthy adults, individuals make healthier, safer choices, and our community is better prepared to respond to disasters and recover from them.

In preparing the CHIP, the South Central PHN and its Public Health Advisory Council (PHAC) reviewed health needs assessment information in the context of region-specific health statistics and key stakeholder interviews. Building on this information, community health improvement needs have been prioritized and work plans have been developed. The CHIP identifies goals, measurable objectives, and strategies to guide collaborative implementation of evidence-based solutions to community health.

We share responsibility for the health of our community and the people who live and work in it. We look forward to working across community sectors to increase understanding about the health problems confronting our community and to implement strategies and solutions that respond to these public health needs.

We invite you to read the CHIP, study the objectives and strategies, and consider how you can become involved. The South Central PHN thanks the individuals, agencies, and state and local governments who have made this plan possible through their contribution of time, effort, and resources.

South Central Regional Public Health Advisory Council

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Michelle Brauch – The Upper Room

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INTRODUCTION

The quality of a community is as important to achieving good health as receiving regular healthcare services, proper nutrition, and adequate physical activity. Individual and community health outcomes are influenced by many factors, including: the physical environment, economic and social factors, and the availability of and access to clinical care.

This Community Health Improvement Plan (CHIP) for the South Central Public Health Region (PHR) provides measurable goals, objectives, and strategies to address high priority health issues in our communities. The South Central Public Health Network (PHN) and its Public Health Advisory Council (PHAC) provide the framework for implementing the CHIP in collaboration with multiple community sectors. These sectors include: public health, healthcare, behavioral health, local government, public safety, education and childcare, social services, business, faith-based and volunteer organizations, and individuals who live and work in our communities.

The CHIP serves as a guide for policy and program development, as well as to determine resource needs and their allocation. Working together we can reach our shared vision for healthy communities that are characterized by a public health, healthcare, and behavioral health system that is accessible and meets the needs of underserved populations.

South Central Public Health Network

The South Central PHN is a collaborative of partner agencies that are working to enhance and improve community health and public health services across the region. Our vision is to become the healthiest and safest community in New Hampshire by identifying public health priorities and developing solutions to improve community health and safety.

OUR VISION: The healthiest and safest communities in New Hampshire!

The South Central PHN is one of 13 regional public health networks in New Hampshire. Each includes a host agency that convenes, coordinates, and facilitates partner agencies that contribute to or have a stake in the health of the region. Granite United Way is the host agency in the South Central Region. Leadership is provided through the regional PHAC which assures coordination and delivery of a variety of

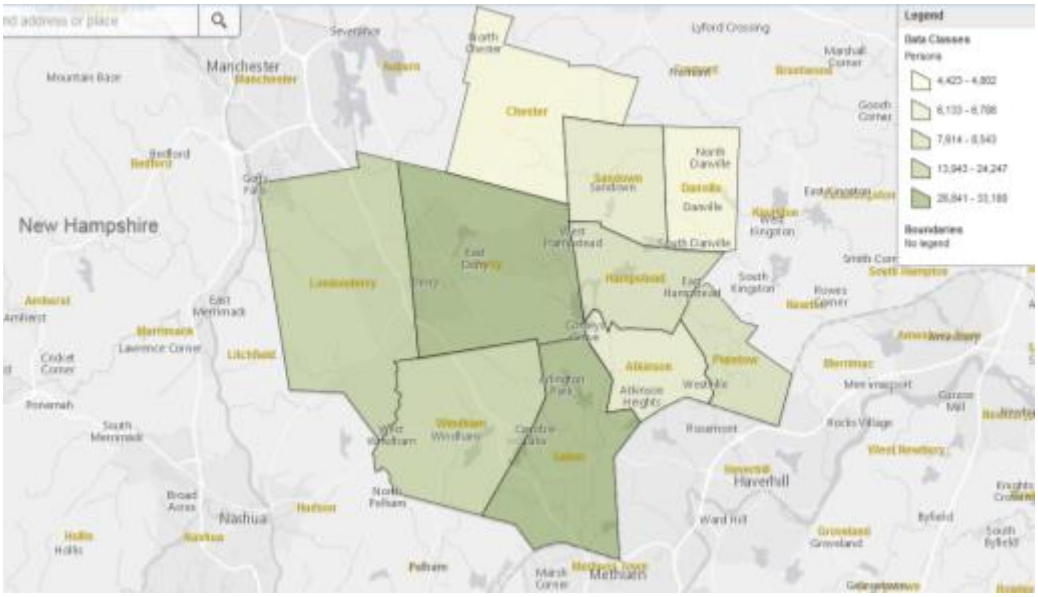
OUR MISSION: Working together we will identify public health priorities and develop solutions to improve community health and safety.

services including Public Health Emergency Preparedness (PHEP) and Substance Misuse Prevention (SMP).

The South Central PHAC assisted in the development of the CHIP. The PHAC is comprised of community leaders and representatives from a diverse group of community sectors including: public health, healthcare, behavioral health, public safety, business, faith-based organizations, government, education, social services, and citizen representatives. The primary work of the PHAC is to set regional health priorities, provide guidance for public health activities, and ensure coordination of health improvement efforts. More information about each of New Hampshire's Public Health Advisory Councils and Networks can be found at nhphn.org/who-we-are/public-health-networks/.

Community Profile

The South Central PHR (see map below) includes the towns of Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Salem, Sandown, and Windham. The South Central PHN serves approximately 138,000 people – about 10% of the total population of New Hampshire.



Growing Population: Between 2000 and 2010, population in the South Central PHR grew by 4.9% compared to a 6.5% increase in population in New Hampshire.[1] The population of the South Central PHR is somewhat younger when compared to the state with about 23% of residents under the age of 18 years (21% statewide). The race/ethnicity composition of the population in the South Central PHR is 95.5% White, 2.7%

[1] Data Source: US Census Bureau, Decennial Census. 2000 - 2010

Hispanic/Latino, 1.9% Asian, 1.3% Multiple Race, and 0.8% Black. The South Central PHR is more densely populated than the majority of regions statewide.

