

February 2022

The Greater Milford Community Health Network: CHNA 6 Community Health Improvement Plan



Greater Milford Community Health Network: CHNA 6

Submitted by:



Health Resources in Action
Advancing Public Health and Medical Research

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Greater Milford Community Health Network: CHNA 6

Dear Greater Milford Community,

We are pleased to present the 2022 Greater Milford Community Health Improvement Plan (CHIP), produced by the Greater Milford Community Health Network: CHNA 6. The CHIP is the culmination of a rigorous five-month process beginning in the fall of 2021 with the first community meeting of CHNA 6 to prioritize key findings of the 2021 Community Health Needs Assessment.

Together we identified three priorities to focus our collective efforts: Mental Health and Substance Use; Food Insecurity; and Homelessness. We also identified a central focus of health equity as a cross-cutting topic that impacts all of these areas. Each priority has a series of objectives, accompanied by metrics and actionable strategies, which provide achievable health improvement for the greater Milford region. We urge residents, municipalities, businesses and nonprofit organizations to review the goals, objectives and strategies outlined in this plan to determine how we can work together to support these efforts and improve the health and wellbeing of all those who work and live in the Greater Milford region.

We are grateful to the steering committee and work group members listed in the appendix who contributed many hours of time to create this plan. That this effort took place during the COVID-19 pandemic requires special mention, and we wish to express our sincerest appreciation to everyone who contributed their thoughtful input. Finally, we want to thank Health Resources in Action for leading us through this effort. Their patient guidance, content expertise, and group facilitation kept us engaged, focused and mindful of equity through the process.

We look forward to partnering with you in this collective work over the next three years.

Sincerely,

Rebecca Donham, Chair

Marcel Descheneaux, Vice Chair

Executive Summary

The conditions in the environments where we live, learn, work, and play affect 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 Community Health Network (CHNA 6) engaged in a comprehensive community health improvement effort to measurably improve the health of the coalition's area residents. This effort included two major phases:

- A **community health needs assessment (CHNA)** to identify the health-related needs and strengths of the coalition's community. The 2021 CHNA was conducted with the Milford Regional Health Center (MRMC) by Holleran Consulting, with many CHNA 6 members participating as key informants and survey participants.
- 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 the coalition's community. The 2022 Greater Milford Community Health Network – CHNA 6 Community Health Improvement Plan was developed over the period of September 2021 to February 2022. The priorities for the CHIP were selected based on key findings from the 2021 CHNA.

CHNA 6 contracted with Health Resources in Action (HRiA), Inc., a non-profit public health organization located in Boston, MA, as a consultant partner to guide and facilitate the CHIP planning process. HRiA has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally, including state-level plans in Massachusetts and Connecticut.

To develop a shared commitment and plan for improved community health, and to help sustain implementation efforts, the CHNA 6 planning process engaged coalition members, community members, public health partners, and members of local organizations. Participants in the process identified priorities for the plan and attended a series of virtual planning sessions. Of note, all engagement for the Community Health Improvement Plan was done virtually due to the ongoing novel coronavirus-COVID-19 pandemic.

CHNA 6 planning participants used common criteria and a multi-voting process to narrow the focus and identify the following priority issues to address in the CHIP:

Priority Area 1: Mental Health and Substance Use

Goal 1: All community members have equitable, inclusive access to community-based and person-centered mental health and substance use services that build and sustain resiliency and overall well-being.

Priority Area 2: Food Insecurity

Goal 2: All community members have equitable access to nutritious and culturally appropriate food resources in a way that promotes individual dignity.

Priority Area 3: Homelessness

Goal 3: All community members can easily access or maintain safe, culturally competent and inclusive shelter/housing in a timely manner, and in a way that maintains and promotes their dignity and that is respectful of their various life experiences.

Health Equity was identified as a cross-cutting theme for the CHIP. It is integrated across the plan and is incorporated into each priority through related strategies.

Implementation of this Community Health Improvement Plan will be a collaborative effort between CHNA 6 coalition members, its partners, and grantees from across the communities of Bellingham, Blackstone, Douglas, Franklin, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, Sutton, Upton and Uxbridge.

Introduction

Background

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. The Greater Milford Community Health Network – CHNA 6 led its second comprehensive community health improvement process to measurably enhance the health of the communities in the Greater Milford area of Massachusetts.

CHNA 6 is a partnership with the Massachusetts Department of Public Health, the Milford Regional Medical Center, local service agencies, schools, businesses, Boards of Health, community health centers and other health organizations, as well as other concerned citizens who are working together to build healthier communities.

Following the development of the Community Health Needs Assessment, CHNA 6 contracted with Health Resources in Action (HRIA), a non-profit public health consultancy located in Boston, MA, as a consultant partner to guide and facilitate the CHIP planning process. HRIA worked closely with CHNA 6 leadership throughout the fall of 2021 and winter of 2021-2022 to develop the Community Health Improvement Plan.

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 coalitions and local public health departments across 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.

Purpose of a Community Health Improvement Plan

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.

The CHIP provides an essential framework for guiding future services, programs, and policies for community agencies and organizations in the area.

