March 2016

Greater Milford Community Health Improvement Plan

Greater Milford Community Health Network: CHNA 6

Submitted by:

Health Resources in Action
Advancing Public Health and Medical Research

Dear Greater Milford Community,

We are pleased to present the **2015 Greater Milford Community Health Improvement Plan (CHIP),** produced by the Greater Milford Community Health Network: CHNA 6. The CHIP is the culmination of an 18 month process beginning in March 2013 with the first strategy meeting of CHNA 6 to prioritize key findings of the 2012 Community Health Assessment (CHA). During the following year, all CHNA 6 meetings were devoted to meeting in work groups to develop goals, objectives and strategies for the priority areas.
We have had the privilege of working with so many incredible, passionate people during this process. We learned a great deal about group process and working together in areas of mutual interest and expertise. Work groups bonded over the span of the year and grew in number to include as many agencies and individuals as possible. Ultimately, the CHIP reflects who was at the table, however the process continues to evolve with new voices and content experts.

The CHNA 6 steering committee and work group leaders have been instrumental in dedicating their time and energy to this plan and the process. Our hope is for the CHIP to balance ideal outcomes with realistic expectations. We expect to keep work groups and the greater community engaged in seeking the best means to achieve the objectives laid out in the CHIP. We know that progress has already been made in many areas even before the ink is dry as a result of the inherent collaboration and shared vision of the coalition.

We believe that the success of the CHIP will bring improved health outcomes to so many residents of our region. CHNA 6 is fortunate to be able to offer substantial grants over the next several years to meet many of these goals and objectives. During this process, we are committed to identifying and replicating successful initiatives and programs to improve the health of our communities. We are also committed to revisiting the CHIP each year to improve and further align expectations with outcomes.

We invite all of you to participate, to seek solutions for strategies identified in the plan, and to develop a community wide effort in the priority areas of eliminating health disparities, improving the access and availability of health care, reducing chronic diseases, and preventing substance abuse and mental health disorders.

Many thanks to Steve Ridini and Amanda Ayers from Health Resources in Action, Inc. (HRiA) for their work and guidance, and to all of you for taking the time to read this plan and to consider how you can contribute to its success.

All the best,

Ellen Freedman

Sara Humiston

Co-chairs, CHNA 6

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EXECUTIVE SUMMARY

Where and how we live, learn, work, and play affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, the Greater Milford CHNA 6 led a comprehensive community health planning effort to measurably improve the health residents of the region.

The community health improvement planning process includes two major components:

1. A MRMC Community Health Assessment (CHA) to identify the health related needs and strengths of the region
2. A Greater Milford Community Health Improvement Plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across the region.

The Greater Milford CHIP was developed over the period December 2013 – March 2015, using the key findings from the 2012 and 2015 CHAs , which included qualitative data from focus groups, key informant interviews and a community survey that were conducted locally; as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. During this time the 2015 CHA was completed and work was supported with updated data, and a community survey.

CHNA 6 led the planning process and oversaw all aspects of the CHIP development, including the establishment of CHIP workgroups and the refinement of details for identified health priorities. CHIP session participants included over 45 members of CHNA 6 with expertise and interest in priority areas identified in the CHA and who represented broad and diverse sectors of the community.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, CHNA 6 led the planning process by engaging community members and local public health partners through different avenues:

a. The CHNA Steering Committee was responsible for overseeing the development of the community health improvement plan,

b. The CHNA Members were responsible for reviewing documents and providing subject matter expertise and data for defined priorities; and

c. The CHIP Workgroups, representing broad and diverse sectors of the community and organized around each health priority area, were responsible for developing the goals, objectives and strategies for the CHIP.

CHNA 6 mission and vision were aligned with the task of developing a CHIP.

The *mission* of CHNA 6 is to facilitate effective collaboration and capacity building using local assets and resources in the service area to promote prevention, health equity and healthy communities.

The *vision* of CHNA 6 is to build healthier communities by including a wide range of accessible, multigenerational and culturally diverse services and programs that assist community members and educate them on the importance of prevention and leading healthier lives.

CHNA 6 hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the resulting reports and plan. HRiA has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally, including state-level plans in Massachusetts and Connecticut.

In March 2014, a summary of the CHA findings was presented to the CHNA, community partners, subject matter experts, and representatives from Milford Regional Medical Center for review and refinement, and to serve as the official launching point for the CHIP.

At this time, priority health issues were identified and subcategories developed. While many areas were significant, it was emphasized that identifying a few priority areas would enable more focus and collaboration for impacting the community. A multi-voting process and agreed upon selection criteria were used to identify the four priority areas to be addressed in the CHIP.

Work groups were established and lead agencies were invited to facilitate work groups over the next year. With support from the CHNA steering committee and HRiA, work groups developed goals, objectives and strategies in each of the four priority areas.

Priority Area 1: **Chronic Disease Prevention and Health Promotion**
Goal 1: Create healthier communities and prevent chronic disease by improving nutrition and increasing physical activity.

Priority Area 2: **Behavioral Health and Substance Abuse**
Goal 2: Increase emotional health across the lifespan and build an accepting community for those who are affected by mental health and substance abuse issues.

Priority Area 3: **Violence Prevention**
Goal 3: Promote non-violent behaviors across the life-span.

Priority Area 4: **Access**
Goal 4: Increase availability, knowledge, and use of services and resources that promote health, wellness, and access for vulnerable populations in CHNA 6 communities.

Health equity was identified as a **cross-cutting strategy** to be addressed by all priority areas in the plan.

This CHIP focuses on the 11 CHNA 6 communities of Bellingham, Blackstone, Franklin, Hopedale, Medway, Mendon, Milford, Northbridge-Whitinsville, Upton and Uxbridge, which include the primary service area of MRMC.

Greater Milford Community Health Improvement Plan

BACKGROUND

Where and how we live, learn, work, and play affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, Greater Milford CHNA 6 led a comprehensive community health planning effort to measurably improve the health of Greater Milford residents.

The community health improvement planning process includes two major components:

1. A community health assessment (CHA) to identify the health related needs and strengths of Greater Milford commissioned by Milford Regional Medical Center.
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Greater Milford.