People Living in Poverty: The correlation between economic prosperity and health is well established. Inversely, poverty can be a barrier to accessing health services, healthy food, and healthy physical environments. With a median household income of $65,637, the Town of Derry is the only community in the South Central PHR where median household income is lower than the median for New Hampshire ($65,986).

The percentage of individuals in the South Central PHR living with incomes at or below 200% of the federal poverty level (14.6%) is notably lower than the rate for New Hampshire overall (22.6%).[2] The percentage of children (ages 0-17) living in poverty across the region (6.5%) is also notably lower than the statewide rate (11.5%).[2]

Disability Status: Disability is defined as the product of interactions between an individual's physical, emotional, and mental health and the physical and social environment in which they live, work, or play. Disability exists where this interaction results in limitations of activities and restrictions to full participation at school, at work, at home, or in the community. In an attempt to capture a diversity of disability characteristics, the US Census Bureau identifies people reporting serious difficulty with four basic areas of functioning: hearing, vision, cognition, and ambulation. As shown by the table below, a lower proportion of the population in the South Central PHR report living with a disability (about 8.8%) compared to the state overall.[2]

Percent of Population with a Disability	New Hampshire	South Central
Males	12.0%	8.9%
Females	11.5%	8.7%
Under 18 years	4.7%	3.7%
18 to 64 years	9.5%	6.9%
65 years and older	32.6%	28.3%

[2] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Health Improvement Plan Development

During the spring of 2016, the South Central PHN engaged partner agencies in a regional health improvement planning process to:

- Identify and evaluate health issues
- Provide information to community members
- Plan effective interventions
- Provide a baseline to monitor changes and trends
- Build partnerships and coalitions
- Identify emerging issues
- Identify current regional public health priorities
- Develop a Community Health Improvement Plan

During the health improvement planning process, population health data was reviewed. Additionally, information regarding existing community health assets was gathered from key stakeholders, as was input on priority areas for the CHIP.

Community Health Needs Assessment

Assessment of community needs is central to addressing health issues in the region. With assistance from the New Hampshire Community Health Institute (CHI), the South Central PHN completed a review of available population demographics and health status indicators. This resulted in the *2016 Regional Health Data Report*, which is available on the South Central PHN website. The data collection process was supplemented by input from key stakeholders to understand community needs and to inform decision-making regarding health improvement priorities and activities.

Additional data resources are also used to identify community public health needs. These include the Youth Risk Behavior Survey (YRBS) of high-school youth in the region, agency-specific survey and demographic data, publicly available state- and county-wide data, and results from agency-specific projects and collaborations in the region.

Planning Process

Assessment activities were used to identify community health concerns, health priorities, and opportunities for improvement to community health and the healthcare delivery systems. Health priorities and opportunities for improvement were identified by considering the following factors:

- Does the health factor or outcome have the potential to result in severe disability or death?
- Does the health factor or outcome impact a large number of people?
- Does the health factor or outcome disproportionately impact a subgroup of the population?
- If not addressed, will the health factor or outcome result in significant healthcare or social costs?
- Is the health factor or outcome feasible for the region to address in terms of cost, resources, and community will?
- Will addressing the health factor or outcome build on existing efforts and partnerships?
- Is the health factor or outcome not being adequately addressed by current efforts in the region?

The current New Hampshire State Health Improvement Plan Priority Areas were also used as a template for identifying regional priorities. The state priority areas include:

- Tobacco
- Obesity/Diabetes
- Heart Disease & Stroke
- Healthy Mothers & Babies
- Cancer Prevention
- Asthma
- Injury Prevention
- Infectious Disease
- Emergency Preparedness
- Misuse of Alcohol and Drugs

The Public Health Networks statewide were asked to select at least five priorities from this list including public health emergency preparedness and misuse of alcohol and drugs.

Regional Health Improvement Priorities and Plans

The South Central PHN selected the priority areas shown below for focused community health improvement efforts over the next five years. In some cases, the strategies included in this plan build on the efforts of existing partnerships and workgroups, while in other cases new workgroups will be formed. In all cases, these efforts advance current cross-jurisdiction, multi-sector collaboration in the region.

1. Prevent obesity through healthy eating and active living.
2. Improve access to behavioral healthcare services.
3. Reduce substance misuse and addiction through prevention, treatment and recovery.
4. Prevent injuries and reduce their consequences.
5. Improve public health emergency preparedness for individuals with access and functional needs.

The remainder of the CHIP provides detailed information about each public health priority area and details plans for improvement. In some cases, objectives that are included in the CHIP are developmental. These objectives describe important areas in which strategic action will occur, but for which quantitative baseline data are not currently available at the regional level. An important aspect of our work will be to engage state and local partners to assemble more specific information that can better describe our progress toward improving the health of our communities.

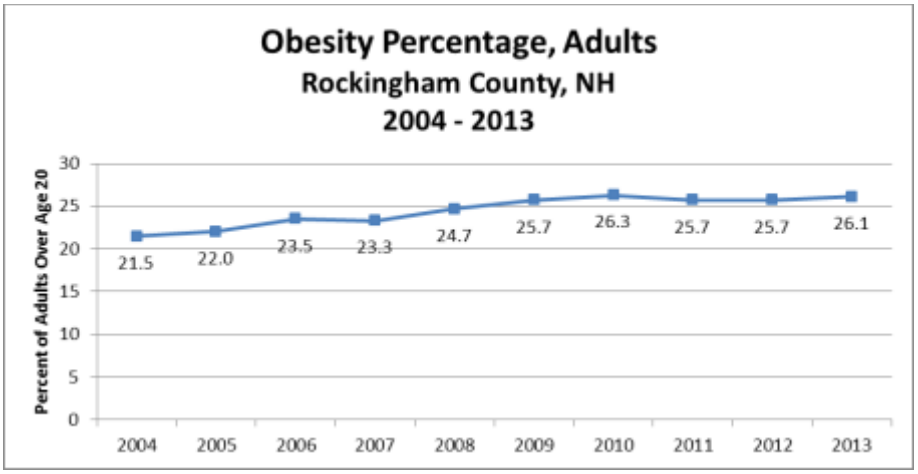
PRIORITY AREA 1:

Healthy Weight Promotion

Background and Importance

Being overweight or obese puts individuals at risk for a number of serious health issues including heart disease, stroke, diabetes, and cancer. Obesity is common in adults and children and contributes to higher costs for medical care. An individual is considered to be overweight or obese when their weight is higher than the healthy weight for their height. The Body Mass Index (BMI) is a screening tool that is used to determine if an individual is overweight or obese. Reaching or maintaining a healthy weight can be achieved through healthy eating and regular physical activity. The social and physical environment of a community can influence our individual habits related to healthy eating and active living.