This CHIP is designed to:

- Identify priority issues for action to improve community health
- Outline an implementation and improvement plan with performance measures for monitoring and evaluation
- Guide future community decision-making related to community health improvement

How to Use the CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should 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, learn, work, and play in the Greater Milford area. People, communities, and organizations should review the CHIP's priorities and goals, reflect on the suggested strategies, and consider how to participate in this effort, in whole or in part.

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 health of CHNA 6's communities. 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 for inclusion in this CHIP.

Context for the Community Health Improvement Plan

COVID-19 Pandemic

The novel coronavirus (COVID-19) pandemic coincided with the activities of the CHNA 6 2022 CHIP. In September 2021, at the beginning of this CHIP process, the COVID-19 pandemic had already been in effect for over a year. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHIP (e.g., work groups for the planning sessions) and the availability of key stakeholders and community members to participate in CHIP activities, given their focus on addressing immediate needs related to the pandemic. As a result, all engagement occurred in a virtual setting.

National Movement for Racial Justice

Over the past 18 months, sparked by the national protests for racial equity amidst the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others, national attention focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHIP. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in 2021 in the form of increased dialogue, locally and nationally, as context for this plan.

Community Engagement

To develop a shared commitment and plan for improved community health, and help sustain implementation efforts, the planning process engaged community members and local public health partners through different avenues:

The **CHNA Steering Committee** was responsible for overseeing the development of the community health improvement plan

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

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

Development of Data-Informed, Community-Identified Health Priorities

Priorities for the community health improvement plan (CHIP) were identified by examining data and themes from the community health needs assessment findings using a systematic, engaged approach. The following themes emerged most frequently and were considered in the selection of the CHIP health priorities:

- Mental Health & Substance Use
- Health Care Access/Health Insurance
- Health Outcomes in Worcester County
- Food Insecurity & Homelessness

CHNA 6 leadership decided to remove Health Outcomes in Worcester County from the list of priorities to be considered, as this issue is much broader than the CHNA's service area and the Milford Regional Health Center would be focusing on health outcomes as part of the hospital's strategic implementation plan (SIP). The decision was also made to separate food insecurity and homelessness into two distinct priorities for consideration.

At a Prioritization Session held in early October 2021, 25 coalition members and other invited community members reviewed the key findings of the community health needs assessment and engaged in a facilitated discussion of the findings using the following questions:

1. Are these findings consistent with your experience and/or understanding of the community?
2. Is there anything new or surprising in these findings?
3. Is there information that you feel is important that is missing as part of this discussion?

As a result of the discussion, childcare was added to the list of potential priorities for consideration. Participants were then guided through the use of an online multi-voting tool to identify their two top choices for CHIP priorities, taking the following selection criteria into consideration:

RELEVANCE How Important Is It?	APPROPRIATENESS Should We Do It?	IMPACT What Will We Get Out of It?	FEASIBILITY Can We Do It?
<ul style="list-style-type: none">- Burden (magnitude and severity; economic cost; urgency) of the problem- Community concern- Focus on equity and accessibility	<ul style="list-style-type: none">- Ethical and moral issues- Human rights issues- Legal aspects- Political and social acceptability- Public attitudes and values	<ul style="list-style-type: none">- Effectiveness- Coverage- Builds on or enhances current work- Can move the needle and demonstrate measurable outcomes- Proven strategies to address multiple wins	<ul style="list-style-type: none">- Community capacity- Technical capacity- Economic capacity- Political capacity/will- Socio-cultural aspects- Ethical aspects- Can identify easy short-term wins

The voting results were as follows:

Potential Priorities	Polling Results
Mental Health & Substance Use	20 votes
Food Insecurity	9 votes
Homelessness	8 votes
Child Care	5 votes
Health Care Access/Health Insurance	4 votes

As a result, Mental Health & Substance Use, Food Insecurity, and Homelessness were selected as the priority areas for the 2022 CHIP. The following table contains a list of potential topics for objectives under each priority based on the assessment findings.

Priorities	Potential Objective Topics
1 Mental Health and Substance Use	<ul style="list-style-type: none"> • Mental Health/Behavioral Health Services & Providers • Suicide Prevention • Substance Use/Alcohol Use Services
2 Food Insecurity	<ul style="list-style-type: none"> • Access to healthy foods • Access to reliable sources of food • Ability to afford healthy foods/high cost of healthy foods
3 Homelessness	<ul style="list-style-type: none"> • Inability to pay rent or mortgage • Importance of safe shelter, especially for families • Providing services to people experiencing homelessness

These three priority areas were the focus of virtual planning sessions conducted to identify goals, measurable objectives, outcome indicators, and strategies to address these issues. **Health Equity** was highlighted as a cross-cutting theme, and, as such, has been integrated across the plan and is incorporated into each priority through related strategies. CHNA 6 leadership had a strong desire to focus the efforts of this CHIP on the root causes, or Social Determinants of Health, and on the policies, systems and environmental factors that contribute to the health issues that emerged from the assessment. This focus is reflected across the elements of this plan.

