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The Greater Milford Community Health Network: CHNA 6

Community Health Improvement Plan

(Revised December 2024)

Greater Milford Community Health Network: CHNA 6

Submitted by:

Health Resources in Action

Advancing Public Health and Medical Research

Greater Milford Community Health Network: CHNA 6

Dear Greater Milford Community,

In 2021, the Greater Milford Community Health Network: CHNA 6 undertook a 5-month process to create a Community Health Improvement Plan (CHIP) for the Greater Milford region. The 2022 CHIP prioritized the findings from the 2021 Community Health Assessment (CHA) and involved over 35 healthcare providers, municipal agencies, and community-based organizations in the process. The CHIP provides a framework for organizations to work collaboratively to address the region's most pressing health issues. This "collective impact" strategy allows for larger-scale and more lasting social change than could be achieved by individual agencies working in isolation. It was used as a guide for the CHNA's 2022 grantmaking. The steering committee of the CHNA was charged with revisiting the CHIP each year to "improve and further align expectations with outcomes." During the fall of 2024, the steering committee reviewed the CHIP with an eye towards how it could align with the needs that have emerged. What follows is a reimagined CHIP that continues to focus on the goals of the three priority areas identified through the CHA but that identifies ways to address health issues resulting from COVID 19, with an emphasis on Health Equity.

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.[1]

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.[2] 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 comparted 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%).[3]

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 (for example, that speak their language) in our region who are offering culturally informed and responsive services.

1.1.2 Provide a broad range of training and recruitment opportunities that educate existing and potential 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-a longs 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 and services by 2025.

Potential Outcome Indicators

- Size of waitlists (Number of people)
- Amount of time to wait for an appointment
- Number of providers who offer 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 (For example, through social media).

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.[4]

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.[5]

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 recovery organizations and community sites to establish a new delivery site(s) to bring the food-to-food insecure residents lacking transportation
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.
2.2.5 Advocate for and promote healthy meal ready programs for the community
2.2.6 Advocate for and promote use of SNAP benefits in farmer's markets
2.2.7 Promote collaboration between colleges and school districts to donate excess food to food pantries or organizations that provide recovered food to the community.

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 and engage 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.

Objective 2.6: Establish three new partnerships between food providers and organizations with food insecure clients by 2025.

Potential Outcome Indicators

- Number of partnerships between food providers (farms, grocery stores, college cafeterias, etc.) and organizations with food insecure clients
- Number of non-traditional food partners providing recovered food to participants by partnering with another organization

Strategies

2.6.1 Identify community access points (senior centers, places of worship, schools, community centers, health providers, municipal programs, etc.) with food insecure individuals.
2.6.2 Conduct outreach to food pantries and non-traditional food partners (after-school programs, libraries, senior centers, community centers, etc.) to develop partnerships to provide food on a regular basis.
2.6.3 Assess community interest in being part of a food resource partnership within or across CHNA 6 towns.

Objective 2.7: Promote communication and collaboration between organizations providing food within CHNA 6.

Potential Outcome Indicators

- Number of food pantries and organizations that attend regional meetings between organizations providing food within CHNA 6.
- Number of regular regional meetings between organizations providing food within CHNA 6 to share ideas, strategies, successes, and failures.

Strategies

2.7.1 Identify the food pantries and organizations providing food within CHNA 6
2.7.2 Conduct outreach to food pantries and organizations providing food within CHNA 6 in meeting regularly to share ideas, strategies, successes, and failures
2.7.3 Assess community interest in being part of a food resource partnership within or across CHNA 6 towns.

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.[6] 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.[7]

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 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.

References

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[4] 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, 11, 33-34, 48.

[5] Healthy People 2030, Social Determinants of Health, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

[6] 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, 47-48.

[7] 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