The 2015 CHA is accessible at:
http://foundation.milfordregional.org/aboutus/communitybenefits/resources/MRMC_CHA_Report_2015.pdf

The MRMC CHA focused on the towns that comprise MRMC's primary service area. These communities include Bellingham, Blackstone, Franklin, Hopedale, Medway, Mendon, Milford, Northbridge-Whitinsville, Upton and Uxbridge. While the CHA process aimed to examine the health concerns across the entire region, there was a particular focus on identifying the needs of the most underserved population groups of the region, including youth, the elderly, and those with the greatest barriers to health care (e.g., low income residents, non-English speakers).

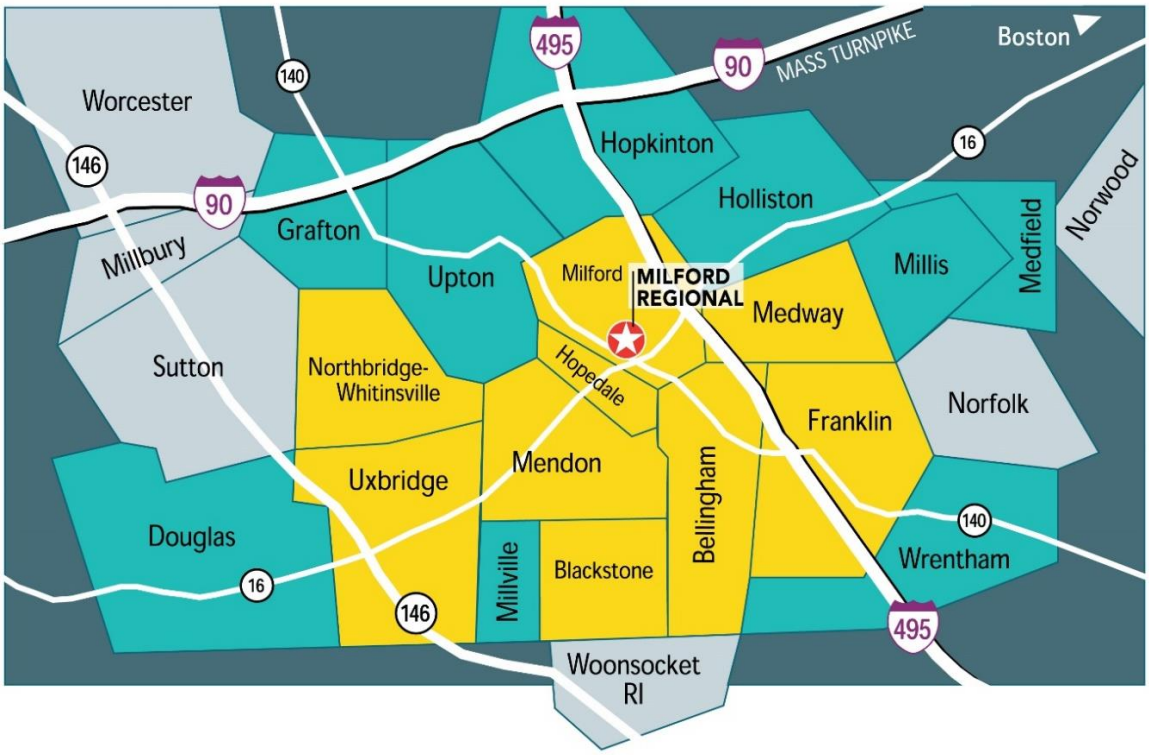

Figure 1: Milford Regional Medical Center Primary and Secondary Service Areas, 2012

The development of a CHIP was a recommendation of MA Department of Public Health which oversees the DoN (Determination of Need) process. As a public hospital, Milford Regional will be contributing DoN funds to the CHNA 6 communities upon completion of the hospital's expansion project in October 2015. Furthermore, Milford Regional Medical Center's Community Benefits Steering Committee developed a Strategic Implementation Plan (SIP) following the completion 2012 CHA, which was intended to align with the CHIP. CHNA 6 in partnership with Milford Regional then charted the CHIP process by engaging community members and local health and social service partners to develop a shared vision and plan for improved community health.

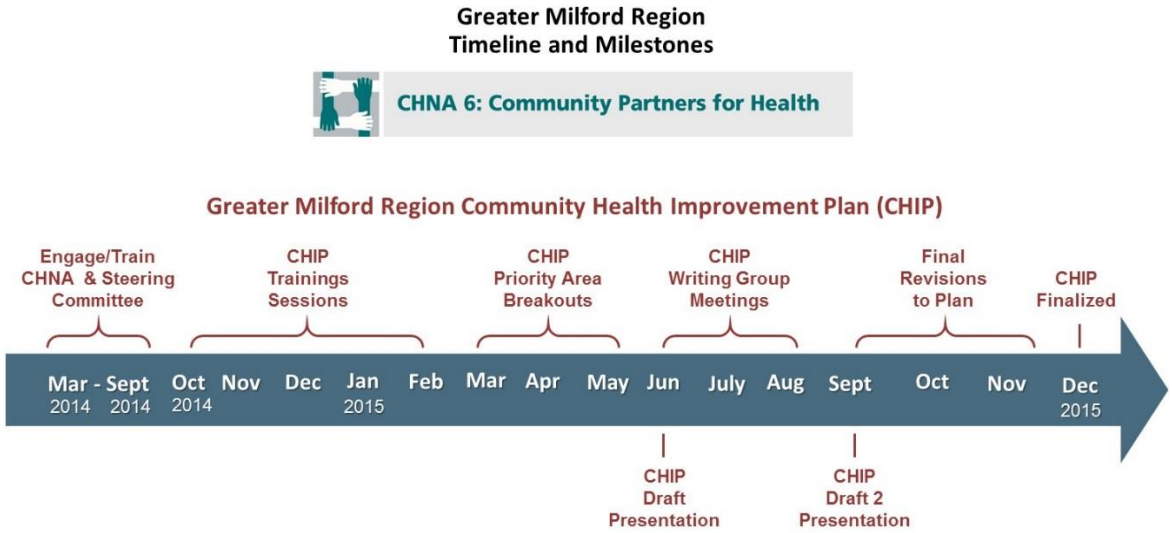

Figure 2: Greater Milford Region Timeline and Milestones

The 2015 Greater Milford Region CHIP was developed over the period of March 2014 - December 2015. The plan used key findings from the 2012 and 2015 CHAs, which included qualitative data from focus groups, key informant interviews and a community survey, as well as quantitative data from local, state and national indicators, to inform discussions and determine health priority areas.

Moving from Assessment to Planning

In 2014, CHNA 6 hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the resulting reports and plan. HRiA has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally, including state-level plans in Massachusetts and Connecticut.