Development of the CHIP Strategic Components

Planning Model

Planning for the CHIP took place virtually via Zoom due to the COVID-19 pandemic. CHNA 6 leadership recruited community members and partners who work in the areas of mental health and substance use, food insecurity, and homelessness to join coalition members as participants in the planning sessions. All planning participants were invited to participate in a Pre-Planning Session conducted by HRiA to ensure planning participants were well prepared for the planning sessions, understood the evolution and context for the CHIP, and were clear about expectations for engagement.

Following the Pre-Planning Session, four virtual planning sessions were held between October and November 2021. The sessions ranged in length from 1.5 to 3 hours and were structured in both small and large group formats to develop plan components (goals, objectives, potential outcome indicators, strategies, and potential partners). Sessions were facilitated by consultants from HRiA and included opportunities for cross-priority feedback and refinement of each of the core elements of the CHIP. Over 35 people participated across the Prioritization, Preplanning and Planning Sessions. See Appendix A for a list of CHIP planning participants.

Following the planning sessions, HRiA consultants reviewed the draft output from the workgroups and edited the plan components for clarity and consistency. CHNA 6 leadership shared the CHIP with the Steering Committee, subject matter experts, external partners, and other key stakeholders for input and feedback. The input and feedback were reviewed and has been incorporated into the final version of the CHIP where appropriate. See Appendix B for a list of CHNA 6 Steering Committee members.

The working groups established for implementation of the CHIP will finalize outcome indicators, including identification of baselines, targets and data sources, as part of the Year 1 Action Planning process for implementation.

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

The following pages outline the Goals, Objectives, Outcome Indicators, Strategies, and Potential Partners for the three priority areas outlined in the CHIP. See Appendix C for definitions of these planning terms. See Appendix D for a list of Acronyms used in the CHIP.

CHIP Snapshot

Priorities	Goals	Objectives
Priority Area 1: Mental Health and Substance Use	Goal 1: All community members have equitable, inclusive access to community-based and person-centered mental health and substance use services that build and sustain resiliency and overall well-being.	1.1: Expand and enhance the mental health and substance use workforce who are providing culturally informed and responsive services by 2025.
		1.2: Increase the number of places all community members can access culturally informed and responsive mental health and substance use resources by 2025.
		1.3: Increase awareness and understanding of mental health and substance use as health needs to reduce stigma in accessing services by 2025.
Priority Area 2: Food Insecurity	Goal 2: All community members have equitable access to nutritious and culturally appropriate food resources in a way that promotes individual dignity.	2.1: Increase the number of residents who access available resources by 20% by 2025.
		2.2: Increase the number of delivery options by five by 2025.
		2.3: Assess the food security barriers of the three most underserved cultures/populations represented in our communities by 2025.
		2.4: Establish three new food resource partnerships by 2025.
		2.5: Promote sustainability of healthy food practices by increasing participation in food preparation and nutrition programs by 20% by 2025.
Priority Area 3: Homelessness	Goal 3: All community members can easily access or maintain safe, culturally competent and inclusive shelter/housing in a timely manner, and in a way that maintains and promotes their dignity and that is respectful of their various life experiences.	3.1: Establish a centralized online site where existing resources to address shelter and housing insecurity are easily accessible by 2025.
		3.2: Increase the awareness of skills programs that address the needs identified by individuals experiencing or at risk of homelessness by 2025.
		3.3: Identify and support legislation that spans the social determinants of health in regard to housing (e.g., livable wage, safe and healthy housing, shelters, and affordable housing) by 2025.
		3.4: Increase the number of longer-term shelter placement options, including transitional housing, to enable people to secure safe and stable housing by 2025.

CHIP Elements by Priority Area

Priority Area 1: Mental Health and Substance Use

Mental health/suicide was identified as a top health issue by three fifths (60.2%) of key informants in the 2021 Milford Regional Medical Center (MRMC) Community Health Needs Assessment (CHNA). *Mental health/suicide* was selected by key informants as the top health issue across all age categories, with the exception of 0-10 years age category. *Substance abuse/alcohol abuse* was identified by over two thirds (67.1%) of key informants as a top health issue, specifically among those aged 21-40, followed by *behavioral health* (53.1%) as a top health issue. In addition, *mental health services* were chosen as the most needed resource in the community and one third of CHNA key informants stated that *substance abuse services* were missing or lacking in the community.²

Mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. According to Healthy People 2030, about half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Estimates suggest that only half of all people with mental disorders get the treatment they need.³ While mental disorders affect people of all age and racial/ethnic groups, some populations such as are disproportionately affected. According to the National Institute of Mental Health, in 2020 the prevalence of any mental illness was higher among females (25.8%) than males (15.8%), was more prevalent in young adults aged 18-25 (30.6%) as compared to adults aged 26-49 years (25.3%) and aged 50 and older (14.5%), and was more prevalent among the adults reporting two or more races (35.8%) than by White adults (22.6%).⁴

This plan intends to address mental health and substance abuse by expanding and enhancing the mental health and substance use workforce who are providing culturally informed and responsive services; increasing the number of places all community members can access culturally informed and responsive mental health and substance use resources; and increasing the awareness and understanding of mental health and substance use as health needs to reduce stigma in accessing services.

Goal 1: All community members have equitable, inclusive access to community-based and person-centered mental health and substance use services that build and sustain resiliency and overall well-being.

