South Central NH Public Health Network

Community Health Improvement Plan

2026 - 2030

SOUTH CENTRAL NH
PUBLIC HEALTH NETWORK
An Initiative of Granite United Way

PREVENTION STARTS WITH PARENTS

To all who participated in this important process throughout the South Central Region:

Our heartfelt thanks to those of you who took the time to complete the Community Health Needs Assessment at the end of 2025. The information shared by you provided the foundation for this Community Health Improvement Plan. We are very grateful for your insights regarding the most pressing needs in the region.

https://southcentralphn.org/wp-content/uploads/2026/02/SCPHN-CHNA.-December-2025-FINAL-1.pdf

The work of the South Central Public Health Network does not happen in a silo. It involves many partners throughout the region that collaborate with the Public Health Teams in Substance Misuse Prevention, Continuum of Care and Pubic Health Emergency Preparedness and response to create and support activities and programs that will benefit all.

Some but not all partners in the work that the Network engages in include:

- Granite United Way
- Parkland Medical Center
- Greater Derry Community Health Services
- Southern Rockingham Coalition for Healthy Youth
- The Upper Room, A Family Resource Center
- Community Alliance for Teen Safety
- Marion Gerrish Community Center and Thrift Shop
- The Center for Life Management
- The Alexander Eastman Foundation
- The regional School Districts, Police and Fire Departments
- NH Department of Health and Human Services
- Heaven's Kitchen
- DMC Primary Care
- The Boys and Girls Clubs of Greater Derry and Salem
- NH Public Health Association
- Parkland Medical Center

We are also extremely grateful to the JSI Research and Training Institute for shepherding us through this lengthy process. Their knowledge, talent and patience have been wonderful.

The South Central Public Health Network is sincerely grateful for your input and participations throughout this process. Your feedback and perspectives have been invaluable and we are confident that the Community Health Improvement Plan will help guide our priorities, strengthen collaboration and improve our work as we continue to work to improve the health and wellbeing of our communities.

If you live or work in the South Central Public Health Network region and are interested in becoming more involved in the work you may reach out to:

Donna Tighe, Pubic Health Advisory Council Lead

dtighe@chsgreaterderry.org

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Plan Overview

The 2026-2030 South Central New Hampshire Community Health Improvement Plan is a collective effort of the South Central NH Public Health Network in collaboration with multiple organizational partners, regional workgroups and committees. The South Central NH Public Health Network (SCPHN), with support from Granite United Way, is grateful for the many partners who contribute their knowledge, perspective, effort and initiative to ensure that all area residents have the opportunity to achieve their highest potential for health.

The purpose of this Community Health Improvement Plan (CHIP) is to serve as a guide for shared strategies and focused activities to address high priority community health needs and concerns in the South Central region of New Hampshire. The process began with a community health needs assessment in 2025 in collaboration with other health and human service organizations across the region. Partners in the CHIP planning process also considered a number of related state-level health improvement plans to assure alignment of goals, strategies and resources as applicable.

This CHIP also serves as an update to the first South Central NH CHIP developed in 2020. Our overarching goal is to build on the progress made since 2020 through sustained and aligned efforts across multiple community partners. The CHIP is not intended to address all health issues facing residents in the communities of South Central New Hampshire, nor does it provide information on every program and initiative that is taking place in the region. However, it is our hope that the CHIP can be used by a broad range of community partners working in concert to protect and promote the health of individuals and families all across our region.

The South Central Public Health Network has a vision of a region with the healthiest and safest communities in New Hampshire.

OUR MISSION is to collaborate with partner agencies to identify public health priorities and to implement solutions that improve health and safety in our communities.

Drivers of Health: The South Central NH CHIP is based on the understanding that the conditions of the communities where we are born, live, age, work, and play are as important to achieving good health as receiving regular health care services, proper nutrition, and adequate physical activity. These conditions can be described as drivers of health that can directly or indirectly affect risks and outcomes related to health and wellness. Drivers of health can include characteristics such as household wealth; availability and quality of health care; access to affordable, healthy food; educational attainment; safe, quality housing; employment opportunities; transportation and public infrastructure; and other social, economic, and environmental factors. The term “drivers” reflects a shift from perhaps more familiar terminology of Social Determinants of Health since “determinants” can imply health outcomes that are pre-

determined. Instead, our focus is on how these factors can actively influence health outcomes while emphasizing the potential for interventions that can positively affect health and well-being. The collective efforts of community organizations, policymakers, and individuals can have profound effects on the health and happiness of community members.

The **County Health Rankings Model** (Figure 1), developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, provides a framework for population health that emphasizes the many drivers of health which, if improved, help make communities healthier places to live.

The model describes a set of inter-related domains including societal policies and practices, community conditions such as clinical care, social and economic factors, and physical environment, which together encompass a broad set of modifiable factors influencing individual and community health outcomes such as length and quality of life.

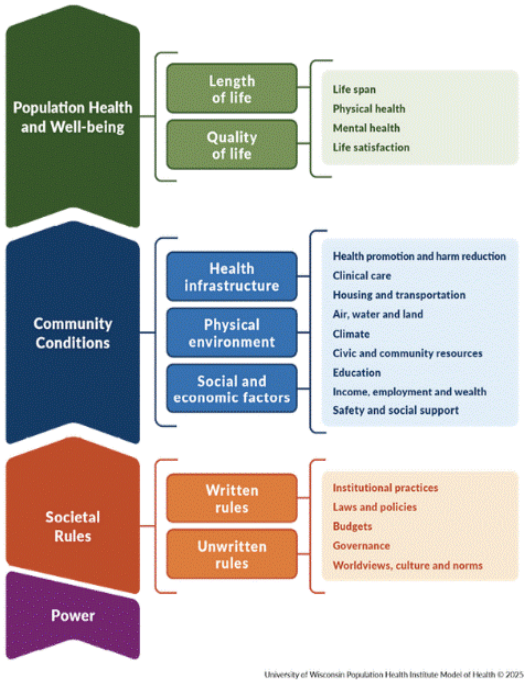


Figure 1: University of Wisconsin Population Health Institute Model of Health, 2024.