About 70% of adults in the South Central PHR self-report consuming less than 5 servings of fruits and vegetables each day.[3] About 1 in 5 adults in the region is considered physically inactive – a rate similar to the rest of New Hampshire.[4] The chart below displays the increasing trend of obesity among adults in Rockingham County.



Data Source: Centers for Disease Control, Diabetes Interactive Atlas

The societal trend toward unhealthy body weight has also occurred among children. The indicators below display the results of a recent sample of third grade students from

[3] Percent of adults who eat fruit and vegetables 5 or more times per day, New Hampshire Health WISDOM.

[4] Adults meeting physical activity requirements, New Hampshire Health WISDOM.

Rockingham County. The proportion of overweight or obese children in the region is similar to overall rates across New Hampshire.

Geographic Area	Percent Obese, 3rd grade students	Percent Overweight or Obese, 3rd grade students	Obesity among WIC enrolled children
Rockingham County	**10.1%**	**24.2%**	**15.7%**
New Hampshire	12.6%	28.0%	14.1%

Data Source, 3rd grade students: NH 2013-2014 Third Grade Healthy Smiles-Healthy Growth Survey, NH DHHS.
Data Source, WIC enrolled children: Pediatric Nutrition Surveillance System, 2013.

Regional Initiatives and Opportunities

The following community assets support obesity prevention through healthy eating and active living:

- Natural recreational resources
- Local farms and local foods initiatives
- Physical activity and nutrition education (5-2-1-0 health education)
- Policies in workplaces, community centers, and schools
- Screening and counseling practices (primary care and other community based settings)
- Community gyms and fitness clubs

Goals, Objectives and Strategic Approach

Goal 1	**Reduce serious health issues associated with obesity by promoting healthy eating and active living to children and adults.**
Objective 1	Establish a regional Healthy Eating/Active Living (HEAL) workgroup by October 2016.
Objective 2	Complete an assessment of existing regional assets and compile a directory for individuals and families by March 2017.

Goal 2	**Support children and adults to achieve healthy weight goals by engaging primary care physicians and other partner agencies to screen for healthy weight and to provide nutrition and physical activity counseling.**
Objective 1	Reduce overweight and obesity rates among adults in the South Central region by 3% by 2020 (from 66% of adults to 63%).

STRATEGIC APPROACH

STRATEGY 1: Develop of a regional, multi-sector HEAL workgroup to enhance supportive community environments for physical activity and healthy food options.

STRATEGY 2: Initiate social media outreach on healthy food and community-based active living options in the South Central PHR.

STRATEGY 3: Implement universal screening using BMI measurement and obesity counseling (diet and exercise) in primary care and other settings.

STRATEGY 4: Increase access to healthy and affordable fruits and vegetables through community gardens, farmer's markets, the WIC program, and food pantries.

STRATEGY 5: Support safe, accessible public spaces for physical activity (walkable and age friendly communities, complete streets initiatives, parks, trails, sidewalks, and bike paths).

PRIORITY AREA 2:
Behavioral Healthcare Access

Background and Importance

An individual's mental health is considered optimal when they can successfully demonstrate the ability to engage in productive activities, maintain fulfilling relationships, and adapt to and cope with life's challenges. Mental health is essential to youth and adults for personal well-being, family and interpersonal relationships, and the ability to contribute to one's community.

Behavioral healthcare services promote personal well-being by preventing or intervening in mental illness, such as depression or anxiety, and substance misuse and addiction. Unfortunately, mental illness and addictions continue to be associated with stigma that may prevent an individual from seeking or receiving necessary behavioral healthcare services. Additionally, capacity for behavioral healthcare services is often insufficient and in some cases not well connected to other parts of the healthcare system. People with both acute and chronic mental health conditions are often under-diagnosed and under-treated, leaving them with significantly poorer health and social outcomes including shortened life spans, lower rates of steady employment, higher risk of self-harm or injuries to others, and higher rates of homelessness.

A shortage of behavioral healthcare professionals can contribute to reduced access and poorer health outcomes. In the South Central PHR, the ratio of residents per behavioral care provider (571) is higher than for New Hampshire overall (420).[5] Nearly 1 in 10 adults in the region report that their mental health "was not good" on 14 or more days out of the past 30 days.

Geographic Area	Percent of adults reporting their mental health "was not good" on 14 or more days out of the past 30 days[6]
South Central Region	**9.3%**
New Hampshire	11.8%

[5] Source: NH Board of Mental Health Practice/ NH Board of Licensing of AOD Use Professionals, Certified Recovery Support Workers/New Hampshire Board of Medicine licensure; 2010-2011 information.

[6] Data Source: NH Youth Behavioral Risk Factor Survey, 2011-2012. Regional rate is not significantly different than overall state rate.

Regional Initiatives and Opportunities

The following community assets support behavioral healthcare access through enhanced workforce capacity and eliminating stigma to treatment:

- The Affordable Care Act and the expansion of Medicaid provide improved access to behavioral healthcare services through health insurance plans that include mental health coverage and treatment benefits and the new substance use disorder benefit through the New Hampshire Medicaid program.
- The Center for Life Management (CLM) works to increase the depth and breadth of services available for individuals with mental health and addiction illnesses. This includes serving as the Continuum of Care Facilitator of the South Central PHN, mapping the existing behavioral health assets in the region, identifying barriers and gaps, and developing a plan for improved capacity, coordination, and transitions across the Continuum of Care.
- The Parkland Center for Emotional Wellness provides a local option for addressing the shortage of resources for individuals with emotional, behavioral and mental health disorders.
- The Derry Medical Center provides onsite Level 1 behavioral healthcare and medication management services for patients in its practice. As its partner in the work, Greater Derry Community Health Services provides comprehensive case management and resource identification to behavioral health patients as needed.
- The South Central PHN and related stakeholders are involved in planning activities associated with the New Hampshire Delivery System Reform Incentive Payment initiative intended to improve the delivery of behavioral health services for patients covered by Medicaid.