Objective 1.1: Expand and enhance the mental health and substance use workforce who are providing culturally informed and responsive services by 2025.

Potential Outcome Indicators

- Number of providers in our region accepting insurance
- Number of providers in our region accepting MassHealth
- Number of providers who speak languages other than English

Strategies

- 1.1.1 Research and promote the development of incentive programs to increase the number of providers in our region who are providing culturally informed and responsive services.
- 1.1.2 Provide a broad range of training opportunities that educate existing workforce and community leaders around topics such as cultural humility, trauma-informed approaches, early and comprehensive assessment and awareness of the root causes of health.
- 1.1.3 Gather more information, as needed about issues/barriers providers face in providing culturally relevant services.
- 1.1.4 Assess the region's jail diversion programs and possibilities for expansion of social worker ride-alongs with law enforcement (e.g., to other towns and hours beyond 9:00am-5:00pm)

Objective 1.2: Increase the number of places all community members can access culturally informed and responsive mental health and substance use resources by 2025.

Potential Outcome Indicators

- Size of waitlists (Number of people)
- Amount of time to wait for an appointment
- Number of providers who provide culturally relevant Mental Health/Substance Use services
- Number of providers who accept MassHealth

Strategies

- 1.2.1 Establish a baseline of the number of places including where there are gaps in services – based on where and how people want to get services (e.g., telehealth, texting appointments, self-care, length of appointments).
- 1.2.2 Educate and promote the use of existing resources (e.g., 988, 211, behavioral health access lines) through various channels (e.g., community forum, database, social media).
- 1.2.3 Work to increase the number of providers who accept MassHealth.
- 1.2.4 Advocate for MassHealth members to have expanded access to culturally relevant resources.

Objective 1.3: Increase awareness of and understanding of mental health and substance use as health needs to reduce stigma in accessing services by 2025.

Potential Outcome Indicators

- Specific data points from the MetroWest Adolescent Health Survey
- Specific data points from the Behavioral Risk Factor Surveillance System (BRFSS)
- Share outcome indicators from NAMI
- Informal pre- and post-tests at community forums
- Number of people attending community forums
- Survey town leaders on their perceptions

Strategies

- 1.3.1 Foster community discussion and sharing of stories through community forums or other methods.
- 1.3.2 Create opportunities for families supporting those with SUD/MH challenges to better advocate for their loved ones and find emotional support for themselves.
- 1.3.3 Align messaging with the state's new Behavioral Health Roadmap.
- 1.3.4 Educate town leaders on the importance and urgency of mental health and substance use care; and the need for more services/resources.

Priority Area 2: Food Insecurity

Food insecurity was identified as a top health issue by over a third (36.7%) of CHNA key informants. The high *cost of healthy foods and/or gym memberships* was the top barrier to staying healthy as identified by over half (55.2%) of CHNA key informants. Key informants identified *difficulty meeting basic needs* as the second highest barrier (44.8%) to staying healthy and identified *lack of access to fresh fruits and vegetables* (17.7%) as another barrier. Within the 0 to 10 years age bracket, key informants identified *food insecurity* and *nutrition* as the second and third top health issues, surpassed only by, *behavioral health*.

Nearly a third (32.3%) of CHNA key informants identified *basic needs not met (food/shelter)* as a barrier to accessing health care, with about one in six (16.8%) identifying that barrier as one of the most significant. Almost a third (30.2%) of key informants indicated that *basic needs not met (food/shelter)* was a missing or lacking resource/service related to health.⁵

Access to nutritious foods is one of the social determinants of health (SDOH) – factors that have a major impact on people’s health, well-being, and quality of life. As an example, people who don't have access to grocery stores with healthy foods are less likely to eat a variety of foods that provide the nutrients needed to maintain health, feel good, and have energy. This raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.⁶

This plan intends to address food insecurity by assessing the barriers of the most underserved populations in our communities; increasing the number of residents who have access to available resources; increasing the number of food delivery options for nutritious and culturally appropriate food; establishing new food resource partnerships; and promoting the sustainability of healthy food practices.

Goal 2: All community members have equitable access to nutritious and culturally appropriate food resources in a way that promotes individual dignity.

Objective 2.1: Increase the number of residents who access available resources by 20% by 2025.

Potential Outcome Indicators

- Food pantry access numbers
- Number of program participants
- Supplemental Nutrition Assistance Program (SNAP) Enrollment
- Farmers Market visits

Strategies

- 2.1.1 Promote the food calendar through a wide variety of locations and organizations (e.g., faith-based organizations, daycares, hairdressers, urgent care, clinics, municipal buildings, libraries, schools, universities, grocery stores, senior centers)
- 2.1.2 Promote partnerships between smaller communities to develop regional food calendars.
- 2.1.3 Promote available resources, including programs such as SNAP WIC, through existing communication mediums (e.g., local cable access, social media, radio (highlight resources through series on food resources), local newspapers)
- 2.1.4 Develop informational sessions on available food resources and how to access them in multiple platforms and languages (e.g., Conduct Q&A sessions, develop YouTube video).
- 2.1.5 Provide educational materials to local agencies and community partners (e.g., case managers, community health workers, first responders).

Objective 2.2: Increase the number of healthy food access and delivery options by five by 2025.