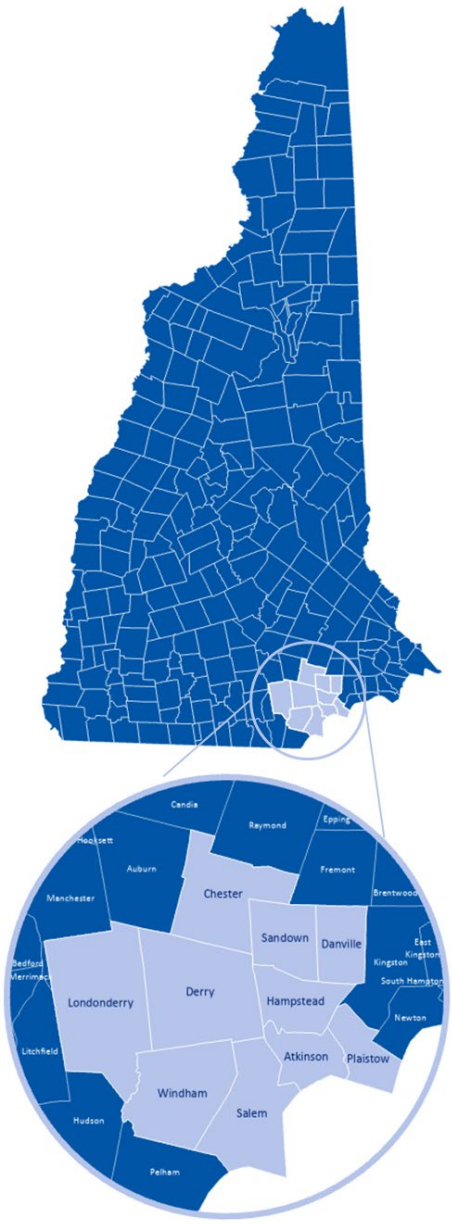
The 2026-2030 South Central CHIP was developed with these considerations in mind, as well as considerations for alignment with the New Hampshire State Health Improvement Plan, existing organizational assets and strengths in the region, and opportunities for collaboration on shared goals and strategies. The CHIP identifies seven priority areas for focused work to achieve improved health in our community over the next few years. These priority areas are:

- Access to Mental Health Services
- Substance Misuse Prevention
- Access to Adult Dental Care
- Healthy Aging
- Support for Healthy and Active Lifestyles
- Food Security and Other Drivers of Health and Wellbeing
- Public Health Emergency Preparedness, Response, and Recovery

Goals, objectives and potential strategies for action in each of these focus areas are outlined later in this document. The next section provides an overview of the region and identified community health needs.

Community Overview

Service Area Demographics: The South Central NH Public Health Region is comprised of 10 towns - Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Salem, Sandown, and Windham – with a total resident population of nearly 148,000 people. Compared to New Hampshire overall, the service area population has a slightly lower proportion of older adults - about 17% are 65+ compared to about 19% in New Hampshire overall – while the median age of service area residents is similar at about 43 years of age. A wide range is observed within the region for the percentage of residents under the age of 18 from about 14% of residents in Atkinson to 26% of Windham residents. A similar, inverse range is observed for the percentage of residents who are 65 years of age or older, from about 12% of residents in Sandown and 14% in Derry to about 26% of Atkinson residents who are 65 or older.



The table on the next page displays selected demographic information for the towns of the South Central New Hampshire region. In general, the region has substantially higher median household income ($121,298) compared to New Hampshire overall ($95,628); and all towns in the region have median household income exceeding the statewide median. The percent of people living in households with income below the federal poverty level (about 4%) is also somewhat lower than the New Hampshire statewide statistic (7%). Additional demographic information is included in the Appendices.

| Selected Service Area Demographics |

Municipality (in alphabetical order)	2023 Population Estimate	% Under 18 years of age	% 65+ years of age	% of residents with a disability	Median Household Income
Atkinson	7,222	14%	26%	13%	$144,481
Chester	5,263	19%	15%	8%	$138,606
Danville	4,489	21%	18%	11%	$112,845
Derry	34,335	20%	14%	14%	$104,718
Hampstead	9,062	21%	20%	13%	$99,536
Londonderry	26,217	21%	16%	12%	$130,841
Plaistow	7,850	20%	17%	13%	$109,040
Salem	30,646	17%	20%	11%	$101,339
Sandown	6,590	23%	12%	13%	$137,813
Windham	15,922	26%	17%	5%	$189,450
South Central NH PHR	**147,596**	**20%**	**17%**	**11%**	**$121,298**
New Hampshire	1,387,834	19%	19%	13%	$95,628

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

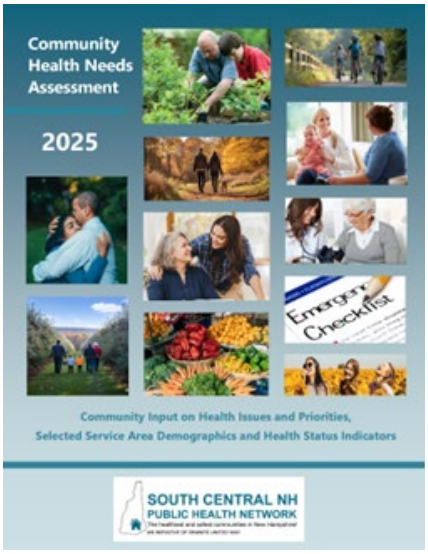
Community Health Needs Assessment: As previously mentioned, the process for developing the 2026-2030 CHIP for the South Central region began with a community health needs assessment in 2025. The assessment was completed by the South Central New Hampshire Public Health Network in collaboration with Center for Life Management, Greater Derry Community Health Services, Marion Gerrish Community Center, NH Hunger Solutions, Parkland Medical Center, Southern NH Services, and The Upper Room, a Family Resource Center.