Similar to the process for the CHA, the CHIP utilized a participatory, collaborative approach guided by the Mobilization for Action through planning and Partnerships (MAPP) process.[1] MAPP, a comprehensive, community-driven planning process for improving health, is a strategic framework that local public health departments and coalitions across

[1] Advanced by the National Association of County and Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

the country have employed to help direct their strategic planning efforts. MAPP comprises distinct assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/ implementation/ evaluation/ correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

In March 2014, a summary of the CHA findings was presented to CHNA 6, community partners, subject matter experts, and representatives from Milford Regional Medical Center for review and refinement, and to serve as the official launching point for the CHIP.

CHNA 6 members identified issues and themes from the identified priority health issues and subcategories were developed. While many areas were significant, it was emphasized that identifying a few priority areas would enable more focus and collaboration for impacting the community. A multi-voting process and agreed upon selection criteria were used to identify the four main priority health issues to be addressed in the CHIP. Work groups were organized and leaders were identified to coordinate the development of goals, objectives and strategies. Workgroups met over the course of a year under the following structure:

a. The CHNA Steering Committee was responsible for supporting the work of CHNA 6 members and overseeing the development of the Community Health Improvement Plan;

b. The CHNA Members were responsible for reviewing documents and providing subject matter expertise and data for defined priorities, and

c. The CHIP Work Groups, representing broad and diverse sectors of the community and organized around each health priority area, were responsible for developing the goals, objectives and strategies for the CHIP.

OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[2]

Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP:

- Identifies priority issues for action to improve community health
- Outlines an implementation and improvement plan with performance measures for evaluation
- Guides future community decision-making related to community health improvement

The CHIP will guide future services, programs, and policies for participating agencies and the area overall.

B. How to Use the CHIP

A CHIP is designed to be a broad, strategic framework for community health, and can be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens – can unite to improve the health and quality of life for all people who live, work, learn, and play in Greater Milford. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort, in whole or in part.

C. Relationship between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Greater Milford. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources wherever possible.

[2] As defined by the Health Resources in Action, Strategic Planning Department, 2012

PROCESS FROM PLANNING TO ACTION

A. Community Engagement

CHNA 6 led the planning process for Greater Milford and oversaw all aspects of the CHIP development, including the establishment of CHIP workgroups and the refinement of details for identified health priorities.

CHIP session participants included over 45 individuals with expertise and interest in priority areas identified in the CHA and who represented broad and diverse sectors of the community.

B. Development of Data-Based, Community Identified Health Priorities

Issues and Themes Identified in the Community Health Assessment

In March 2014, a summary of the CHA findings was presented to the CHIP workgroup members for further discussion. The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

Access to Health Care

- Insurance
- Costs
- Navigating the healthcare system
- Transportation
- Limited primary care

Health Promotion & Disease Prevention

- Access to healthy food
- Lack of physical activity
- Youth obesity
  Chronic Disease

Behavioral Health & Substance Abuse

- Resources for mental health and substance abuse services across the lifespan

Violence Prevention

- Domestic violence
- Cyber bullying

Process to Set Health Priorities

Facilitators engaged participants in many discussions to identify the most important public health issues for Greater Milford from the list of major themes identified from the CHA. Each planning participant identified their top 5 public health priorities, after reviewing, discussing, and agreeing upon the following selection criteria:

RELEVANCE *How Important Is It?*	**APPROPRIATENESS** *Should We Do It?*	**IMPACT** *What Will We Get Out of It?*	**FEASIBILITY** *Can We do It?*
- Burden (magnitude and severity economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measureable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins

Based on the results of this exercise, members agreed upon the following four health priority areas for the CHIP:

Priority Area 1: **Chronic Disease Prevention and Health Promotion**
Priority Area 2: **Behavioral Health and Substance Abuse**
Priority Area 3: **Violence Prevention**
Priority Area 4: **Access**

In addition, The CHNA Steering Committee and membership identified health equity as a cross-cutting strategy for each of the CHIP priorities, as appropriate. It was determined that all priorities identified should be aimed at addressing access and social determinants of health inequity in Greater Milford. The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances in turn are shaped by a wider set of forces: economics, social policies, and politics.[3] Addressing the role of social determinants of health is important because it is a primary approach to achieving health equity. Health equity exists when everyone has the opportunity to attain their full potential and no one is disadvantaged.[4]

[3] The World Health Organization http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

[4] Brennan Ramirez LK, B.E., Metzler M., Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. 2008, Department of Health and Human Services, Atlanta, GA.)

Cross-Cutting Strategy

Health Equity: Addressing health issues for underserved or vulnerable populations with significant health disparities.

Vulnerable Populations

- Seniors
- Adolescents/youth
- Immigrant communities
- Low income residents

Social Determinants of Health Issues

- Housing affordability
- Lack of Transportation
- Employment opportunities
- Food Security

The diagram in Figure 3 provides a visual representation of the multitude of factors that affect health, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as quality of housing and educational opportunities.

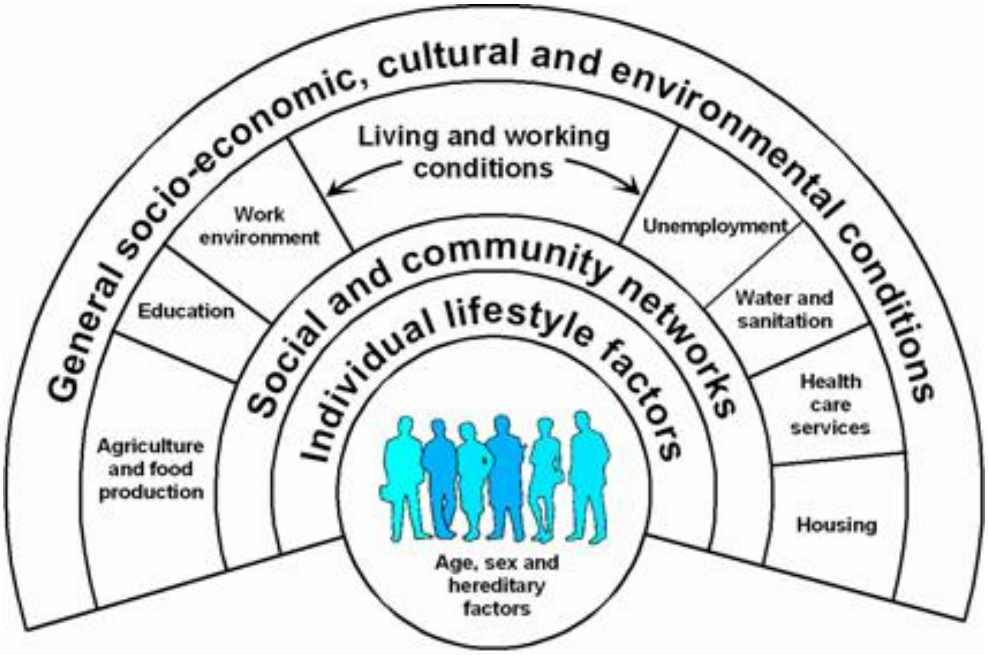

Figure 3: Social Determinants of Health Framework

Health Access: Addressing access to health, where access is meant to be broadly inclusive. In this document, access includes the ability to get to and obtain needed healthcare services. Thus, the definition of "access" could include:

