

2017 COMMUNITY HEALTH IMPROVEMENT PLAN



MetroWest Region of Massachusetts

July 2017

Introduction

In 2016 several healthcare providers, health departments and community-based organizations came together to conduct a second Community Health Assessment (CHA) for the MetroWest region (<https://www.mwhealth.org/Portals/0/Uploads/Documents/MetroWestCommunityHealth%20Assessment2016.pdf>). This assessment, like the first, compiled local health data and community input to provide a detailed and complete profile of our region's health needs.

Following the release of the CHA, the working group continued to meet to create a revised Community Health Improvement Plan (CHIP). Once again, the CHIP's geographic focus area was the following towns: Ashland, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland and Westborough.

The data revealed that the four priority areas from the 2013 assessment were still the top concerns. These were access to care, behavioral health, healthy aging, and healthy eating/active living. The working group hosted a community meeting to identify the top objectives within each priority area. Over 40 people representing diverse agencies and community organizations attended the planning meeting.

The CHIP provides a framework for organizations to work collaboratively to address the region's most pressing health issues. This "collective impact" strategy will allow for larger-scale and more lasting social change than could be achieved by individual agencies working in isolation. This year's CHIP reflects an important change from the 2015 plan: greater focus on fewer objectives. When it came to evaluating the impact of the 2015 CHIP, the working group learned that establishing too many objectives and strategies diluted the impact of the work and created challenges to measuring achievement.

Priority Improvement Areas (in alphabetical order)



ACCESS TO CARE

- Health Literacy
- Patient Navigation
- Insurance Coverage



BEHAVIORAL HEALTH

- Opioid Overdoses
- Youth Mental Health and Substance Use
- Cultural and Linguistic Competency



HEALTHY AGING

- Behavioral Health
- Falls Reduction
- Access to Care



HEALTHY EATING/ACTIVE LIVING

- Food Insecurity
- Fresh Fruits & Vegetables
- Physical Activity

Progress on 2015 CHIP

As a first step in creating an updated Community Health Improvement Plan, the working group conducted a survey of health and human service organizations to assess progress towards the 2015 CHIP. Twenty-six agencies completed the survey.

ACCESS TO CARE

Insurance Enrollment and Education: Agency providers worked toward insurance enrollment by breaking down barriers for individuals seeking insurance coverage. Organizations focused on working with minority groups by providing assistance in multiple languages (Spanish and Portuguese). To acknowledge transportation barriers, organizations provided services in community spaces (schools, churches, local sites) with public transit or offered ambulatory clinics. Many organizations worked with individuals and families with children by providing one to one education of insurance benefits and supporting the enrollment process. Community education also occurred through forums, presentations, community events, and collaborative education on preventative procedures (e.g. screening for diabetes). Agencies often talked about insurance enrollment and education in relation to one another rather than mutually exclusive categories.

Increase Primary Care and Care Coordination: Only one respondent identified itself as directly impacting primary care by including two new internists and one new family practice physician. The same respondent opened two new urgent care facilities with evening and weekend hours. Most respondents did not directly increase the number of primary care providers in the region. However, respondents were able to introduce community health workers and other medical providers that helped improve access. Respondents indicated that they are constantly trying to increase provider networks, but find difficulty recruiting providers based on market competition; innovative approaches, such as loan repayment, are being utilized to attract potential candidates. Agencies providing care coordination focused on disease management, cultural competency, high risk patient connectivity, follow-up visits, prescription medication compliance, social determinants of health, providing referrals and creating interagency partnerships and contracts.

Example

Agency	Progress
Marlborough Hospital	1) Primary care practice was established in Northborough which included two internists and one family practice physician. 2) Opened two urgent care facilities – one in Marlborough and one in Northborough to augment primary care practices by providing evening and weekend hours of care.
Edward M. Kennedy Community Health Center	1) Hired two Community Health Workers to work with adults out of compliance with preventative and chronic disease care and to enroll children new to Framingham to increase access to care.

BEHAVIORAL HEALTH

Integration/Coordination: Many behavioral health providers reported working across agencies as partners to offer a vast array of behavioral health services to their patients. Some services reported included providing integrated care management programs and co-located BH services at primary care practices. Primary care practices have made a shift towards inclusion of behavioral health assessments or “warm hand offs”. School systems reported working with behavioral health care providers and sharing information to support the needs of students and families.

Increased Access: There has been some progress in reducing disparities among ethnic and linguistic minority MetroWest residents. One organization reported expanding psychiatry and outpatient therapy services for uninsured Spanish and Portuguese speakers. Several respondents provided translated documents in Spanish and Portuguese and hired bilingual or trilingual staff in direct service and management positions to support the needs of the population. While many organizations offer services in multiple languages, some respondents reported that the need exceeds the organization’s capacity.