Methods employed in the assessment included surveys of community residents made available through social media, email distribution, website links and through paper surveys widely distributed in multiple locations and gatherings across the region; a direct email survey of community leaders and service providers representing multiple community sectors; and assembly of available population demographics and health status indicators including drivers of health characteristics of the service area communities.

High-level priorities that emerged from the Community Health Needs Assessment include:

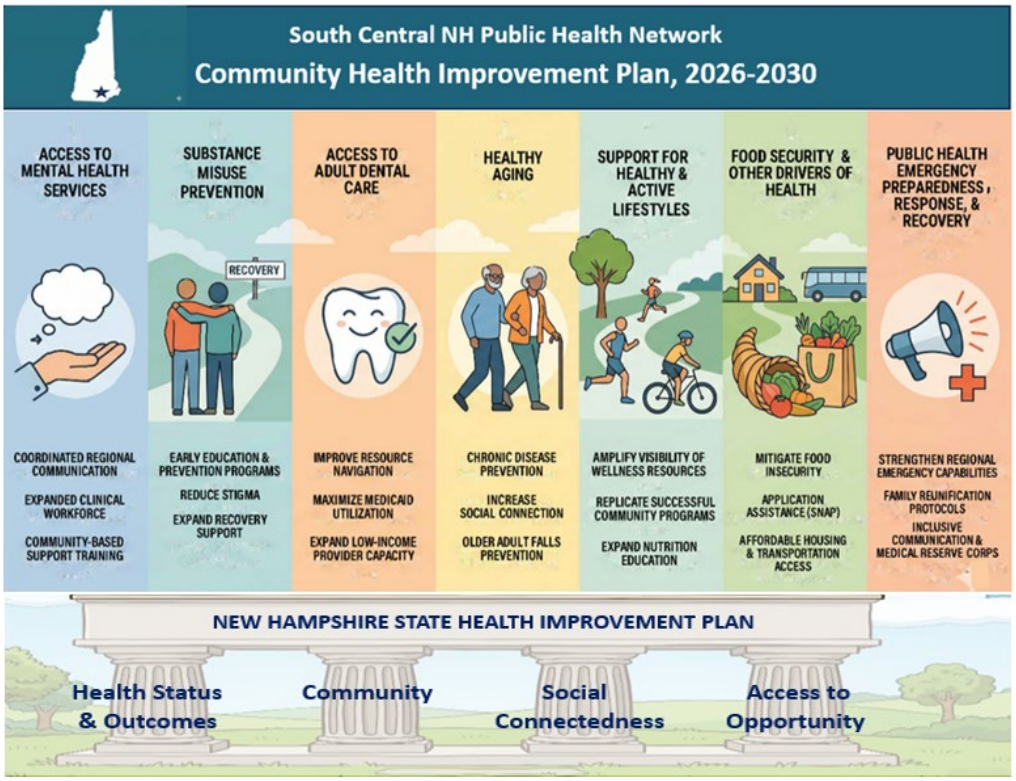
- Access and availability of mental health services
- Access to affordable adult dental care
- Cost of health care services including medications, affordability of health insurance

- Availability of primary care and medical sub-specialty services
- Services for older adults including opportunities for social interaction and supports for aging in place
- Social drivers of health and well-being such as affordable access to housing, healthy foods and affordable child care
- Improved services and supports for pursuing healthy and active lifestyles
- Health and human service workforce shortages and challenges navigating the health care system



Complete findings from the 2025 Community Health Needs Assessment can be found on the South Central NH Public Health Network website.

Based on these findings, the SCPHN planning committee identified seven priority areas – as illustrated by the image below - where the network can have impact for improved health in our community over the next few years. Goals, objectives and potential strategies for action in each of these focus areas are outlined beginning on the next page.



Access to Mental Health Services

Access to comprehensive mental health care is a fundamental component of a thriving, resilient community. However, navigating the complex landscape of available services often presents significant barriers for residents seeking help. This section of the Community Health Improvement Plan outlines our network's strategic commitment to simplifying that journey over the next five years. By establishing a coordinated regional communication network, advocating for an expanded clinical workforce, and equipping non-clinical community agencies to provide essential interim support, we will work to ensure that all community members can easily identify, locate, and access the right level of mental health care when they need it.

Access to Mental Health Services

Aim: Improve Resource Awareness and System Navigation

Goal: Ensure all community members can identify, locate, and access the appropriate level of mental health care through a coordinated regional communication and resource network.

Objective 1.1: Establish a regional work group of mental health service providers to facilitate information sharing about service availability and specialty care.

Strategy	Description	Focus
Inter-agency workgroup	Host quarterly coalition meetings and workshops.	Focus on clarifying 'who does what', eliminating referral 'red tape', and ensuring warm handoffs between agencies.
Build on related initiatives	Assure collaboration with, not duplication of current state and regional efforts	Connect SCPHN activities with initiatives such as Salem CARES, Southern NH Human Services Council, and NH Care Connections / Unite Us.