Potential Outcome Indicators

- Number of delivery options
- Number of new access points
- Number of food pantry barriers in CHNA 6 communities
- Number of new stakeholders engaged
- Number of advocacy efforts

Strategies

- 2.2.1 Engage local farms and community stakeholders to collaborate on mobile farmer's markets.
- 2.2.2 Promote collaboration between food rescue organizations and community sites to establish a new delivery site(s).
- 2.2.3 Confirm and promote enrollment in home grocery delivery services using SNAP benefits
<https://www.mass.gov/snap-online-purchasing-program>
- 2.2.4 Advocate for the importance of public/community transportation related to food insecurity.

Objective 2.3: Assess and address the food security barriers of the three most underserved populations represented in our communities by 2025.

Potential Outcome Indicators

- Number of barriers identified
- Number of barriers addressed
- Number of residents from underserved populations who are food insecure

Strategies

- 2.3.1 Identify the three most underserved cultures/populations represented in our communities.
- 2.3.2 Identify community leaders who are part of and/or work with the cultures/populations to establish trust.
- 2.3.3 Engage community representatives to identify food insecurity barriers for underserved populations.
- 2.3.4 Share assessment findings with community food providers.
- 2.3.5 Work collaboratively with community representatives and stakeholders to address food insecurity barriers identified.

Objective 2.4: Establish three new food resource partnerships by 2025.

Potential Outcome Indicators

- Number of CBO's/non-traditional partners engaged in partnerships
- Establishment of quarterly food collaborative

Strategies

- 2.4.1 Identify existing and facilitate new food resource partnerships.
- 2.4.2 Conduct outreach to non-traditional food partners (e.g., tech schools, churches, CBO's).
- 2.4.3 Assess community interest in being part of a food resource partnership.
- 2.4.4 Explore quarterly food collaborative and invite interested organizations.

Objective 2.5: Promote sustainability of healthy food practices by increasing participation in food preparation and nutrition programs by 20% by 2025.

Potential Outcome Indicators

- Number of individuals participating in educational programs
- Number of partners engaged in providing programs
- Number of languages programs are offered in

Strategies

- 2.5.1 Assess existing resources/trainings and promote them (e.g., Milford Regional, MassHire, YMCA – Cooking Matters).
- 2.5.2 Engage the community in assessment of knowledge, skills and resources needed to promote sustainability of nutritious food purchasing, preparation, and overall diet.
- 2.5.3 Identify opportunities and mediums to share these resources.
- 2.5.4 Explore incentives to engage community members in trainings (childcare, stipends, food preparation materials).
- 2.5.5 Distribute information about skill building programs to food resource providers and stakeholders.

Priority Area 3: Homelessness

Homelessness was identified as a top health issue by over a quarter (26.5%) of key informants in the 2021 MRHC Community Health Needs Assessment. People experiencing *homelessness* were identified by CHNA key informants as the third highest of specific populations that were underserved in the community, surpassed only by *low-income/poor* and *uninsured/underinsured*, which were number one and number two respectively.⁷ The COVID-19 pandemic has exacerbated the challenges faced by people experiencing homelessness with the loss of employment and barriers in access to COVID-19 testing and immunizations.

Access to housing is another of the social determinants of health (SDoH) – factors that have a major impact on people’s health, well-being, and quality of life. The link between homelessness and health is evident in the high rates of chronic mental and physical health conditions that are faced by people experiencing homelessness, the greater risk of contracting and spreading communicable diseases, and barriers to care, such as inability to access care when needed or comply with prescribed medications.⁸

This plan intends to address homelessness in the region through legislation that spans the social determinants of health in regard to housing; increasing longer-term shelter placement options; increasing awareness of skills programs that address the needs identified by people experiencing or at risk of homelessness; and establishing a centralized online site where existing resources to address shelter and housing insecurity are easily accessible.

Goal 3: All community members can easily access or maintain safe, culturally competent and inclusive shelter/housing in a timely manner, and in a way that maintains and promotes their dignity and that is respectful of their various life experiences.

Objective 3.1: Establish a centralized online site where existing resources to address shelter and housing insecurity are easily accessible by 2025.

Potential Outcome Indicators

- Establishment of the centralized resource

Strategies

- 3.1.1 Outreach to community partners to gather information on similar efforts and to identify existing resources.
- 3.1.2 Identify a host for the centralized, online site (e.g., explore potential corporate sponsor(s) or other financial backers).
- 3.1.3 Establish expectations for developing and maintaining the centralized, online site, including instructions for use of existing tools (e.g., Google Translate) to translate site information into other languages.
- 3.1.4 Include information on accessibility of resources (e.g., languages, ADA accessibility).
- 3.1.5 Make community partners and community members aware of the “new” resources.

Objective 3.2: Increase the utilization of skills programs that address the needs identified by individuals experiencing or at risk of homelessness by 2025.