1. Transportation (i.e., public options near provider locations/hubs)
2. Insurance coverage
3. Medicaid/Medicare coverage (and gaps)
4. Provider Supply: location, qualifications, numbers to handle demand
5. Hours of service/operation (i.e., evening and weekend hours for those who cannot leave work and/or work multiple jobs)
6. Culture and language sensitivity
7. Services/Program Supply: available foods, classes, outreach, support groups,

C. Development of the CHIP Strategic Components

The Greater Milford CHNA 6 met in March 2014 with consultants from HRiA to begin planning sessions. Participants selected one of four workgroups to join. Each workgroup being responsible for drafting goals, objectives, strategies, outcome indicators, and community partners and resources for their identified priority area. (See Appendix B for a full list of partners/resources).

HRiA provided sample evidence-based strategies from a variety of resources including *The Community Guide to Preventive Services, County Health Rankings*, and the *National Prevention Strategy* for the strategy setting sessions. As policy is inherently tied to sustainability and effectiveness, workgroups indicated whether or not strategy implementation would necessitate policy changes. In addition, as noted by one of the local content experts Andrew Springer, "the strategies were meant to be broad enough to allow for creative thinking in terms of how to operationalize the strategy."

Following the planning sessions, subject matter experts; from within CHNA, as well as external partnerships and HRiA consultants, reviewed the draft output from the workgroups and edited material for clarity, consistency, and evidence-based measures. This feedback has been incorporated into the final version of the CHIP contained in this report.

CHIP FRAMEWORK

Goals, Objectives, Strategies, Key Partners, and Outcome Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether efforts are making a difference. Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies.

The following pages outline the Goals, Objectives, Strategies, and Outcome Indicators for the four health priority areas outlined in the CHIP.

Data from the Community Health Assessment are included in the beginning section of each priority area. See Appendix A for a glossary of terms used in the CHIP.

A list of partners for each priority area follows each section. A full list of partners is located in Appendix B.

A. Priority Area 1: Chronic Disease and Health Promotion

The Community Health Assessment included a community survey which found that chronic disease is a growing concern for respondents and their families. Chronic conditions, such as asthma, diabetes, and heart disease were mentioned by participants across the interviews and community dialogues, although the behaviors that contribute to these diseases—such as physical inactivity or unhealthy eating—were the greater focus of concern.

Approximately one in five adults in the region is obese and the percent diagnosed with diabetes rose from 5.4% in 2008 to 9.3% in 2013, according to state data. This rate of increase is higher than the Massachusetts state average. One in five adolescents in the region is considered overweight or obese. The associated healthcare and social costs of diabetes and obesity continues to grow. The impact is disproportionally higher for low income, immigrant, and minority populations due to financial constraints and cultural barriers that limit access to healthy foods, physical activity, and preventive health care.

PRIORITY AREA 1: CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION	
Goal:	**Create healthier communities and prevent chronic disease by improving nutrition and increasing physical activity.**
Objective 1.1:	**Increase the number of adults, living in the CHNA 6 region, reporting consuming five or more servings of fruits and vegetables daily from 22-26% by 2018.**
Strategies	
1.1.1	Increase use of SNAP, WIC, SWIC benefits at farmers markets by 15%.
1.1.2	Increase utilization of mobile veggie mobile.
1.1.3	Create two new community gardens.
1.1.4	Increase the number of the *Cooking Matters* Program trainings by 10%.
1.1.5	Distribute healthy food donation guidelines to six food pantries.
1.1.6	Expand availability of fruits and vegetables at local convenience stores in Milford.
Outcome Indicators: • Increase use of SNAP,WIC,SWIC benefits at farmers markets • Increase number of *Cooking Matters* classes • Two new community gardens are added • Number of food pantries adopting healthy donation guidelines increases	
Objective 1.2:	**Increase the number of youth who report consuming more than one servings of fruits and vegetables daily by 10% by 2018.**
Strategies	
1.2.1	Increase the number of schools utilizing *Healthier US School Challenge* (HUSSC) standards (http://www.fns.usda.gov/hussc/healthierus-school-challenge) by two new communities.
1.2.2	Increase the number of schools who utilize *Farm to School* Programs by 10%.
1.2.3	*Nutrition Detectives* is utilized by schools in six communities.
Outcome Indicators: • Two new communities adopt HUSSC • Increase in *Farm to School* programs • Increase in *Nutrition Detectives* program	

PRIORITY AREA 1:
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Goal: Create healthier communities and prevent chronic disease by improving nutrition and increasing physical activity.

Objective 1.3: Increase implementation of programs, in the CHNA 6 region, that promote physical activity across the lifespan by 2018.

Strategies

1.3.1	Identify the number of evidence-based before and after school physical activity programs for youth in public schools.
1.3.2	Increase the number of evidence-based before and after school physical activity programs for youth in public schools.
1.3.3	5 early education centers will adopt at least one *Healthier Eating and Physical Activity* (HEPA) Guideline. (http://www.ymcaeuc.org/content/promo/2013%2004%20HEPA%20Standards.pdf)
1.3.4	Implement *Complete Streets* transportation policy language into a town's master plan in at least one targeted community. (http://www.smartgrowthamerica.org/complete-streets/)
1.3.5	Implement 3 new *Enhance Fitness* Programs for seniors. (http://www.cdc.gov/arthritis/interventions/physical-activity.html)

Outcome Indicators:

- Number of before and after school physical activity programs increases
- At least one community will adopt a *Complete Streets* Transportation Policy
- 1 HEPA standard is implemented
- *Enhance Fitness* Programs are implemented

Objective 1.4: Increase utilization of evidenced-based diabetes prevention, and self-management, programs by 25% in six communities by 2018.