Objective 1.2: Develop and distribute a comprehensive regional mental health resource guide that includes information on walk-in services, support groups, and telehealth options.

Strategy	Description	Focus
Resource Mapping & Publication	Compile and publish an on-line, accessible directory of regional assets and referral resources	Highlight providers accepting Medicaid/Medicare and specialized support groups (e.g., postpartum support, substance use recovery, family caregivers).

Objective 1.3: Launch a public awareness campaign to increase resident awareness of "acute care" walk-in opportunities and alternative provider platforms to reduce barriers to initiation of care.		
Strategy	**Description**	**Focus**
Digital & Physical Outreach	Launch a unified "Right Care, Right Time" public awareness campaign.	Use social media, community centers, and local agencies to promote existing walk-in clinics and telehealth platforms.
Aim: Enhance Workforce Capacity and Community-Based Support **Goal: Strengthen the regional continuum of care by expanding the clinical workforce and equipping non-mental health specific agencies with the skills to provide interim support.**		
Objective 2.1: Develop a "bridge" support model to ensure individuals waiting for individual counseling are offered immediate group support options.		
Strategy	**Description**	**Focus**
Interim Support Programming	Develop or expand peer-led or clinician-facilitated support group offerings.	Designed primarily for individuals currently on waitlists for one-on-one therapy.
Objective 2.2: Provide training to staff of non-mental health specific partner agencies in foundational behavioral health skills such as motivational interviewing and de-escalation techniques to manage first-point-of-contact interactions.		
Strategy	**Description**	**Focus**
Cross-Sector Skills Training	Provide evidence-based training for staff at non-clinical "first point of contact" agencies.	Skills include Motivational Interviewing, De-escalation, and Trauma-Informed Care (e.g., for community center, family resource center, and food pantry staff).
Objective 2.3: Identify opportunities to advocate for increased clinical staff capacity in the region with a focus on providers accepting public insurance (Medicaid/Medicare).		
Strategy	**Description**	**Focus**
Workforce Development Advocacy	Partner with educational institutions, state associations, and policymakers.	Promote incentives (e.g., loan repayment, streamlined licensing) to recruit and retain behavioral health clinicians practicing in our region.

Substance Misuse Prevention

Addressing substance misuse requires a compassionate, multi-faceted approach that spans from early education to sustained recovery support as needed. This section details our strategic priorities for the coming years, emphasizing the reduction of stigma and the expansion of evidence-based prevention programs through strong local partnerships and community-based education. By strengthening communication and collaboration among professionals across the continuum of care, and by optimizing our collective resources, our network aims to support individuals and families in every stage of their recovery journey.

Substance Misuse Prevention

Aim: Enhance Substance Misuse Prevention, Education, and Stigma Reduction

Goal: Promote and expand evidence-informed substance misuse prevention and education programs while actively working to reduce the stigma associated with substance use disorders.

Objective 1.1: Increase the number of youth and adults participating in evidence-based substance misuse prevention and education programs over the next 2 to 5 years.

Strategy	Description	Focus
Expand Existing Prevention Programming	Collaborate with partners throughout the region to expand and strengthen evidence-informed programs.	Youth and adult prevention and early intervention education.
Community Education Delivery	Deliver targeted educational workshops as detailed in the NH DHHS approved substance misuse prevention plan for the South Central NH Public Health region.	Direct outreach to schools, community centers, and local agencies.

Objective 1.2: Measurably decrease community stigma surrounding substance use to foster a safer, more supportive environment for individuals in all stages of recovery.		
Strategy	**Description**	**Focus**
Anti-Stigma & Peer Support Campaigns	Collaborate with regional partners to launch community-wide anti-stigma messaging.	Promote safe spaces and peer-based support for individuals in all stages of recovery (example: On the Road to Wellness).
Aim: Strengthen Care Coordination and Access to Services **Goal: Improve communication and collaboration among health and community service providers to increase awareness of, and access to, the full continuum of care (early intervention, treatment, and recovery).**		
Objective 2.1: Increase community-wide awareness of how to access local services for early intervention, treatment, and recovery.		
Strategy	**Description**	**Focus**
Resource Mapping & Promotion	Create and distribute a unified guide or digital hub highlighting local resources.	Increase awareness of specific education and support programs (e.g., Derry Friendship Center, The Upper Room).
Objective 2.2: Improve communication and collaboration protocols among regional health and community service providers to help streamline the system of care.		
Strategy	**Description**	**Focus**
Continuum of Care Network Building	Leverage South Central PHN's resources to convene regular cross-sector meetings of local providers.	Strengthen connections and coordination across prevention, support, and recovery.
Provider Cross-Training	Facilitate shared training sessions among coalition partner agencies.	Ensure all community touchpoints understand available services and how to efficiently and effectively connect residents to care.

Aim: Resource Development and Program Sustainability

Goal: Optimize use of existing community assets while collaboratively identifying and securing new funding streams to sustain and expand substance misuse programming.

Objective 3.1: Conduct an assessment within the first 12 months to identify opportunities for increased use of current program resources among network partners.

Strategy	Description	Focus
Optimize use of current resources	Inventory existing community resources and programs such as educational workshops and support groups to identify opportunities for increased use.	Expand impact of existing funds and non-monetary resources (e.g., shared space, volunteer networks) in the region.

Objective 3.2: Collaborate with network partners to share resource-gathering efforts and jointly apply for new funding over the next 2 to 5 years.

Strategy	Description	Focus
Collaborative Resource Acquisition	Leverage the network's role to help partners access resources through a team-based approach to grant writing and fundraising.	Offset state funding cuts with collaborative, multi-agency proposal and fundraising efforts.
Diversified Funding	Research alternative funding sources (such as federal grants, private foundations, or local corporate sponsorships) to support ongoing programming.	Develop a sustainable financial foundation for community-based substance misuse education and prevention services.