Goals, Objectives and Strategic Approach

Goal 1	**Increase capacity for and access to behavioral health services* in the South Central Public Health Region.**
Objective 1	Convene an workgroup of key stakeholders of the behavioral health system by September 2016.
Objective 2	Complete an analysis of the regional behavioral health system to identify priority action areas in Workforce Capacity and Barriers to Access by April 2017.

STRATEGIC APPROACH

STRATEGY 1: Establish working groups on Workforce Capacity and Barriers to Access to gather data and information, conduct analysis, compile reports, and draft an action plan to be presented to the South Central PHAC and other key stakeholders.

STRATEGY 2: Coordinate activities with the Region 4 Integrated Delivery Network team, the Bureau of Behavioral Health, and others to develop a structure and process for information sharing including service gaps and opportunities for change.

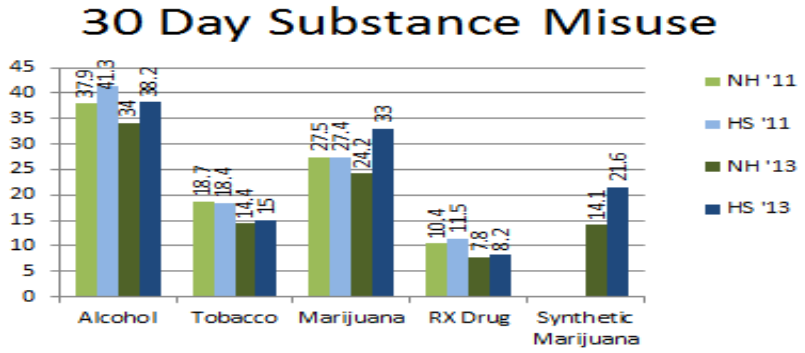
*Note: Additional goals and objectives for increasing access to substance misuse treatment are addressed in the next priority area of Substance Misuse and Addiction Prevention, Treatment and Recovery.

PRIORITY AREA 3:
Substance Misuse and Addiction Prevention, Treatment and Recovery

Background and Importance

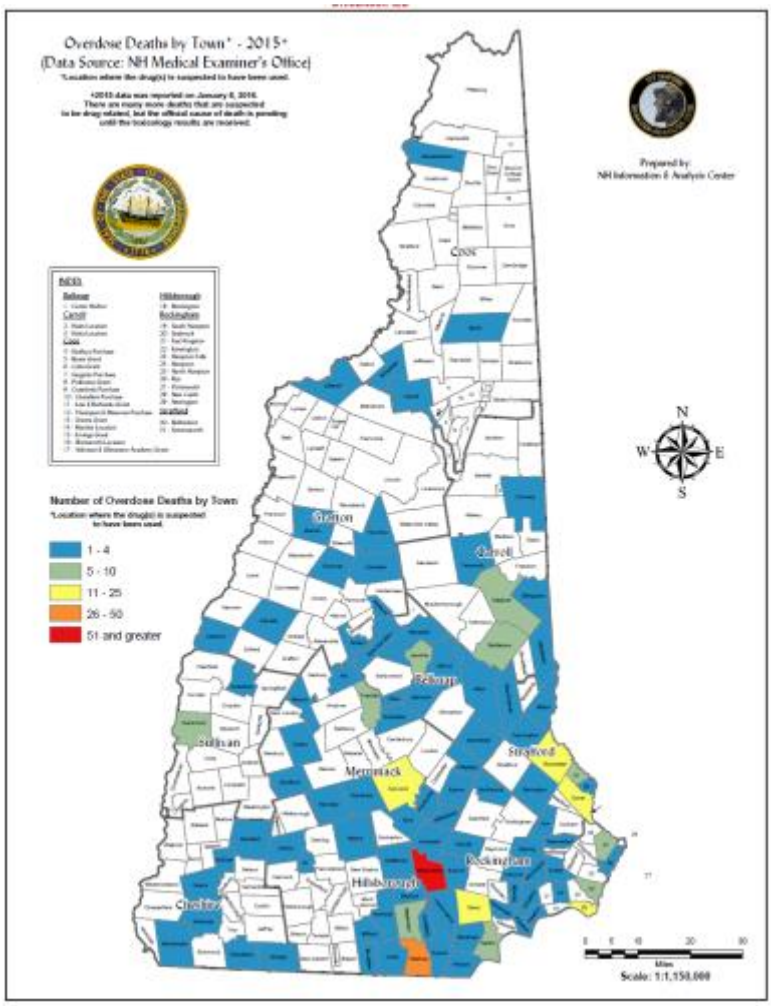
Substance misuse is one of the most prevalent and problematic public health issues. It presents a wide range of safety and health risks and impacts an individual's physical, social, and emotional well-being. Substance misuse involving tobacco, alcohol, illicit drugs, misuse of prescription drugs, or combinations of all of these behaviors poses negative consequences for the health and well-being of individuals, families, and communities. In addition to contributing to both acute and chronic disease and injury, substance misuse is associated with destructive social conditions, including family dysfunction, lower prosperity, domestic violence, and crime.

Alcohol remains the most prevalent substance misused in the United States and in New Hampshire. Underage drinking, binge drinking, regular heavy drinking, and drinking during pregnancy are some forms of alcohol misuse that pose highest risk. Marijuana is the illicit drug most likely to be used by teens and young adults. A majority of people being admitted to treatment programs in New Hampshire cite marijuana as a primary or secondary reason for seeking treatment. Marijuana use has a wide range of effects, particularly on cardiopulmonary and mental health, and is also known to be a contributing factor leading to the use of other drugs. The chart below displays rates of current substance misuse (reported use in the past 30 days) among high school aged youth in the South Central PHR (HS) compared to the state overall (NH).[7]



[7] Data Source: NH Youth Risk Behavior Survey as reported in the South Central Substance Misuse Prevention Plan; 2016-2019.