Strategies

1.4.1	Identify and implement evidence-based physical activity and nutrition programs in 25% of targeted communities.
1.4.2	Increase the medical community's knowledge of, and referrals to, evidence-based programs for diabetes prevention and self-management.
1.4.3	Increase health practitioners' role in identification, education, and prevention of Type II diabetes through the Prevent Diabetes STAT Campaign.

Outcome Indicators:

- Number of sites offering evidenced-based diabetes prevention program increases
- Number of patients referred, enrolled and completed *YMCA Diabetes Prevention Program* (YDPP) and *Chronic Disease Self-Management Program* (CDSMP).
- Outreach to medical practices with information on evidenced -based programs in diabetes prevention and management.
- Number of physicians referrals to evidence-based diabetes prevention, and support, programs increases

Chronic Disease Prevention Lead Agencies

Hockomock Area YMCA
Reliant Medical Group
South Central WIC

PRIORITY AREA 1:
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Goal: Create healthier communities and prevent chronic disease by improving nutrition and increasing physical activity.

Participating Agencies

- Beginning Bridges
- Central MA Council on Aging
- Edward M Kennedy Community Health Center
- Franklin Food Pantry
- Franklin Senior Center
- Milford Public Schools
- Milford Regional Medical Center
- Milford Youth Center
- Salmon Milford VNA
- Share Our Strength
- SMOC
- Tri Valley Inc.
- Whitin Community Center

B. Priority Area 2: Behavioral Health and Substance Abuse

Substance abuse and mental health are seen as the most pressing health concerns in the region, particularly for youth, and are not currently able to be addressed by existing services. Anxiety, depression, and self-harming behaviors continue to be of concern, particularly for youth. In addition to impacting health and quality of life, mental health issues contributed to substance abuse and interpersonal violence. Opioid use across the state has climbed significantly with a 63% increase from 2012-2014. Milford has seen the greatest number of opioid fatalities in the region.

Scarcity of mental health services and lack of integration of primary care and behavioral health services were identified as barriers. For substance abuse in particular, the lack of treatment and recovery resources were key concerns.

Goal:	**PRIORITY AREA 2: BEHAVIORAL HEALTH AND SUBSTANCE ABUSE** **Increase emotional health across the lifespan and build an accepting community for those who are affected by mental health and substance abuse issues.**
Objective 2.1:	**Decrease the number of middle and high school students overall reports of feeling "very" stressed in the past 30 days and youth who reported feeling depressive symptoms in the past 12 months by 2% by 2018.**
Strategies	
2.1.1	Conduct an assessment of the existing number of school districts in CHNA 6 region who have evidence based social and emotional curriculum implemented in their frameworks.
2.1.2	Identify disparities in the CHNA 6 region that contribute to negative mental/behavioral health outcomes and substance abuse using the MWAHS data.
2.1.3	Conduct and promote integration of *Youth Mental Health First Aid* and NAMI training in community based organization and schools in CHNA 6 region.
2.1.4	Increase the number of evidence based educational programs in the CHNA 6 region that address prevention of mental health and substance abuse among school aged children, adolescents and young adults.
2.1.5	Promote and increase the integration of behavioral health into school districts in the CHNA 6 region.
2.1.6	Conduct and assessment of the existing number of community-based programs for school-age kids in the CHNA 6 region.
Outcome Indicators: • Increase in number of schools providing social and emotional learning programs in CHNA 6 region • Number of community-based programs for school-age youth increases • Increase number of people trained in *Youth Mental Health First Aid* in CHNA 6 region • Increase number of people trained in NAMI peer to peer training • Number of schools providing school based behavioral health care increases • Decrease high school and middle school student self-reported data for stress, depression and self-injury (MWAHS) • Maintain high level of high school and middle school student self-reporting a connection to a trusted adult	

PRIORITY AREA 2: BEHAVIORAL HEALTH AND SUBSTANCE ABUSE	
Goal:	**Increase emotional health across the lifespan and build an accepting community for those who are affected by mental health and substance abuse issues.**
Objective 2.2:	**Incorporate mental health and substance abuse and education into 25% of the primary care settings in the CHNA 6 region.**
Strategies	
2.2.1	Conduct an assessment of the existing number of primary care settings in CHNA 6 region that provide mental health and substance abuse screening and treatment services.
2.2.2	Enhance existing websites and improve easily accessible information and resources for all community organizations, resources and linkages in the CHNA 6 region.
2.2.3	Identify local primary care settings that are willing to develop their team with skills and competencies to identify mental disorders and substance abuse, provide basis medication, and psychosocial interventions, refer to specialist when appropriate and provide education and support to patients and families.
2.2.4	Develop and effective referral system between primary health-care and secondary mental health and substance abuse facilities for instances when more severe cases need to be referred to specialists.
2.2.5	Improve access to culturally and age appropriate behavioral health services.
Outcome Indicators: • Increase the number of Primary Cary Physicians (PCPs) that provide mental health and substance abuse screening and treatment services • Increase that number of PCP that refer mental health and substance screening and treatment services • Increase the number of mental health and substance abuse providers embedded in PCP settings • Increase the number of PCP's aware of available mental health and substance abuse services • Number of primary care practices that have integrated behavioral health model increases • Training for providers at primary care sites on integrated behavioral health model	
Objective 2.3:	**Reduce opioid use/ abuse in the CHNA 6 region by 2018.**
Strategies	
2.3.1	Conduct analysis on available overdose data in order to establish a baseline number of overdoses and track progress on 2019 target.
2.3.2	Educate families about the risks associated with non-medical use of prescription drugs and the progression of the disease.
2.3.3	Advocate and provide for support for parents and family members for opiate abuse (i.e., Learn to Cope).
2.3.4	Increase and/or implement the safe disposal programs for prescription drugs in the CHNA 6 region.
2.3.5	Increase and/or implement the safe disposal programs for syringes in the CHNA 6 region.
2.3.6	Engage the community and promote safe storage and disposal of prescription drugs and syringes through public education campaign.