Access to Adult Dental Care

Oral health is deeply connected with overall physical well-being, yet accessing affordable adult dental care remains a challenge for many residents. This section outlines our commitment to bridge this gap by improving resource navigation and expanding community outreach regarding available providers and benefit alternatives. By working collaboratively to maximize the utilization of adult Medicaid dental coverage and other regional resources, we aim to ensure that equitable, high-quality oral healthcare is within reach for our entire community.

Access to Adult Dental Care

Aim: Increase Awareness of and Assistance to Access Affordable Dental Resources

Goal: Improve community knowledge of and access to available resources for free or reduced-fee services, and low-cost dental coverage options.

Objective 1.1: Develop and distribute a dental resource guide detailing affordable dental care options for adults.

Strategy	Description	Focus
Resource Guide Development	Create a comprehensive, easy-to-read 'Dental Resource Guide' outlining all affordable dental care pathways.	Highlight free clinics, educational institution clinics (e.g., NHTI Dental Hygiene clinic), and low-cost insurance options.
Community Education Campaign	Distribute the resource guide through coalition partners and community touchpoints.	Educate residents on how to qualify for and get assistance obtaining free or reduced-fee dental services.

Objective 1.2: Deliver targeted information and education to increase resident awareness and use dental programs such as New Hampshire Smiles (Medicaid), the NHTI dental hygiene clinic, and low-cost Delta Dental plans.		
Strategy	**Description**	**Focus**
Family Dental Education	Integrate basic preventive education into broader resource sharing.	Provide information on basic oral care and navigating the system for the whole family.
Aim: Expand Local Provider Capacity for Low-Income Adults **Goal: Engage local private dental practices to increase the number of accessible treatment slots available for uninsured or underinsured adults.**		
Objective 2.1: Initiate an outreach to regional dental offices to encourage the adoption of sliding-scale fee structures for a designated number of patients annually.		
Strategy	**Description**	**Focus**
Provider Outreach & Advocacy	Conduct targeted outreach to local private dental practices to advocate for community needs.	Ask practices to carve out a specific, manageable number of patient slots annually for sliding-scale treatment.
Objective 2.2: Assess the feasibility of re-establishing a formal dental referral program (similar to a previous CHS program model) to connect patients with participating local providers.		
Strategy	**Description**	**Focus**
Referral Network Reactivation	Research and build upon the framework of the past CHS dental referral program.	Create a streamlined, reliable process for referring low-income adults to willing private practices.

Healthy Aging

Ensuring that older adults in our region can age safely, healthfully, and independently is a vital public health priority. This section highlights targeted strategies to strengthen clinical linkages, focusing on chronic disease prevention and management through unified, interagency referral systems. Recognizing that social connection and active engagement are crucial to aging in place, we are also committed to increasing awareness of and access to community-based programs and support, including working to overcome transportation barriers that can isolate older residents. Additionally, we outline a comprehensive, cross-sector approach to older adult falls prevention—partnering with local first responders and community volunteers—to significantly reduce injury, preserve independence, and promote lasting mobility.

Healthy Aging

Aim: Enhance Awareness and Coordination of Existing Programs and Services for Older Adults

Goal: Maximize the impact of existing regional resources by improving inter-municipal and inter-agency coordination, expanded communication and outreach.

Objective 1.1: Establish a regional planning collaborative among town Community Centers, Senior Centers, Recreation Departments, and health partners to share programming, reduce duplication, and create an interactive, centralized schedule of activities.

Strategy	Description	Focus
Regional Program Hub	Create a centralized, interactive link or directory detailing regional activities and associated transportation options.	Foster regional planning and communication so towns can work together to share existing programs instead of duplicating them.
Cross-Agency Promotion	Cross-promote programs and services of regional partners organizations	Increase participation in regional initiatives such as balance programs, Memory Cafés, Community Caregivers, and Meals on Wheels.

Objective 1.2: Within 18 months and ongoing, develop and implement multi-channel outreach strategies, including digital and non-digital channels, to effectively connect with older adults who may be isolated and not easily reached through social media or word-of-mouth.		
Strategy	**Description**	**Focus**
Broadening Outreach Campaigns	Design communication strategies that reach beyond digital platforms to inform seniors about resources such as social events and assistive support for aging in place.	Overcome the limitations of social media and word-of-mouth to reach isolated older adults.
Aim: Address Transportation and Infrastructure Barriers **Goal: Expand regional transportation solutions and facility capacities to ensure older adults can reliably travel to and participate in shared community programs.**		
Objective 2.1: Form a workgroup to explore opportunities for more coordinated regional transportation services that connect older adults to shared activities across different towns, increasing overall access to existing resources.		
Strategy	**Description**	**Focus**
Shared Transit Coordination	Work with regional planners to develop shared transportation solutions to help people get from one activity to another across town lines.	Overcome transportation as a primary barrier to accessing senior centers and community resources.
Objective 2.2: Secure funding or community partnerships to acquire dedicated transit assets (e.g., a van) and expand physical space for high-demand senior programs over the next 2 to 5 years.		
Strategy	**Description**	**Focus**
Targeted Asset Acquisition	Identify and apply for grants, sponsorships, or shared funding to purchase a dedicated transport van for the Marion Gerrish center.	Provide direct, reliable transit for vulnerable populations attending specific support programs.
Facility Expansion Advocacy	Support initiatives to identify and secure larger meeting spaces for growing community programs.	Accommodate larger groups for successful, expanding initiatives like the Marion Gerrish activities.