The misuse of prescription drugs, particularly prescription pain relievers, has significantly increased in the state and nation. Prescription drug misuse poses a risk to individual health and can be a contributing factor to misuse of other drugs, including heroin, and a cause of unintentional overdose and mortality. The map on the right displays drug overdose deaths, which have become epidemic, by town throughout the state.



Several towns in the South Central PHR experienced a large number of overdose deaths in 2015. The towns of Derry and Salem have consistently been in the top 10 communities in New Hampshire for use of Naloxone from 2011-2015. (NH Information & Analysis Center, 31 March 2015) In 2015, Continuum of Care focus groups with people in recovery were conducted in the South Central PHR and highlighted that 100% of those in attendance who were recovering from heroin addiction first used prescription pain pills (75% of whom obtained the prescriptions legally).

Regional Initiatives and Opportunities

The following community assets support substance misuse and addiction prevention treatment, and recovery:

- The South Central PHN provides staff, infrastructure, and coordination to increase the number and reach of evidence-based substance misuse prevention programs, policies, and practices that are implemented in the region.
- The Center for Life Management works with other partners across the region to assess system capacity and gaps and to develop a plan for improvement of

workforce capacity, behavioral health services, and community supports across a Continuum of Care.

- The South Central PHN Prevention Coordinator, regional Substance Misuse Prevention Task Force, and partners engage and support substance misuse prevention efforts across core community sectors including business, education, health, safety, government, and community and family supports.
- The South Central PHN has high levels of readiness and partnerships to address these issues as evidenced by the extensive collaboration and support of prevention programs by community partners over many years.
- Regional prevention efforts are aligned with the State Plan for Reducing Substance Misuse and Promoting Recovery: Collective Action, Collective Impact.

Goals, Objectives and Strategic Approach

(Also refer to the South Central Public Health Region 2016-2019 Substance Misuse Prevention Strategic Plan for additional detail on specific prevention goals, objectives and strategies.)

Goal 1	**Strengthen the capacity of the South Central PHN to address substance misuse.**
Objective 1	Increase the number of sector representatives and service organizations that are engaged in substance misuse prevention by 5% annually.
Objective 2	Increase the level of participation among partner organizations or representatives to harness resources and knowledge and to foster sustained collaboration.
Goal 2	**Promote the implementation of effective prevention policies, practices, and programs across the region.**
Objective 1	Increase sector implementation of proven and effective prevention policies, practices, and programs from 1 per year to 2 per year.
Objective 2	Increase the number of community sector organizations or representatives that have the necessary trainings and technical assistance to implement effective policy and practices from 3 to 6.

Objective 3	Support implementation of effective policies, practices, and programs with sufficient on-going training and technical assistance.
Goal 3	**Increase data collection in the South Central PHR.**
Objective 1	Increase participation in high school Youth Risk Behavior Survey (YRBS) from one school to five schools (as measured by the number of high schools participating by 2019).
Objective 2	Administer the middle school YRBS in at least 4 middle schools (as measured by the number of middle schools participating by 2019).
Objective 3	Acquire regional data from local partner agencies annually.
Goal 4	**Expand knowledge and skills relative to addressing alcohol and drug misuse by increasing training, technical assistance, and professional development resources.**
Objective 1	Increase awareness of substance use disorders and their impact on the community by educating lawmakers, policy makers, and regional decision makers annually.
Objective 2	Increase community capacity to address behavioral health and substance misuse.
Objective 3	Increase the PHN and PHAC members' knowledge of substance misuse prevention.

Goal 5	**Increase public awareness of the harm and consequences of substance misuse, the availability of treatment and recovery support services, and the achievability of recovery.**
Objective 1	Leverage resources for a coordinated and comprehensive public education strategy.
Objective 2	Produce and disseminate effective messages for a range of topics, public audiences, and media channels each year.
Goal 6	**Increase local capacity to address substance misuse and addiction across the region.**
Objective 1	Complete an assessment of service gaps and limitations on access across the substance misuse "continuum of care" (prevention, intervention, treatment, and recovery support services) by May 2016.
Objective 2	Develop a regional strategic plan to address identified gaps in services across the continuum of care, including expanded treatment options and peer-based recovery supports by September 2016.

STRATEGIC APPROACH

STRATEGY 1: Leadership – Cultivate expanded leadership and develop champions for prevention efforts by improving understanding of the community impacts of substance misuse and the effective use of policies, programs, and practices to address it.

STRATEGY 2: Financial resourcing – Advocate for and support adequate and sustained financial support of substance misuse prevention, intervention, treatment and recovery services.

STRATEGY 3: Public education – Increase public awareness relative to the harm and consequences of substance misuse, the availability of treatment and recovery support services, and the achievability of recovery.

STRATEGY 4: Training and professional development – Support access to broad training on substance misuse for a wide range of professionals and practitioners across different community sectors.

STRATEGY 5: Collaboration – Foster partnerships among key community sectors including alignment of efforts with the financial stability partnership.

STRATEGY 6: Technical assistance – Provide technical assistance to support and enhance efforts of existing local coalitions, develop local coalitions in additional communities, and expand treatment services and recovery supports for youth and adults.

STRATEGY 7: Data utilization – Collect and share data about the impact of substance misuse on individuals, families, communities, and community sectors, as well as to share best practices to reduce misuse and to promote recovery.

STRATEGY 8: Effective policy, practice, and programs – Promote the implementation of effective policies, practices, and programs across and within community sectors and systems and through a combination of direct programming, early intervention, and environmental change activities.