Respondents also reported the integration of new systems which led to an increase in behavioral health access. One agency reported the introduction of “same day access for outpatient services” which allowed for increased access to immediate behavioral health care for clients. Brief screenings and referrals to treatment have been put in place at community health centers, primary care appointments, and mental health screening kiosks.

Behavioral Health Education/Stigma Reduction: A wide variety of public education opportunities have been explored to reduce stigma related to mental health. Online mental health screenings, MindKare Kiosks, and SOS Signs of Suicide are tools used to educate the public. The mental health screening kiosks have been included in municipal buildings to increase awareness of mental health conditions. Organizations participated in community meetings, community educational programs (series), task forces, educational forums and local Brazilian radio stations. Education was provided across populations: youth, families, individuals, older adults, ethnic and linguistic minorities. Organizations also reported reviewing internal policies and updating implementation practices to reduce stigma associated with mental health.

Youth Mental Health: While the survey did not generate many responses, there have been mental health services, including sports-based group therapy, introduction of small group education and mindfulness curricula in schools, stress management programs in high schools, nutrition education, hosting wellness fairs and workshops, and working with young adults on mental health recovery issues. Many schools have replicated the Bridge for Resilient Youth in Transition program to help students returning to school from psychiatric or medical hospitalization and Wellesley College has screened every Natick High School student for depression and have referred parents to Interface for treatment providers.

Example

Agency	Progress
Hudson Health Department	1) Created the MetroWest HOPE program, which is a walk-in center providing clinical assessment and referral to treatment for substance users. 2) Installed Massachusetts' first publicly accessible mental health screening kiosk to provide a brief assessment of various mental health conditions and local/regional treatment and support resources.
Advocates	1) Expanded number of clinicians in outpatient clinics in Framingham and Marlborough. 2) Advocates, SMOC and Wayside collaborated to create a new LLC, the Behavioral Health Partners of MetroWest, to improve access to BH and other services. 3) Co-located behavioral health services at two primary care practices with bilingual and trilingual staff.

HEALTHY AGING

Falls Prevention: Marlborough Hospital, MetroWest Medical Center, the Edward M. Kennedy Community Health Center, local senior centers, Natick VNA and the Latino Health Insurance Program offer falls prevention initiatives. Interventions included one to one screenings, in-home safety assessments, peer groups, and classes offered in the community to reduce the risk of falls. An evidence-based program, *A Matter of Balance*, was cited as a resource used.

Mental Health and Social Isolation: A number of interventions were utilized across the region to support the mental health of older adults. Behavioral health providers built partnerships and collaboration with area senior centers. Interventions included homebased mental health services, peer groups, individual and group support, assisting individuals to connect with providers specializing in working with older adults, expanded access to psychiatry and mental health services for uninsured patients, referrals, and screenings and referrals for depression.

Isolation was addressed in a variety of programs offered in the area. Groups provided to seniors focus on reducing isolation by discussing loss and loneliness to increase connection with other older adults. Evidence-based fitness programs were utilized to promote wellness as well as increase social interaction.

Care Coordination: Some respondents provided answers in the “access to care” section and noted that their efforts were directed to older adults as well as the general population. Respondents identified municipality efforts though task forces, senior center collaboration, case management services, YMCA partnerships, and school involvement.

Transportation: Respondents work with Dial-A-Ride, senior centers, Jewish Family Service, MetroWest Regional Transit Authority and BayPath Elder Services to coordinate local transportation to primary and specialty care. The focus on transportation largely surrounded older adults’ ability to attend medical appointments with no mention of social engagement or social determinants of health.

Example

Agency	Progress
Advocates & BayPath Elder Services	Continue to offer Elder Community Care, a collaborative program that offers in-home mental health services to homebound seniors.
Jewish Family Service of MetroWest	Over 100 older adults annually receive enhanced medical escort services to doctor appointments using trained volunteers.

HEALTHY EATING/ACTIVE LIVING

Fresh Fruits/Vegetables: This section yielded a predominant focus on providing fresh fruits and vegetables through schools. Respondents identified collaboration as the backbone to accomplishing this work. Collaborations occurred with a Place to Turn, United Way, food pantries, schools, community health centers and YMCAs. Mobile technologies were utilized to promote farmers’ markets and the availability of SNAP/WIC benefits for payment. Efforts are also being made to begin new farmers’ markets in downtown areas where many lower income residents reside. Respondents identified being in the planning stages of new fresh fruit/veggies programs intended for 2017.

School Nutrition: Respondents largely did not report progress made in school nutrition. As noted, this may be a reflection of organizations missing from the data set. Respondents who did answer this question focused more on the delivery and amount of meals provided rather than the nutritional value of meals.

School Kitchen: One school reported efforts to better equip school kitchens so workers can prepare healthy foods. This respondent was able to order some additional coolers for one town’s summer and year-round meal program.