Potential Outcome Indicators

- Number of programs
- Number of filled slots in programs

Strategies

- 3.2.1 Determine what programs exist and accessibility of each (e.g., in what languages they are offered, translation/interpreter services offered, whether they are ADA compliant, culturally appropriate/competent (establish criteria), cost of program, financial assistance available, location, transportation (in-person/virtual)).
- 3.2.2 Pull together the people who work on transition/life skills, and who engage the community, (e.g., summit) to share information, ideas, and ways to raise awareness, and define the scope of the homelessness/at risk of homelessness situation in each community.
- 3.2.3 Encourage service providers and organizations to offer new/expanded skills programs in areas where gaps in programming may exist.
- 3.2.4 Coordinate efforts between service providers and organizations offering skills programs to match people, including marginalized populations, with skills programs based on individual needs.

Objective 3.3: Identify and support legislation that spans the social determinants of health in regard to housing (e.g., livable wage, safe and healthy housing, shelters, and affordable housing) by 2025.

Potential Outcome Indicators

- Number of pieces of legislation supported

Strategies

- 3.3.1 Develop a “short list” of action steps on what to do to when legislation is being considered and whether CHNA 6 will advocate for support of the legislation.
- 3.3.2 Connect with partners in Massachusetts to learn about upcoming legislation to be considered.
- 3.3.3 Communicate with CHNA 6 partners on ways that they can advocate for or against upcoming legislation.
- 3.3.4 Offer education, including the impact on public health, to partners and local legislators on the pending legislation.

Objective 3.4: Increase the number of longer-term shelter placement options, including transitional housing, to enable people to secure safe and stable housing by 2025.

Potential Outcome Indicators

- Number of longer-term options for shelter beds
- Number of transitional housing beds

Strategies

- 3.4.1 Identify the need by community for shelter/transitional housing needs. See also Strategy 3.2.2
- 3.4.2 Share information on successful models and/or best practices from other communities (e.g., Fitchburg example of Catholic Charities).
- 3.4.3 Explore options for cooperating with shelters in communities that border the Greater Milford service area, including RI.
- 3.4.4 Raise awareness of the need for increased capacity, where needed (e.g., community members, organizations who work with the homeless, local leaders).
- 3.4.5 Promote programs that enable people to find long-term solutions to potential homelessness.

Next Steps – Implementation Phase

The components included in this report represent the strategic framework for a data-informed, Community Health Improvement Plan. The members of the CHNA 6 coalition, CHIP workgroups, partners, stakeholders, and community residents, have finalized the CHIP and will develop a Year 1 Action Plan that includes: prioritized strategies and specific 1-year action steps, identified lead responsible parties and resources for each prioritized strategy. The implementation plan will include monitoring and evaluation processes and procedures to ensure that successes and challenges are captured on an annual basis. Working groups for each priority area, comprised of partners, stakeholders, and community participants, will be responsible for this annual process for updating the plan. A yearly CHIP progress report will illustrate performance, incorporate, new data, identify environmental changes, and will inform subsequent annual implementation planning.

Appendices

Appendix A: CHIP Planning Participants

Appendix B: CHNA 6 Steering Committee Members

Appendix C: Planning Definitions

Appendix D: Acronyms

Appendix E: Potential Partners

Appendix A: CHIP Planning Participants

Priority Area 1: Mental Health & Substance Use (MHSU)

Priority 2: Food Insecurity (FI)

Priority 3: Homelessness (H)

Kate Baker, MetroWest Health Foundation (H)
Donna Boynton, Milford Regional Medical Center (FI)
Kori Brousseau, New Hope, Inc. (FI)
Sue Clark, Ruth Anne Bleakney Senior Center (H)
Craig Consigli, Milford High School (H)
Marcel Descheneaux, Riverside Community Counseling (MHSU)
Rebecca Donham, MetroWest Health Foundation (MHSU)
Sue Durkin, Loaves and Fishes Food Pantry (FI)
Heather Elster, Whittin Community Center (MHSU)
Debbie Froehlich, Complete VNA
Rebecca Gallo, MetroWest Health Foundation (FI)
Terri Graham, Bellingham Senior Center
Maggie Gunderson, Franklin Senior Center (H)
Alyssa Henry, Seven Hills Foundation
Sara Humiston, Milford Family and Community Network (MHSU)
Cathleen Liberty, Franklin Health Department
Craig Maxim, Family Continuity (MHSU)
Kayla Marinelli, Tri-Valley, Inc. (FI)
Noriasha Adomako Mensah, Central Mass Tobacco-Free Community Partnership
Kimberly Mu-Chow, New England Chapel (H)
David Nefussy, Spectrum Health Systems
Erin O'Brien, Worcester County Food Bank (FI)
Leslie Reichert, The Cleaning Coach
Candice Richardson, Edward M. Kennedy Community Health Center (MHSU)
Alex Robtoy, Catholic Charities Worcester County (FI)
Anna Spencer, Wayside Youth & Family Support Network (MHSU)
Ryan Sherman, Medway Public Schools
Daniel Stone, First United Methodist Church of Milford (H)
Ana Maia Talma, Edward M. Kennedy Community Health Center (H)
Hannah Tavares, Milford Board of Health (H)
Lisa Trusas, Chris' Corner Recover Resource Center
Jennifer Ward, Milford Youth Center (FI)
Jacquelyn Woznicki, Tri-Valley, Inc.