Goal:	**PRIORITY AREA 2: BEHAVIORAL HEALTH AND SUBSTANCE ABUSE** **Increase emotional health across the lifespan and build an accepting community for those who are affected by mental health and substance abuse issues.**
2.3.7	Train groups who frequently come in contact with opioid users or overdoses hot-spots (non-healthcare staff in police stations, community agencies, motels, residential hotels) in the use of overdose reversal strategies such as the administration of Naloxone/Narcan.
2.3.8	Train and inform opioid users and bystanders (family, friends, and co-users) on how to appropriately respond to an overdose by performing rescue breathing and administering Narcan.
2.3.9	Conduct assessment to identify frequent uses of emergency services and develop integrated care plans.
2.3.10	Engage pharmacies to disseminate information about risks associated with non-medical use and safe storage and disposal of prescription drugs and syringes.
2.3.11	Train and inform opioid users and bystanders (family, friends, and co-users) on overdose risk factors including: Danger of using alone, concomitant use of alcohol, benzodiazepines or other drugs, re-initiation of use after periods of abstinence, and signs and symptoms of an overdose and what to do.
Outcome Indicators: • Number of community programs offering prevention education • Decrease in youth prescription drug misuse (MetroWest Adolescent Health Survey) • Number of risk- reduction community programs (safe disposal of Rx drugs, needles,) • Public awareness campaign on misuse, storage and disposal of Rx drugs and needles developed • Decrease in number of over doses (ODs) reported by hospital • Increase number of Learn to Cope support groups in CHNA 6 region • Increase the number of police department in CHNA 6 region partnering on opiate abuse/overdose • Increase the number of groups receiving Narcan and training	
Behavioral Health and Substance Abuse Lead Agencies	
Community Impact Inc. Family Continuity Inc.	
Participating Agencies	
Ahimsa Yoga Blackstone Valley Technical High School Center for Tobacco Control/UMass Medical School Congressman Joseph Kennedy's Office Dean College Healthy Families Kennedy Donovan Center MA Department of Public Health Bureau of Substance Abuse Services Metrowest Health Foundation Nipmuc Regional High School Riverside Community Care Spectrum Health Systems Inc. Uxbridge and Northbridge High School You Inc.	

C. Priority Area 3: Violence Prevention

When the issue of violence and safety were discussed by interviewees and community dialogue participants, two types of violence were noted as of particular concern: bullying among youth and domestic violence. Bullying was perceived as a major issue by youth and adults, and was seen as taking place both in and out of schools. In conversations, cyberbullying specifically was mentioned as an issue that has become more pervasive and detrimental among youth as text messages, Facebook, and other social media have become a ubiquitous part of young people's lives.

Several assessment participants mentioned domestic violence as a concern in the region. Intimate partner violence and family violence specifically were mentioned as problems that occur, but are not something discussed.

PRIORITY AREA 3: VIOLENCE PREVENTION	
Goal: Promote non-violent behaviors across the life-span.	
Objective 3.1:	**Identify and decrease incidents of relationship violence among high school students in 2 communities by 15% by 2018.**
Strategies	
3.1.1	Review MetroWest Adolescent Health Survey (MWAHS) data and Youth Risk Behavior Survey data (YRBS) data for schools in CHNA 6 area.
3.1.2	Assess readiness of schools to participate in project using a readiness assessment tool.
3.1.3	Gather additional data from other sources, e.g. school nurses, guidance counselors, school resource officers, police departments (SRO/PD) and the medical community.
3.1.4	Provide evidence-based educational programs to students; inclusive to all populations.
3.1.5	Provide professional development to school staff, administrators to recognize and address dating violence.
3.1.6	Implement a peer leadership program from first targeted group of ninth graders to commence in year two.
3.1.7	Determine vulnerable populations with a higher incidence of violence.
3.1.8	Implement educational programs parents to increase awareness.
Outcome Indicators: • Number of students reporting relationship violence among high school students in 2 communities • Trend data on numbers and rate of relationship violence • Established student groups to address relationship violence	
Objective 3.2:	**Identify and decrease incidents of bully among middle school students in 2 communities by 15% by 2018.**
Strategies	
3.2.1	Review MWAHS and YRBS data for schools in CHNA 6 area.
3.2.2	Assess readiness of schools to participate in project using a readiness assessment tool.
3.2.3	Gather additional data from other sources, e.g. school nurses, guidance counselors, (School Resource Officer/Police Department) SRO/PD, and the medical community.
3.2.4	Provide evidence-based educational programs to students; inclusive to all populations.

PRIORITY AREA 3: VIOLENCE PREVENTION **Goal: Promote non-violent behaviors across the life-span.**	
3.2.5	Provide professional development to school staff, administrators to recognize and address bullying.
3.2.6	Implement a peer leadership program from first targeted group of seventh graders to commence in year two.
3.2.7	Determine vulnerable populations with a higher incidence of violence.
3.2.8	Implement educational programs parents to increase awareness.
Outcome Indicators: • Number of students reporting bullying among middle school students in 2 communities • Trend data on the number and rate of bullying • Established student groups to address bullying	
Objective 3.3:	**Improve awareness and utilization of domestic violence prevention services for at risk populations in Greater Milford by 2018.**
Strategies	
3.3.1	Obtain data on incidence of domestic and sexual assault from hospital ED, police reports, and court reports.
3.3.2	Increase awareness and educate community on the issue of domestic and sexual violence (i.e., *Know the Signs of Domestic & Sexual Violence*).
3.3.3	Identify needs of non- English speaking populations in Greater Milford for domestic violence services.
3.3.4	Establish domestic violence prevention coalition/task force through linkages with key stakeholders.
3.3.5	Increase screening of patients for domestic violence.
3.3.6	Increase training of primary care and dental providers on signs and symptoms of domestic violence and sources of referral.
3.3.7	Increase hotline use by 10 %.
Outcome Indicators: • Number of persons from at-risk populations seeking services • Number of legal referrals related to domestic violence • Social norms campaigns related to domestic violence • Baseline data for number of patients screened for domestic violence • Outreach to at-risk populations related to domestic violence • Number calling hotlines increases	
Violence Prevention Lead Agencies	
New Hope District Attorney Joseph D. Early's Office	
Participating Agencies	
Wayside Youth & Family Support Network Hockomock Area YMCA Milford Police Department Planned Parenthood	

D. Priority Area 4: Access

The 2012 MRMC Community Health Assessment gathered qualitative and quantitative data to assess the health needs of the population in their service area. While medical services in the MRMC region are of high quality, a number of barriers were identified in accessing healthcare. These include access to affordable health insurance, a shortage of primary care physicians, availability of public transportation, and ensuring that health services accommodate the needs of a diverse population.
While the rate of uninsured in the region is comparable to the state average of 4%, the rate in Milford is higher at 6.5%. In addition, many area residents are underinsured or cannot afford the associated costs such as deductibles, co-pays, and prescriptions even with their health insurance. Finding primary care providers who are accepting new patients was presented as a challenge. Dental care was limited in the region for residents with MassHealth. Transportation is a major barrier to accessing community and health resources and rose to the top as a major determinant of health. Lack of transportation options in the region hampered parents' ability to access healthy foods, youth's ability to access recreational facilities, seniors' ability to access medications, and all residents' ability to access health care. Seniors, who often face isolation, were especially negatively affected by the limited transportation.