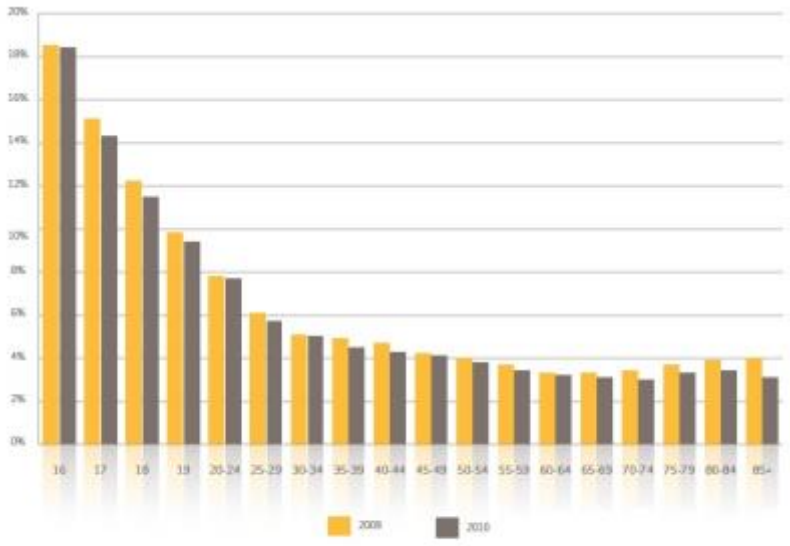
PRIORITY AREA 4:
Injury Prevention

Background and Importance

Injury is the leading cause of death among people 1-44 years old in New Hampshire.[8] Significant causes of injury include both accidental or unintentional injury, such as falls and concussions, and intentional injury, such as suicide or violence. However, many injuries can be prevented through a combination of strategies including behavioral and cultural change, education, environmental change, and effective policy and enforcement.

Youth Injury Prevention (driving safety): Youth motor vehicle operators continue to have the highest crash rates. This is primarily due to their more limited driving and life experience. The crash data for youth operators suggests that New Hampshire teens lack understanding of the risks associated with driving. Over 50% of motor vehicle crashes in New Hampshire involve individuals under the age of 20 (Source: http://nhparentsofteendrivers.com/stats-facts).

Percent of NH Crashes per Licensed Driver Age Group



New drivers, aged 16-19, represent the highest number of crashes among the different age groups of licensed drivers in NH. Many reasons account for this, but distracted driving (texting and cell phone use), in addition to driver inexperience, are the two most important prevalent.

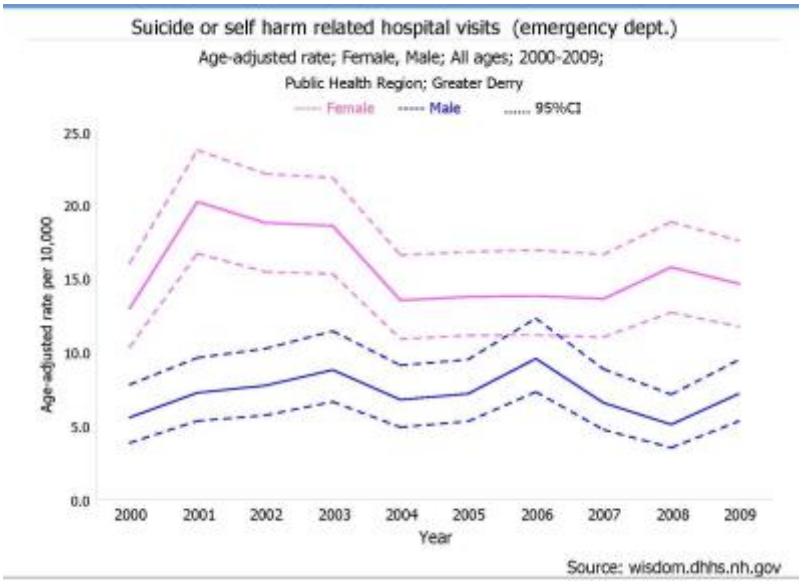
[8] New Hampshire State Health Improvement Plan, NHDHHS, 2013.

Teens are more likely to drive distracted and speed excessively, while being less likely to wear seat belts. 2009 data from the Centers for Disease Control and Prevention (CDC) and the National Highway Traffic Safety Administration (NHTSA) shows that only 55% of teens wear seat belts when they are passengers in a motor vehicle. The Community Alliance for Teen Safety (CATS) has conducted local observational surveys at schools that also demonstrate seat belt use for teen drivers in the upper fifty percent range. These same data sources show that youth operators have a high distraction rate especially through the use of electronic devices and that teens do not fully understand the risks associated with driving. According to 2013 crash data from the New Hampshire Department of Safety, six communities in the South Central region were in the top twenty-five cities or towns for motor vehicle accidents among youth operators age 16-21. The town of Londonderry ranked 4th in the state with 370 youth operator crashes. The towns of Salem (148), Derry (139), Hampstead (116), Windham (112), and Plaistow (74) were among the top communities for youth motor vehicle accidents.

Suicide Prevention: Although New Hampshire has made progress in efforts to prevent suicide, it remains the second leading cause of death (after accidental injury) among youth and young adults up to age 34. It is the fourth leading cause of death among adults up to age 55.

As shown by the chart below, the rate of suicide or self-harm related emergency department visits was significantly higher in the South Central PHR for females than males from 2000 to 2009. The overall rate of suicide or self-harm related emergency department visits in the region over this time period (10.7 per 10,000 population) is equivalent to about 150 emergency department visits per year related to suicide or self-harm.

It is also important to note that there are strong relationships between substance misuse, mental health and suicidal behavior. Drugs and alcohol can be a form of self-medication for underlying mental illness symptoms, can worsen underlying mental illnesses, or can cause a person without mental illness to experience the onset of symptoms for the first time.



Regional Initiatives and Opportunities

The following community assets support injury prevention through driving safety and suicide prevention:

- The Community Alliance for Teen Safety (CATS) has a 20-year record of effective public outreach and education about safe driving, teen education and skill building around prevention of risk behaviors including distracted driving, and advocacy for key changes in state laws and policies.
- Strong collaborative partnerships with local and state law enforcement, local fire and EMS, the Injury Prevention Center at Dartmouth, the NH Office of Highway Safety, NHTSA, the NH Teen Driver Program, NH Brain Injury Association, individuals with expertise in highway safety, and others in the education, media, and business sectors have provided leadership and resources to sustain the focus on this important issue.
- There is an established leadership team focusing on suicide prevention and substance use disorder initiatives, which is comprised of both substance use disorder and mental health content experts from across the region.
- The Center for Life Management maintains regional trainers for professionals and community members in evidence-based suicide prevention programs including CONNECT training in suicide prevention, intervention and postvention, Signs of Suicide (SOS), and Counseling on Access to Lethal Means (CALM). Certified trainers in Mental Health First Aid are also available to facilitate courses throughout the year.
- Regional efforts are intentionally aligned with the state suicide prevention plan.