Aim: Promote Health-Related Programs and Services that Support Healthy Aging

Goal: Increase participation in local programs and services for injury prevention and chronic disease management.

Objective 3.1: Assess current workforce capacity (e.g., Community Health Workers and Patient Care Navigators) to support older adults through complex health and social service systems.

Strategy	Description	Focus
Workforce Knowledge and Capacity	Assess the capacity of care navigators across the region to assist older adults with awareness of and linkage to services for health promotion and injury prevention.	Increase awareness of available resources for health promotion and disease prevention and care coordination workforce capacity.

Objective 3.2: Improve referral connections and completion rates by participating in regional development and implementation of a shared, closed-loop interagency referral database.

Strategy	Description	Focus
Closed-Loop Referral System and Procedures	Participate in state / regional activities to adopt a shared resource database (e.g., monitor development of the New Hampshire Care Connections / Unite Us initiative)	Tracking referrals across agencies to ensure patients successfully connect with health-related services and supports.

Objective 3.3: Increase regional awareness, referrals, and capacity for injury prevention programs including balance classes for falls prevention and home safety assessments.

Strategy	Description	Focus
Volunteer Screening & Coaching	Recruit and train a dedicated network of volunteers, including the SCPHN Medical Reserve Corps, to conduct falls risk screenings, home safety assessments, and balance coaching.	Providing in-home and community-based interventions to identify and mitigate fall risks.
Sponsor Balance Classes	Implement evidence-based classes, such as Matter of Balance or Tai Ji Quan, for fitness and balance improvement	Reduce falls and fall-related injuries among older adults
First Responder Partnerships	Partner with local Fire and Emergency Medical Services (EMS) agencies who share an interest in falls prevention.	Leverage public health emergency partnerships for expanding capacity for education, outreach, and injury prevention.

Support for Healthy and Active Lifestyles

A healthy community is an active community, and providing accessible opportunities for physical fitness and proper nutrition is essential for long-term disease prevention. While our region offers many wellness resources, this section focuses on strategies to amplify their visibility, replicate successful community initiatives across town lines, and directly respond to identified resident needs. By enhancing our built environments with new outdoor exercise infrastructure, advocating for safe walking and biking paths, and expanding nutrition education, we will work to create a landscape that naturally supports healthy daily choices.

Support for Healthy and Active Lifestyles

Aim: Increase Engagement Through Program Promotion and Replication

Goal: Increase community participation in healthy and active lifestyles by improving the visibility of existing resources and replicating successful local programs across town lines.

Objective 1.1: Increase regional communication effort over the next 24 months to "get the word out" about existing recreation, fitness, arts, and cultural events.

Strategy	Description	Focus
Increase Promotion of Existing Resources	Expand mutually reinforcing social media and other communication activities to highlight local recreation and fitness resources and opportunities.	Increase public awareness and use of current health and wellness opportunities.
Expand Promotion of Arts & Culture Events	Actively include regional music, arts, and cultural events in health promotion messaging.	Address the community interest in arts and cultural events as a key component of overall mental and social well-being.

Objective 1.2: Identify and replicate at least one successful community-based wellness initiative (such as the "Walk into Health" activity) in neighboring towns over the next 2 to 5 years.		
Strategy	**Description**	**Focus**
Replicate Existing Programs	Support expansion of successful programs (like "Walk into Health") by sharing tips and tools for implementation.	Expand geographic access to proven health activities.

Aim: Foster Active and Healthy Lifestyles Across the Lifespan

Goal: Encourage active lifestyles and social connection across the age continuum through participation in exercise, arts and cultural programs and events.

Objective 2.1: Develop and maintain collaborative programs that foster social connection and active lifestyles for residents of all ages.		
Strategy	**Description**	**Focus**
Community Gardens	Maintain and expand community garden spaces, promoting access to fresh produce and encouraging participation by residents of all ages.	Promote outdoor activity, healthy foods, and intergenerational knowledge-sharing.
Inter-generational Movement and Arts Programs	Partner with local youth organizations and senior centers to host structured activities, including yoga, dance, art, and music classes.	Encourage physical activity and social connectedness through shared community programs and experiences.

Aim: Enhance Built Environments and High-Demand Programming

Goal: Expand accessible, low-cost opportunities for physical activity and healthy living by developing additional infrastructure for physical activity and programs for nutrition and cooking education.

Objective 3.1: Secure partnerships and funding to establish new outdoor fitness infrastructure (e.g., exercise stations) in central locations like Derry within the next 3 years.

Strategy	Description	Focus
Expand infrastructure for Physical Activity	Partner with local civic groups (e.g., Rotary Clubs) to replicate the Salem 'Field of Dreams' model by sponsoring development of outdoor exercise stations in additional communities.	Improve and expand the built environment to support free, accessible physical fitness.

Objective 3.2: Increase the availability of community-based programs and resources that are responsive to community interests, such as nutrition and cooking programs, and safe walking and biking paths.

Strategy	Description	Focus
Expanded Wellness Programming	Collaborate with local agencies to design and offer nutrition and cooking programs of interest to area residents.	Address the interest of residents in expanded availability for nutrition education.
Improved Pedestrian Infrastructure	Support local and regional planning efforts to maintain, promote, and expand safe biking and walking paths.	Address community interest in more resources for safe routes for active transportation and outdoor recreation.

Food Security and Other Drivers of Health and Wellbeing

Health and wellbeing are fundamentally shaped by the social, economic, and environmental conditions in which our residents live. This section addresses several high-priority drivers of health, with a primary focus on mitigating food insecurity through targeted application assistance and support for local food systems. Recognizing that affordable housing, reliable transportation, and quality childcare are all essential to community resilience, our plan outlines long-term, collaborative approaches to help residents navigate and secure these foundational resources.