PRIORITY AREA 4: ACCESS	
Goal:	**Increase availability, knowledge, and use of services and resources that promote health, wellness, and access for vulnerable populations in CHNA 6 communities.**
Objective 4.1:	**Increase usage of Mass 211 as the primary resource directory in multiple languages for CHNA 6 communities by 10% by 2018.**
Strategies	
4.1.1	Identify and link directories not connected to Mass211.
4.1.2	Update Mass211 services in CHNA 6 region.
4.1.3	Reach out to local agencies to promote knowledge and use of Mass211.
4.1.4	Track usage of Mass211 in CHNA 6 communities.
4.1.5	Target areas of greatest need with education and information (geography, type of services).
4.1.6	Increase non-English usage of Mass 211.
Outcome Indicators: • 100% of CHNA-6 agencies are included on Mass211 • Number of other non-participating agencies listed in Mass211 directory increases • Number of residents reached with knowledge of Mass211 increases • Number of calls to Mass211 in CHNA 6 region increases • Number of calls to Mass211 in non-English languages in CHNA 6 region increases • Listings and knowledge of resources that support CHNA 6 priority areas increases	
Objective 4.2:	**Create and expand public transportation for Milford by 2018.**
Strategies	
4.2.1	Gather relevant data, research and resources available to identify and meet transportation needs in Milford.
4.2.2	Identify and mobilize key stakeholders who have the authority to address transportation needs in Milford (e.g., planners, engineers, town committees, elected officials).

PRIORITY AREA 4: ACCESS **Goal: Increase availability, knowledge, and use of services and resources that promote health, wellness, and access for vulnerable populations in CHNA 6 communities.**
4.2.3 Identify and secure funding to create bus service and routes in Milford to meet the needs of seniors, people with disabilities, teens and working adults from 6:30 am to 7:30 pm, five days per week.
4.2.4 Implement Dial- a -Ride with MWRTA for Milford.
4.2.5 Expand senior center bus transportation.
4.2.6 Develop awareness campaign to promote transportation services.
4.2.7 Produce route schedules in multiple languages.
Outcome Indicators: • Public fixed-route bus transportation exists in Milford • Dial-a-Ride services with Metro West Regional Transit Authority (MWRTA) exists in Milford • Senior center transportation bus service increases • Schedule meets needs of underserved population • Community outreach efforts promote ridership
Objective 4.3: Decrease rate of uninsured in Milford by 2.5% by 2017.
Strategies
4.3.1 Collaborate with key stakeholders to increase insurance enrollment in Milford to statewide average by 2017.
4.3.2 Promote training, certification and infrastructure for utilization of *Certified Application Counselors* to increase insurance enrollment.
Outcome Indicators: • Decrease rate of uninsured in Milford from 6.5% to statewide rate of 4% • Number of hours of insurance enrollment assistance in Greater Milford area increases • Insurance assistance provided at varied days, times and locations
Objective 4.4: Improve access to primary care in the CHNA 6 region by 2018.
Strategies
4.4.1 Promote training, certification and infrastructure for utilization of Community Health Workers (CHWs) to connect patients to primary and specialty care, community resources and address barriers.
4.4.2 Support sustainability and expansion of primary care services to meet the needs of the vulnerable populations.
4.4.3 Provide timely access to primary care appointments for patients referred by ED or discharged from the hospital with urgent needs.
4.4.4 Provide medical interpreter services at primary care sites that serve primarily vulnerable populations.
Outcome Indicators: • Improve access to primary care appointments at health care organizations that serve primarily vulnerable populations for new and existing patients • Number of primary care providers that serve primarily vulnerable populations • Number of Community Health Workers (CHW) who have completed 80 hour training in CHNA 6 region increases • Number of agencies in region employing CHWs increases • Number of CHWs employed in CHNA 6 region increases • Number of medical interpreters training in CHNA 6 region increases • Number of medical interpreters employed in CHNA 6 region increases

PRIORITY AREA 4: ACCESS

Goal: Increase availability, knowledge, and use of services and resources that promote health, wellness, and access for vulnerable populations in CHNA 6 communities.

Objective 4.5: Assess dental care for vulnerable populations in the CHNA 6 region by 2018.

Strategies

4.5.1	Implement survey of dental providers in CHNA 6 area to determine acceptance level of Mass Health and sliding fee scale payment options.
4.5.2	Outreach to vulnerable populations in the CHNA 6 area to determine perceptions of dental care availability and assess challenges to access to care.
4.5.3	Engage stakeholders in discussion on strategies to improve access to dental care for vulnerable populations in the CHNA 6 area.

Outcome Indicators:

- Number of dental providers in CHNA 6 area accepting children with Mass Health
- Number of dental providers in CHNA 6 accepting adults with Mass Health
- Number of dental providers in CHNA 6 with a sliding fee scale for dental patients
- Establishment of dental health task force in CHNA 6 area

Access Lead Agencies

Edward M Kennedy Community Health Center
Milford Regional Medical Center
Mendon Council on Aging

Participating Agencies

Health Care for All
Trinity Episcopal Church of Milford
Family Continuity Inc.
Central West Justice Center
Milford Commission on Disability
Milford Chamber of Commerce
Milford Public Library
Milford Family and Community Network
SHINE
St. Mary's Church of Milford
Welcoming Milford
495 Partnership

NEXT STEPS – IMPLEMENTATION PHASE

The components included in this report represent the strategic framework for a data-driven, CHIP. The Greater Milford CHNA, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will have an opportunity to apply for funding from CHNA 6 beginning in the spring of 2016. Grants will be awarded to ensure successful CHIP implementation and coordination of activities and resources among key partners in the Greater Milford area. The funds over the next five years will significantly impact the goals, objectives and strategies of the CHIP. An annual CHIP progress report and meeting will illustrate performance and will guide subsequent annual implementation planning.