Goals, Objectives and Strategic Approach

Goal 1	**Reduce youth injury and fatality associated with reckless and distracted driving by promoting use of seatbelts and distraction-free driving.**
Objective 1	Increase knowledge and awareness of seatbelt safety and the dangers of distracted driving.
Goal 2	**Reduce youth and adult suicide rates by increasing community awareness, knowledge, and capacity to recognize individuals at risk for suicide and to connect them with appropriate resources.**
Objective 1	Reduce the rate of suicide or self-harm related emergency department visits to 9.0 per 10,000 population by 2020 (baseline=10.7 per 10,000 population).
Objective 2	Increase the number of people trained in Suicide Prevention, Postvention, and Counseling on Access to Lethal Means (CALM) within key community sectors.

STRATEGIC APPROACH

STRATEGY 1: Empower youth to encourage their peers, parents, and community to make safe choices when driving and as passengers through education and training.

- Collaborate with the education sector to conduct meetings of high school aged youth to develop and implement youth leader Action Plan for driver and passenger safety.
- Collaborate with local media resources to develop social media campaigns that increase awareness of seatbelt safety and distracted driving.
- Promote inclusion of driving safety programs (i.e. NH Teen Driver Program Tool Kit) in all high schools.

STRATEGY 2: Engage parents as positive role models to influence youth driving habits and behaviors through education and training.

- Identify and facilitate opportunities for youth engagement by parents and community members on the importance of positive role modeling and safe driving habits.
- Collaborate with youth to develop educational materials and media messages that are targeted to parents of K-12 youth about road safety and kids.
- Promote the www.NHparentsofteendrivers.com website and other resources as guides.

STRATEGY 3: Promote the integration and coordination of suicide prevention and postvention best practices, policies, and protocols across multiple community sectors and settings.

STRATEGY 4: Identify emerging issues, best practices, research, and resources through continued collection, analysis, and reporting of qualitative and quantitative data on injury prevention.

PRIORITY AREA 5:
Emergency Preparedness for Individuals with Access and Functional Needs

Background and Importance

New Hampshire is not immune from public health emergencies resulting from disease outbreaks, natural disasters, or acts of terrorism. Prior to an emergency, a community must build strong, multi-sector relationships and collaborate to develop, exercise and improve emergency response plans.

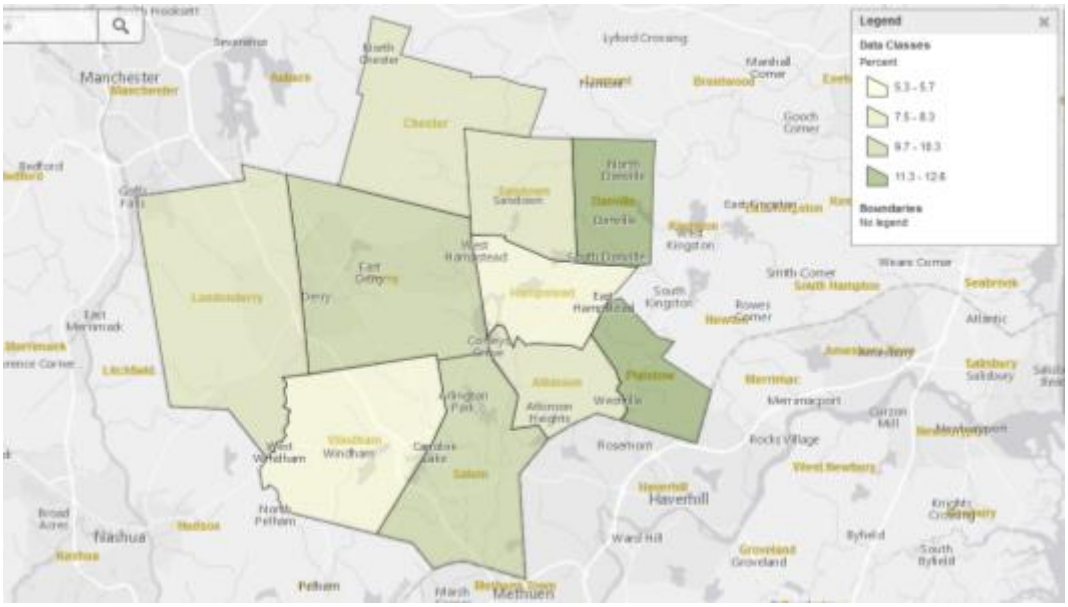
Equally important to an effective community response to emergencies is the level of personal preparedness of individuals and families. Personal Preparedness lessens the impact on families, workplaces and communities. While government and volunteer organizations can provide important functions in an emergency, it is important for all citizens to identify personal support networks and to have an understanding of shared responsibilities at home and within the community. These responsibilities include emergency planning for individuals who may be more vulnerable to the threat or at higher risk of negative health outcomes. Individuals with access and functional needs may require enhanced support services to access public health, healthcare, and behavioral health services. Specifically, they may require assistance to:

- Act on information (Communication)
- Maintain their health (Medical Care)
- Function independently (Independence)
- Maintain appropriate behavior (Supervision)
- Get to services (Transportation)

In the South Central region, an estimated 10,270 individuals, equivalent to about 7.4% of the civilian non-institutionalized population, have one or more functional need.[9] As displayed by the map on the next page[7], the communities with the highest proportion of individuals with access and functional needs in the region are Danville and Sandown.

[9] Data source: US Census Bureau, American Community Survey, 5 year estimates, 2010 – 2014.

Percent of Residents with One or More Functional Needs



In an attempt to capture the diversity of characteristics that encompass functional difficulties, the US Census Bureau (American Community Survey) identifies people reporting serious difficulty with six basic areas of functioning – hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent living difficulty. In addition to these categories, other difficulties related to the ability of an individual to communicate during an emergency may include limited English proficiency. Individuals who speak English less than "very well" may require translation and interpretation support services to receive, understand, and act upon information.