Food Security and Other Drivers of Health and Wellbeing

Aim: Improve Food Security through Direct Access and Application Support

Goal: Increase community food security by removing administrative barriers to assistance programs and promoting local avenues for healthy, affordable food.

Objective 1.1: Assess current capacity and procedures across partner agencies to assist eligible community members with SNAP enrollment.

Strategy	Description	Focus
SNAP Application Assistance	Maintain or expand dedicated support services within existing community agencies to help residents with SNAP applications.	Remove administrative and literacy barriers to accessing federal food assistance.

Objective 1.2: Within 18 months and ongoing, measurably increase community utilization of local food distribution points such as food pantries and farmers markets among populations facing food insecurity.

Strategy	Description	Focus
Farmers Market Promotion	Launch targeted outreach highlighting local farmers markets, specifically emphasizing those accepting SNAP/EBT and Granite State Market Match program.	Encourage the purchase of local, healthy, and fresh foods.

Summer Feeding Program	Continue the collaboration with Heaven's Kitchen, The Upper Room, and the Marion Gerrish Community Center to deliver meals to youth and families.	Ensure children continue to have access to nutritious food while school is out, fostering connection, nourishment, and care for neighbors.
Resource Partnership	Collaborate with NH Hunger Solutions to ensure all local food resources are accurately mapped and accessible.	Leverage existing state-level expertise to bolster local food access initiatives.

Aim: Maximize Resource Visibility through Partner Cross-Promotion

Goal: Bridge the gap between existing resources and community utilization by developing a network of cross-agency navigators dedicated to advancing program visibility and awareness.

Objective 2.1: Establish a regional "Partner Promoter" network, identifying and empowering key staff across coalition agencies to serve as champions for social support programs.

Strategy	Description	Focus
Partner Promoter Network	Identify, connect, and cross-train enthusiastic community navigators across different agencies.	Foster a person-centered approach to cross-promoting services and increasing visibility.
Cross-Agency Visibility	Encourage all coalition members to actively promote each other's non-medical support services during client intakes and interactions.	Ensure that every agency touchpoint becomes an opportunity to connect residents with food and other family and community support resources.

Objective 2.2: Launch a unified, cross-agency awareness campaign to educate the community on the array of food and social resources already available in the region.

Strategy	Description	Focus
Targeted Awareness Campaigns	Design and distribute unified messaging that clearly outlines what programs are available and who qualifies.	Close the gap between the abundance of available resources and limited community awareness.

Public Health Emergency Preparedness, Response, and Recovery

The ability to rapidly and effectively respond to public health crises is vital for protecting our most vulnerable populations and minimizing community disruption. This section outlines our strategic framework for strengthening regional emergency preparedness, response, and long-term recovery capabilities, which includes establishing clear family reunification protocols. We will also focus on enhancing inclusive public communication networks, maintaining a trained, ready volunteer workforce through our local Medical Reserve Corps, and ensuring community organizations are fully integrated into emergency protocols. Our overall goal is to build a region that is prepared and resilient in the face of any public health threat.

Public Health Emergency Preparedness, Response, and Recovery

Aim: Improve Individual and Family Preparedness Through Outreach and Education

Goal: Enhance individual and family readiness for public health emergencies by expanding community education and deploying accessible, multilingual communication strategies.

Objective 1.1: Increase community participation in Emergency Preparedness presentations over the next 2 to 5 years, with a specific focus on expanding outreach to the more southern towns of the South Central region.

Strategy	Description	Focus
Expanded Community Presentations	Maintain or expand existing capacity for delivering Emergency Preparedness presentations throughout the region including a focus on outreach to towns in the southern tier.	Direct community education on individual and family emergency readiness.

Objective 1.2: Develop and launch a series of Emergency Preparedness Public Service Announcements (PSAs) accessible in different languages and formats to ensure all populations receive essential information.

Strategy	Description	Focus
Inclusive Media Relations & PSAs	Work with local media outlets to provide emergency messaging and produce PSAs translated into the primary languages spoken in the community.	Overcome language barriers in emergency preparedness and emergency communications.

Aim: Build and Maintain Regional Response Capacity and Community Resilience

Goal: Strengthen regional partnerships through the South Central Emergency Preparedness Task Force to improve community resilience and maintain response capabilities through regular training and exercises.

Objective 2.1: With support from Parkland Medical Center, sustain the regional emergency response network through formal partnerships, joint planning and exercises including municipal public safety and emergency response, health care and community-based human service agencies.

Strategy	Description	Focus
Regional Partnership Coordination	Convene regular preparedness planning and training activities with community partners.	Build strong cross-sector relationships to improve the overall system of care and community resilience.

Objective 2.2: Continue to supplement regional response capacity through Medical Reservice Corps recruitment and training over the next 5 years.

Strategy	Description	Focus
Medical Reserve Corps Recruitment and Retention	Maintain a cohort of medical and non-medical volunteers trained to respond to public health emergencies and conduct outreach in the community to promote public health initiatives.	Supplement community capacity for emergency preparedness, response, and recovery.

Objective 2.3: Within the next 24 months, complete, distribute, and increase community awareness of the Family Assistance and Family Reunification plans for the region currently in progress.