Complete Streets and Safe Routes to School: Framingham, Marlborough, and Hudson adopted Complete Street policies. The same three communities have at least one school each enrolled in safe routes to school program with MA Department of Transportation. One respondent identified the participation in elementary school physical activity and nutrition programs in the City of Marlborough through the use of the “walking school bus”.

Example

Agency	Progress
Lovin’ Spoonfuls	Since expanding into MetroWest in 2016 has distributed 213,000 pounds of food harvested from over 10 area grocers, including fresh fruits and vegetables. Program delivers to food pantries, congregate meal programs, local shelters and supported housing providers.

2017 CHIP Priorities

Priority 1: ACCESS TO CARE

Goal: Improve the health of the region through the availability of affordable, quality health care services.

Objective 1: Increase health literacy and health education among vulnerable populations

Strategy 1: Train providers on techniques to improve health literacy/patient empowerment and how to integrate those techniques into practice

Outcome Indicators: Number of trainings, number of providers trained, increased knowledge of providers

Strategy 2: Host community forums/events on health care navigation, being an active & informed patient, and on general health care topics

Outcome Indicators: Number of events, number of attendees, increased knowledge of attendees

Strategy 3: Distribute health education materials that are accurate and easy to understand to targeted populations

Outcome Indicators: Number of materials distributed, increased knowledge by targeted populations

Objective 2: Increase the use of Community Health Workers (CHWs) to enhance the coordination of care

Strategy 1: Advocate for sustainable funding of CHWs by collecting and sharing the success that CHWs have for improving health outcomes and reducing costs

Outcome Indicators: Number of legislative visits, number of advocacy communications, successful advocacy for sustainable funding

Strategy 2: Further develop models for the use of CHWs as part of the health care team and for coordination of care

Outcome Indicators: Number of models developed

Objective 3: Increase the rate of insurance coverage, with a particular focus on young adults and minorities

Strategy 1: Support Certified Application Counselors to assist individuals and families with new health insurance applications during Open Enrollment (all types of insurance) and throughout the year (MassHealth)

Outcome Indicators: Number of individuals and families assisted by CACs

Strategy 2: Support provider agencies to assist with insurance applications for individuals and families who are new to the community

Outcome Indicators: Number of insurance applications prepared by provider agencies

Strategy 3: Support efforts to reduce health insurance coverage churn by educating patients on renewals and open enrollment and creating systems to improve coordination among providers when patients have lost coverage

Outcome Indicators: Number of education sessions, number of patients educated, reduced churn rate

Measurement: Age-Adjusted Cardiovascular Disease Mortality (MassCHIP), Percentage of Adults Diagnosed with Diabetes (BRFSS), Percentage of Adults Without a Personal Doctor (BRFSS), Percentage of Adults without a Checkup in the Past Year (BRFSS), Percentage of all Births with Inadequate Prenatal Care (Mass. Department of Public Health), Rates of Uninsurance (Blue Cross Blue Shield of Massachusetts Foundation)

Priority 2: BEHAVIORAL HEALTH

Goal: Improve the health of the region through access to culturally competent mental health and substance use prevention and treatment services.

Objective 1: Reduce opioid-related overdoses

Strategy 1: Increase community clinical supports for early intervention and treatment

Outcome Indicators: Number of new community-clinical supports, e.g. MAT prescribers, recovery coaches, etc.

Strategy 2: Leverage community coalitions to increase the number of educational opportunities for youth, families and providers

Outcome Indicators: Number of educational opportunities offered, attendance

Objective 2: Reduce youth mental health symptoms and substance use

Strategy 1: Offer educational programs on stress management, wellness and healthy decisions

Outcome Indicators: Number of educational programs offered, attendance

Strategy 2: Leverage partnerships among behavioral health agencies, schools and community organizations to ensure early intervention and treatment

Outcome Indicators: Number of new partnerships

Objective 3: Improve timely access to culturally- and linguistically-appropriate behavioral health services

Strategy 1: Offer educational programs for cultural/ethnic minority communities to reduce stigma

Outcome Indicators: Number of programs offered, number of attendees

Strategy 2: Increase the number of bilingual behavioral health clinicians

Outcome Indicators: Change in the number of clinicians

Strategy 3: Create a plan to address behavioral health needs of new immigrants

Outcome Indicators: Plan created

Measurement: Percentage of Adults Reporting Poor Mental Health (BRFSS), Percentage of Adults Who Report Binge Drinking (BRFSS), Number of Confirmed Unintentional Opioid Overdose Deaths (Mass. Department of Public Health), Percentage of Adolescents Reporting Mental Health Issues (MetroWest Adolescent Health Survey), Percentage of Adolescents Engaging In Substance Abuse Behaviors (MetroWest Adolescent Health Survey)

Priority 3: HEALTHY AGING

Goal: Improve the health of the region by ensuring that older adults have access to physical and behavioral health services.