SUSTAINABILITY PLAN

As part of the sustainability and success of this plan, CHNA 6 will continue to reach out to new partners and inform the community of efforts to address the goals of the plan. New and creative ways to feasibly engage all parties will be explored. Regular communication/reports will be made available via the CHNA 6 website and other social media to community members and stakeholders throughout the implementation phase. General CHNA 6 meetings will be dedicated to engage partners in the work, share progress, solicit feedback, introduce members to content experts to further their work, and strengthen the CHIP. Work groups will reconvene each year to evaluate progress in each priority area and serve in an advisory role for the CHIP.

Appendices

APPENDIX A: GLOSSARY OF TERMS

Active Transportation: Any method of travel that is human-powered, but most commonly refers to walking, bicycling and using public transit. OR - non-motorized transportation modes, such as bicycling and walking, which are well integrated with public transportation.

Behaviorally Integrated Medical Home: Service delivery system that coordinates behavioral care with medical care

Built Environment: Man-made surroundings that include buildings, public resources, land use patterns, the transportation system, and design features.

Community Health Improvement Plan (CHIP): Action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed.

Complete Streets: Streets that are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities.

Comprehensive Care Strategies: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Cultural Competence: Set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework

Distribution Point: Physical location where affordable quality nutritious food can be accessed, including, but not limited to, grocery stores, farmers markets, and farm-to-site programs.

Evidence-based Method: Strategy for explicitly linking public health or clinical practice recommendations to scientific evidence of the effectiveness and/or other characteristics of such practices

Goals: Identify in broad terms how the efforts will change things to solve identified problems

Health Disparity: Type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who systematically have experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.

Health Equity/Social Justice: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances.

Health Literacy: Degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

Linguistic Competence: Providing easy access to oral and written language services to limited English proficiency (LEP) patients through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Multiple specified targets: Objectives that are applicable to more than target population or indicator.

Objectives: Measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

Patient Centered Care: Patient-centered care is oriented towards the whole person and is relationship-based. Building a partnership with each patient and his/her family is foundational to that person learning to manage and organize his/her own care at the level he/she chooses. Such a partnership necessitates understanding and respect for each patient's needs (including health literacy), culture, language, values, and preferences.

Percentages: All percentages are relative; absolute change as a percentage of the baseline value

Performance Measures: Changes that occur at the community level as a result of completion of the strategies and actions taken

Priority Areas: Broad issues that pose problems for the community

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Strategies: Action-oriented phrases to describe how the objectives will be approached

APPENDIX B: PARTNERS AND RESOURCES

2016 CHNA 6 Steering Committee

Ellen Freedman, Milford Regional Medical Center, Chair
Sara Humiston, Milford Family and Community Network, Co-chair
Fr. William MacMurray,Trinity Church of Milford, Treasurer
Michelle DaFonte, Blackstone Valley Technical High School
Luisa Fundora, MA Department of Public Health, Bureau of Substance Abuse Services
Francisco Ramos, Health Care for All
Sue Schlotterbeck, Edward M. Kennedy community Health Center
Shelly Yarnie, MA Department of Public Health

Priority Area Leaders

Priority Area 1: Chronic Disease Prevention and Health Promotion

Michelle Dalal, MD, Pediatrician, Reliant Medical Group
Kimberly Cohen, Senior Director of Health Innovations, Hockomock Area YMCA
Stacey Tucker, Community Coordinator, South Central WIC Nutrition Program

Priority Area 2: Behavioral Health and Substance Abuse

Craig Maxim, Director of Program Development, Family Continuity Inc.
Amy Leone, Owner, Community Impact and Chair, Juvenile Advocacy Group (JAG)

Priority Area 3: Violence Prevention

Julie Lesure, Assistant District Attorney, Office of District Attorney Joseph D. Early Jr.
Marcia Szymanski, Executive Director, New Hope Inc.

Priority Area 4: Access

Brenda Figueroa, Practice Manager, Edward M. Kennedy Community Health Center/Milford
Kevin Rudden, Mendon Council on Aging
Ellen Freedman, Manager, Milford Regional Healthcare Foundation Office of Community Benefits

CHNA 6 Partner Organizations

Successful development and implementation of any Community Health Improvement Plan involves a cross collaboration of multi-sector partners. The following list includes those partner organizations who were involved in the development of the CHNA 6 Greater Milford Region CHIP and/or who will be involved in its implementation.

Ahimsa Yoga

Alternatives

Alzheimer's Association

American Cancer Society

American Heart Association

Beginning Bridges

Blackstone Valley Chamber of Commerce

Blackstone Valley Regional Vocational Technical High School

Brightstar Care

Caregivers Inc.

Catholic Charities of Worcester

Center for Adolescent and Young Adult Health at Milford Regional

Center for Tobacco Treatment/ UMass Medical School

Central Massachusetts Agency on Aging

Central West Justice Center

Community Impact, Inc.

Congressman Joseph Kennedy's Office

Daily Bread Food Pantry

Dean College

District Attorney Joseph D. Early Jr's Office

Edward M. Kennedy Community Health Center

Family Continuity, Inc.

Franklin Senior Center

Franklin Food Pantry

Friends of the Milford Rail Trail

Health Care for All

Health Foundation of Central MA

Health Resources in Action

Healthy Families

Heartsong Wellness

Hockomock Area YMCA

Juvenile Advocacy Group

Kennedy-Donovan Center

MA Department of Public Health Bureau of Substance Abuse Services

Medway Board of Health

Mendon Council on Aging

Metrowest Health Foundation

Milford Board of Health

Milford Chamber of Commerce

Milford Disability Commission

Milford Family and Community Network

Milford Farmers Market

Milford Police Department

Milford Public Library

Milford Public Schools

Milford Youth Center

Milford Regional Medical Center

NAMI

New Hope Inc.

Nipmuc Regional High School

Northbridge Association of Churches

Planned Parenthood

Reliant Medical Group

Riverside Community Care

Ruth Anne Bleakney Senior Center

Sacred Heart Church of Milford

Salmon Milford VNA

SHINE

SMOC

South Central WIC

Spectrum Health Systems Inc.

St Camilla Adult Day Health

St. Mary's Church of Milford

State Representative Jeffrey Roy

State Representative John Fernandes

Trinity Church of Milford

Tri-Valley Inc.

United Way of Tri-County

Unitarian Universalist Church of Milford

Uxbridge and Northbridge High Schools

Wayside Youth and Family Support Network

Welcoming Milford

Whitin Community Center

You Inc.

495 Partnership