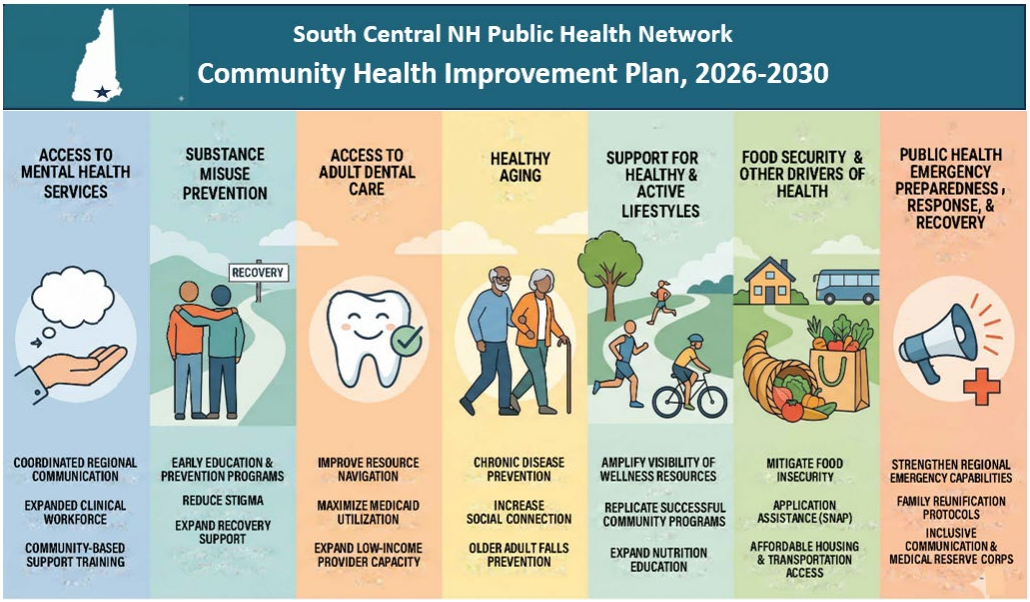
Strategy	Description	Focus
Family Reunification & Assistance Planning	Finalize operational plans for Family Assistance and Reunification and conduct community awareness campaigns so residents know what to do and where to go during an emergency.	Ensure safe and organized reunification of families in the aftermath of a community emergency or disaster.

Framework for Collective Action

The South Central NH Public Health Network's Community Health Improvement Plan for 2026 – 2030 represents more than just a list of goals; it is a shared roadmap for collective impact. By addressing these seven interconnected priority areas—from expanding access to mental health and dental services, to preventing substance misuse and promoting healthy aging—we are taking a holistic approach to individual, family, and community well-being. We recognize that true health is shaped not only in clinical settings, but also in our neighborhoods, through our built environments, and by the fundamental social drivers that impact our daily lives.

A Community Health Improvement Plan is only as strong as the action it inspires. The objectives and strategies outlined in this document are intended to be dynamic and measurable, serving as a guidepost for the coordinated efforts of our network partners including healthcare providers, first responders, and community organizations over the next five years. We are committed to maximizing our existing community assets, securing diverse funding streams, and continually assessing our progress to ensure our initiatives remain responsive to the evolving needs of our region. Success in this endeavor will require sustained collaboration, open communication, and a shared dedication to health equity.

Ultimately, this framework is built on the essential belief that every resident deserves the opportunity to thrive. As we move from planning to implementation, we invite all sectors of our community to join us in this pivotal work. Together, by fostering resilient systems, supporting one another, and remaining adaptable in the face of new challenges, we can achieve the vision of the South Central region being the healthiest and safest in New Hampshire.



APPENDICES

| TABLE 1. Service Area Population by Municipality |

Municipality (in alphabetical order)	2023 Population Estimate	% of Service Area Population	Median age	% Under 18 years of age	% 65+ years of age
Atkinson	7,222	5%	55	14%	26%
Chester	5,263	4%	47	19%	15%
Danville	4,489	3%	44	21%	18%
Derry	34,335	23%	40	20%	14%
Hampstead	9,062	6%	46	21%	20%
Londonderry	26,217	18%	43	21%	16%
Plaistow	7,850	5%	42	20%	17%
Salem	30,646	21%	45	17%	20%
Sandown	6,590	4%	39	23%	12%
Windham	15,922	11%	43	26%	17%
South Central NH PHR	**147,596**	**100%**	**43**	**20%**	**17%**
New Hampshire	1,387,834		43	19%	19%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

| TABLE 2. Selected Demographic and Economic Indicators |

Municipality (highest to lowest median household income)	Median Household Income	% with income under 100% FPL	% of family households with children headed by a single parent	% of population with a disability
Windham	$189,450	2%	16%	5%
Atkinson	$144,481	2%	8%	13%
Chester	$138,606	2%	22%	8%
Sandown	$137,813	10%	41%	13%
Londonderry	$130,841	2%	22%	12%
South Central NH PHR	**$121,298**	**4%**	**26%**	**11%**
Danville	$112,845	11%	34%	11%
Plaistow	$109,040	5%	40%	13%
Derry	$104,718	5%	32%	14%
Salem	$101,339	5%	26%	11%
Hampstead	$99,536	3%	13%	13%
New Hampshire	$95,628	7%	27%	13%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

| TABLE 3: Health Insurance Coverage Estimates |

Area (in order of highest to lowest % uninsured)	Percent of the total population with No Health Insurance Coverage	Percent with Medicare Coverage*	Percent with Medicaid Coverage*	Percent with VA health care coverage*
Sandown	9%	16%	14%	2%
Derry	6%	16%	12%	3%
New Hampshire	6%	21%	13%	2%
South Central NH	**4%**	**18%**	**9%**	**2%**
Plaistow	4%	18%	6%	1%
Salem	4%	20%	10%	1%
Londonderry	4%	16%	8%	2%
Hampstead	4%	24%	8%	2%
Windham	3%	16%	4%	1%
Atkinson	2%	26%	4%	2%
Danville	2%	19%	15%	3%
Chester	1%	15%	3%	3%

Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023.

**Coverage alone or in combination*