Objective 1: Improve older adults' access to timely and appropriate mental health and substance use services

Strategy 1: Connect homebound older adults to in-home mental health services

Outcome Indicators: Number of older adults served

Strategy 2: Connect older adults with substance use disorders to treatment services

Outcome Indicators: Number of older adults in treatment

Strategy 3: Increase use of Community Health Workers to connect older adults to primary and specialty care, including behavioral health services

Outcome Indicators: Number of CHWs working with older adults

Objective 2: Reduce fall-related injuries in older adults

Strategy 1: Implement STEADI screening for fall risk at clinical and community settings for older adults

Outcome Indicators: Screenings implemented, number of older adults screened

Strategy 2: Connect older adults with elevated fall risk to evidence-based fall prevention programs, e.g. A Matter of Balance, Tai Chi: Moving for Better Balance

Outcome Indicators: Attendance

Objective 3: Improve access to primary and specialty care for older adults

Strategy 1: Increase the use of Community Health Workers to connect older adults to primary and specialty care, including behavioral health services

Outcome Indicators: Change in number of Community Health Workers working with older adults

Strategy 2: Improve access to medical transportation

Outcome Indicators: Creation and expansion of transportation options

Measurement: Injuries from Falls (Tufts Health Plan Foundation), Rates of Fair or Poor Health Status (Tufts Health Plan Foundation), Rates of Poor Mental Health (Tufts Health Plan Foundation), Rates of Flu and Pneumonia Vaccination (Tufts Health Plan Foundation), Percentage with Checkup in Past Year (Tufts Health Plan Foundation), Percentage with Regular Doctor (Tufts Health Plan Foundation), Percentage Did Not See a Doctor Due to Cost (Tufts Health Plan Foundation)

Priority 4: HEALTHY EATING/ACTIVE LIVING

Goal: Improve the health of the region by ensuring that residents have access to nutritious food and engage in physical activity.

Objective 1: Decrease food insecurity among vulnerable populations, especially older adults

Strategy 1: Increase the number of mobile markets offered by food safety net providers

Outcome Indicators: Increase in number of mobile markets

Strategy 2: Pilot at least one CSA in a low-income neighborhood where individuals can use SNAP/EBT to purchase

Outcome Indicators: Increase in number of CSAs accepting SNAP/EBT

Objective 2: Increase the intake of fresh fruits and vegetables for low-income children and adults

Strategy 1: Increase the number of farmers' markets, farm stands, mobile markets and CSA shares who offer the Health Incentives Program

Outcome Indicators: Increase in number of venues offering Health Incentives Program

Strategy 2: Expand fruit and vegetable options available to consumers at local food pantries

Outcome Indicators: Increase in fresh produce offerings

Strategy 3: Have at least three organizations host cooking classes/demonstrations to teach residents how to create easy meals consisting of fruits and vegetables

Outcome Indicators: Number of cooking classes, attendance

Objective 3: Increase the number of residents who achieve at least 150 minutes of moderate aerobic activity weekly

Strategy 1: Promote existing opportunities for physical activity via media and social media outlets

Outcome Indicators: Increase in media coverage and social media promotion

Strategy 2: Pilot at least 1 social support intervention, such as a buddy system or neighborhood walking group

Outcome Indicators: New pilot

Measurement: Food Insecurity Rate (Feeding America), Adult Fruit and Vegetable Consumption (BRFSS), Adult Physical Activity (BRFSS), Adolescent Physical Activity (MetroWest Adolescent Health Survey), Adolescent Fruit and Vegetable Consumption (MetroWest Adolescent Health Survey), Youth Obesity Rates (Mass. Department of Public Health)

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Participating Organizations

Advocates
BayPath Elder Services
Bellingham Council on Aging
Caron Treatment Centers
CHNA7 MetroWest
Doc Wayne Youth Services
Elder Dental Program
Employment Options
Family Continuity
Family Promise MetroWest
Foundation for Metrowest
Framingham Adult ESL Plus
Framingham Council on Aging
Framingham Health Department
Framingham Public Schools
Foxborough Council on Aging and Human Services
Greater Boston Food Bank
Harvard Pilgrim Health Care
Harvard Pilgrim Health Care Foundation
Health Care for All
Health Law Advocates
Hockomock Area YMCA
Holliston Fire Department
Hudson Health Department
Hudson Public Schools
Edward M. Kennedy Community Health Center
KidsConnect
Latino Health Insurance Program
Marlborough Board of Health
Marlborough Community Development Corporation
Marlborough Hospital
MetroWest Free Medical Program
MetroWest Medical Center
MetroWest Regional Transit Authority
Natick Housing Authority
Natick Public Schools
Natick VNA
Needham Public Health Department
Northborough Family & Youth Services
REACH
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Screening for Mental Health
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