Hearing Difficulty - Individuals who are deaf or experience serious difficulty hearing may require support services to receive, understand, and act upon information, as well as to access public health services. Hearing support services may include sign language interpreters, audiologists, closed captioning, written materials, pictograms, and hearing aids.

Vision Difficulty - Individuals who are blind or experience serious difficulty seeing, even when wearing corrective lenses, may require support services to receive, understand, and act upon information, as well as to access public health services. Vision support services may include braille, large print materials, audio messages, readers, magnifiers, and service animals.

Cognitive Difficulty - Individuals who experience difficulty comprehending, remembering, concentrating, or making decisions may require support services to receive, understand, and act upon information, as well as to access public health services. The cognitive difficulty may be the result of a physical, mental, or emotional disability. Cognitive support services may include behavioral health

workers, supervision, social structure and routine, and counseling or spiritual guidance.

Ambulatory Difficulty - Individuals who experience serious difficulty with mobility, such as walking or climbing stairs, may require support services to maintain their independence, as well as to access public health services. Ambulatory support services may include Personal Care Attendants (PCA), wheelchairs, walkers, canes, ramps, and accessible transportation.

Self-Care Difficulty - Individuals who experience difficulty with activities of daily living, such as eating, bathing, toileting, and dressing, may require support services to maintain their independence, as well as to access public health services. Self-care support services may include PCAs, assistive devices, technology and equipment, and access to private restrooms or other public accommodations.

Independent Living Difficulty - Individuals who experience difficulty with completing errands, such as shopping or going to medical appointments, may require support services to maintain their independence, as well as to access public health services. The independent living difficulty may be the result of a physical, mental, or emotional disability. Independent living support services may include PCAs, durable medical equipment, and accessible transportation.

The table below displays the proportion of the population with functional needs by type of difficulty and age group in the South Central PHR.[7]

	Age Category			
% of South Central population with:	Under 5 years	5 to 17	18 to 64	65 years and over
any functional difficulty	0.4%	3.3%	5.8%	24.9%
a hearing difficulty		0.7%	1.3%	10.1%
a vision difficulty		0.7%	0.6%	4.2%
a cognitive difficulty		2.2%	2.0%	5.4%
an ambulatory difficulty		0.5%	2.7%	15.2%
a self-care difficulty		0.5%	0.9%	5.3%
an independent living difficulty			1.7%	10.0%

(Note: Column detail does not total to the 'any functional difficulty' statistic because individuals can have more than one functional difficulty).

Regional Initiatives and Opportunities

The following community assets support emergency preparedness for individuals with access and functional needs:

- The South Central PHN facilitates the cross-jurisdiction, multi-sector development of the regional Public Health Emergency Response (PHER) Plan, provides responder training on public health response capabilities, and conducts exercises to evaluate and improve the response plan. This includes plans to rapidly provide emergency medicine and vaccines to the at-risk population through Point of Dispensing (POD) sites.
- The South Central PHN coordinating efforts to recruit, train, and deploy a volunteer Medical Reserve Corps (MRC) during public health emergencies. The MRC supports local emergency responders to provide emergency public health services throughout the region. MRC volunteers include medical, public health, and non-clinical professionals.
- The South Central PHN disseminates information and conducts training on personal emergency preparedness and Functional Needs Support Services (FNSS).

Goals, Objectives and Strategic Approach

Goal 1	**Improve access to public health, healthcare, and behavioral health services for individuals with functional needs, limited English proficiency, and limited access to transportation.**
Objective 1	Develop a regional Public Health Resource Guide for individuals with functional needs, limited English proficiency, and limited access to transportation.
Objective 2	Update the regional PHER Plan to include strategies that improve access to emergency services for individuals with functional needs, limited English proficiency, and limited access to transportation.

STRATEGIC APPROACH

STRATEGY 1: Identify partner agencies in the region that provide support services to the identified populations by September 30, 2016. (Lead: Parkland Medical Center, PHEP Coordinator; Support: Community Health Services, PHAC Coordinator)

STRATEGY 2: Convene a regional workgroup on functional needs by December 31, 2016. (Lead: Parkland Medical Center, PHEP Coordinator; Support: Community Health Services, PHAC Coordinator)

STRATEGY 3: Publish a regional Public Health Resource Guide that meets functional needs requirements by March 31, 2017. (Lead: Community Health Services, PHAC Coordinator; Support: Parkland Medical Center, PHEP Coordinator)

STRATEGY 4: Submit the updated regional response plan with strategies for functional needs support services by June 30, 2017). (Lead: Parkland Medical Center, PHEP Coordinator)

Summary

A single organization or individual cannot achieve the health improvements outlined in this Community Health Improvement Plan. The success of this endeavor hinges on the community's ability to embrace a shared vision, sign on to a common agenda, and leverage our existing resources and expertise.

Collective impact occurs when organizations from different sectors agree to solve specific health and social problems using a common agenda, aligning their efforts, and using common measures of success.

The Five Conditions of Collective Impact[10]	
Common Agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared Measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually Reinforcing Activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous Communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
Backbone Support	Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

The process for developing the South Central CHIP has encompassed the five components of the collective impact model to ensure an inclusive and effective plan. This process has engaged a wide array of stakeholders including the community at large to: determine priority areas of concern; support the development of a common vision for community health; identify multi-sector, cross-cutting strategies; conduct outreach to existing and new communication channels for dissemination of

[10] Kania, J., Kramer, M., Collective Impact. 2011: Stanford Social Innovation Review.

information; and develop a shared focus on measurable outcomes for monitoring progress and facilitating accountability.

Next Steps

The South Central PHAC and the South Central PHN are committed to achieving the goals and objectives outlined in the CHIP over the next three to five years. Due to the regional focus of this health improvement strategy, we will employ the Action Cycle recommended by the *County Health Rankings and Roadmaps,* a program of the Robert Wood Johnson Foundation, as depicted by the schematic on the right.

We challenge YOU to find a way to utilize your strengths – both personally and organizationally – to support the implementation of the CHIP. We must all share in the responsibility of caring for our region's health and well-being. The future growth and vitality of the South Central Public Health Region depends on it.

www.countyhealthrankings.org/roadmaps/action-center

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