Appendix B: CHNA 6 Steering Committee Members

Chair: Rebecca Donham, MetroWest Health Foundation

Vice-Chair: Marcel Descheneaux, Riverside Community Care

Donna Boynton, Milford Regional Medical Center

Susan Clark, Ruth Anne Bleakney Senior Center

Craig Consilgi, Milford Public Schools

Luisa Fundora, MA Department of Public Health

Sara Humiston, Milford Family and Community Network

Cathleen Liberty, Franklin Health Department

Kimberly Mu-Chow, New England Chapel

Candice Richardson, Edward M. Kennedy Community Health Center

Ryan Sherman, Medway Public Schools

Appendix C: CHIP Planning Definitions

Term	Definition/Description
Priority	Key issues identified from an assessment that provide a focus for planning.
Goal	A goal is a broadly stated, non-measurable change in the priority area. It describes in broad terms a desired outcome of the planning initiative.
Objective	Objectives articulate goal-related outcomes in specific and measurable terms. Objectives state how much of what you hope to accomplish and by when. Objectives are SMART (specific, measurable, achievable, relevant, time-phased).
Outcome Indicators	Indicators are ways to track progress for each of the objectives. They describe the baseline and target values for each objective based on data that are relevant and available.
Strategies	A strategy is a statement of HOW an objective will be achieved. It is less specific than action steps but tries broadly to answer the question, "How can we get from where we are now to where we want to be?"

Appendix D: Acronyms

AA	Alcoholics Anonymous
ADA	Americans with Disabilities Act of 1990
BCBS	Blue Cross Blue Shield
BRFSS	Behavioral Risk Factor Surveillance System
BSAS	Bureau of Substance Addiction Services
CHA	Community Health Assessment
CHAPA	Citizens' Housing & Planning Association
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CMHA	Central Massachusetts Housing Alliance
CMRPC	Central Massachusetts Regional Planning Commission
CNHA 6	Greater Milford Community Health Network
COVID-19	Novel coronavirus pandemic
DHCD	Department of Housing and Community Development
DPH	Department of Public Health
EOHHS	Executive Office of Health and Human Services
FI	Food Insecurity
H	Homelessness
HRiA	Health Resources in Action, Inc.
MA	Massachusetts
MAPP	Mobilization for Action through Planning and Partnerships
MHSU	Mental Health & Substance Use
NA	Narcotics Anonymous
NAMI	National Alliance on Mental Illness
NOWA	No One Walks Alone
RCAP	Rural Community Assistance Partnership
RI	Rhode Island
SBHC	School-Based Health Centers
SIP	Strategic implementation plan
SMART	Specific, measurable, achievable, Relevant, time-phased
SMOC	South Middlesex Opportunity Council
SNAP	Supplemental Nutrition Assistance Program
SUD/MH	Substance Use Disorder/Mental Health
WIC	Women, Infants and Children's Program
YMCA	Young Men's Christian Association

Appendix E: Potential Partners Across Objectives

Potential Partners	Objectives											
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4
Activists											•	
Adult Education Program Providers (low-cost)										•		•
Advocates, Inc.	•											
Alcoholics Anonymous (AA)	•											
Animal Shelters							•					
Assisted Living Facilities					•							
Association for Behavioral Healthcare		•										
Attleborough Area Interfaith Collaborative										•		•
Banks (Financial Literacy Programs)								•				
Before and After School Programs			•	•					•			
Beginning Bridges				•								
Behavioral Health Partners of MetroWest	•	•										
Blackstone Valley Connector									•			
Blackstone Valley Emergency Shelter										•		•
Boards of Health	•	•	•	•		•			•			
Boards of Health/Public Health Inspectors											•	
Bureau of Substance Addiction Services (BSAS)		•										
Career Readiness Programs in Public Schools	•											
Case Managers				•								
Catholic Charities				•	•	•			•	•		•
Celebrate Recovery	•											
Central Massachusetts Housing Alliance (CMHA)									•	•	•	•
Central Massachusetts Regional Planning Commission (CMRPC)												•
Chambers of Commerce		•	•						•	•		•
Childcare Providers		•	•		•	•	•		•	•		
CHNAs		•		•				•	•	•		•
Chris' Corner	•	•	•	•		•		•	•	•		
Citizens Housing and Planning Association (CHAPA)									•	•	•	•
College and University Students			•						•			
Colleges and Universities	•			•	•		•	•	•	•		
Commonwealth Corporation										•		
Community Based Organizations (CBOs)				•	•		•			•		•
Community Centers						•						
Community Disability Coordinators										•		
Community Harvest Project				•	•	•	•	•				
Community Health Centers	•		•	•				•		•		
Community Health Workers (CHW's)				•								
Community Impact	•	•		•					•	•		
Community Leaders			•									
Community Meal Organizers				•	•	•	•	•				

Potential Partners	Objectives											
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4
Community Service Organizations (e.g., Knights of Columbus, Franklin Elks, Bellingham Women of Today)								•				
Continuing Ed Programs				•								
Cooking Matters								•				
Criterion				•								
Daycare Facilities				•				•				
Department of Housing and Community Development (DHCD)										•		•
Edward M. Kennedy Community Health Center	•	•										
Elder Services					•							
Executive Office of Health and Human Services (EOHHS) - State Awareness Campaigns – Behavioral Health Roadmap			•									
Existing Public Organizations (e.g., PTO's)											•	
Faith-Based Organizations	•	•	•	•	•	•	•		•	•	•	•
Family Continuity	•	•	•						•			
Family Resource Center (Milford, others)	•									•		
Farmer's Market vendors				•								
First Responders				•		•			•	•		•
Food Banks				•	•	•	•	•				
Food Pantries				•		•						
Food Rescue Organizations					•							
Food Service Providers						•						
Food Service Providers (food pantries and food rescues)							•					
Grafton Job Corps					•		•	•				
Grocery Stores and other Food Retailers (e.g., Wal-Mart, Target, convenience stores)				•	•		•	•				
Habitat for Humanity												•
Hairdressers				•								
Head Start									•			
Health Care Providers (including Primary Care Providers & Pediatricians)	•	•		•							•	
Healthy Families				•								
Hockomock YMCA									•	•		
Hospitals	•			•						•		
Hotel Grace in Worcester												•
Hotels								•	•			
Housing Authorities and Organizations					•				•			•
Job Search Organizations										•		
Justice System										•		
Law Enforcement / Police Departments	•		•		•	•						
Learn to Cope			•									
Libraries		•		•					•			
Lobbyists											•	
Local Affordable Housing Trusts									•	•	•	•

Potential Partners	Objectives												
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	
Local Businesses		●											
Local Coalitions				●				●	●	●		●	
Local Farmer’s Markets					●								
Local Farms					●		●	●					
Local Large Businesses – Avecia, Target, Amazon, Consigli, Caterpillar, Mien, bigger banks, bigger insurance companies, manufacturers			●						●				
MA Coalition for Suicide Prevention		●											
MA Housing and Shelter Alliance											●		
MA Housing Partnership											●		
MassHealth		●											
MassHire								●		●			
Media (Cable, Radio, Newspapers)		●	●	●			●				●	●	
MetroWest Health Foundation	●												
MetroWest Hunger Group and other collaboratives				●			●						
Milford Regional Medical Center			●					●					
Milford Youth Center			●										
Municipal Departments					●								
Municipal Human Resources			●										
Municipal Leaders Local Leaders, Local Governing Bodies	●		●	●			●		●		●	●	
Narcotics Anonymous (NA)	●												
National Alliance on Mental Illness (NAMI)		●											
Network of Care	●												
New Hope	●		●						●	●			
No One Walks Alone (NOWA) Recovery Support Center	●	●	●	●		●		●	●	●			
Nutritionists								●					
Open Sky Community Service	●	●	●						●				
Organizations Related to Homelessness											●		
Organizations who advocate for Livable-Wage											●		
Organizations who work with Food Insecurity									●				
Pathways to a Better Life Shelter										●			
Potential State-level partners												●	
Project Bread				●	●	●	●	●					
Property Owners & Managers											●		
Realtors												●	
Regional Transit Authorities										●			
Regional Transportation Programs/Services					●								
Restaurants				●			●	●					
Restaurants, fast food, cafes					●								
Ride Share Services (Uber, Lift, DoorDash)					●								
Riverside	●	●	●										
Rural Community Assistance Partnership (RCAP)									●	●	●	●	
Saint Vincent DePaul									●	●			

Potential Partners	Objectives											
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4
Salvation Army									•	•		
School-Based Health Centers (SBHC)				•								
Schools: PreK-12	•	•	•	•	•	•	•		•	•		
Senior Centers			•	•	•	•	•	•	•	•		
Shelters				•					•			
Social Media Networks											•	•
Social Media Pages for Towns				•								
Social Workers	•					•	•					
South Middlesex Opportunity Council (SMOC)									•	•		•
Spectrum			•									
State Department of Public Health	•											
State Elected Officials			•						•		•	
Substance Use Coalitions		•										
Transportation Services										•		
Tri Valley Inc				•	•	•	•	•	•	•		
United Way				•	•	•	•	•	•	•	•	•
Urgent Care Facilities				•								
Veteran's Agencies and Groups								•	•	•		•
Veterans' Service Officers											•	
Vocational Programs										•		
Vocational Technical Schools							•	•				
Wayside Youth and Family Support Network	•		•									
Whitin Community Center			•	•	•		•	•				
WIC				•	•	•						
Worcester Community Action Council				•		•				•	•	
YMCA			•	•	•	•	•	•	•			
YOU Inc	•	•	•									
Youth Centers				•	•		•	•		•		
Zoning Departments					•							•

References

- ¹ Advanced by the National Association of County and City 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/>
- ² Milford Regional Medical Center Community Health Needs Assessment 2021 Final Report, <https://www.milfordregional.org/app/files/public/f71683c8-c7a4-455b-98ba-8a91bcef4416/Milford%20Regional%20Medical%20Center%20-%202021%20CHNA.final.pdf>, 8-9, 48.
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- ⁸ American Public Health Association (APHA), Housing and Homelessness as a Public Health Issue, from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2018/01/18/housing-and-homelessness-as-a-public-health-issue#:~:text=Ending%20homelessness%20is%20a%20public,or%20comply%20with%20prescribed%20medications>