

This CHIP focuses on the municipalities of the Central Massachusetts Regional Public Health Alliance (CMRPHA), which includes the six communities of Holden, Leicester, Millbury, Shrewsbury, West Boylston, and Worcester.

GREATER WORCESTER REGION COMMUNITY HEALTH IMPROVEMENT PLAN

VISION:

Worcester will be the healthiest city and CMRPHA the healthiest region in New England by 2020.

Executive Summary

Improving the health of a community is critical for not only enhancing residents' quality of life but also for supporting their future prosperity.

To this end, the City of Worcester Division of Public Health (lead agency of the Central Massachusetts Regional Public Health Alliance), UMass Memorial Medical Center, and Common Pathways, a Healthy Communities coalition, led a comprehensive community health planning effort to measurably improve the health of Greater Worcester region residents including the communities of Holden, Leicester, Millbury, Shrewsbury, West Boylston, and Worcester. Our focus on these five towns and the City of Worcester is primarily due to regionalization of public health services with the aforementioned communities, which are collectively known as the Central Massachusetts Regional Public Health Alliance. The Central Massachusetts Regional Public Health Alliance (CMRPHA) serves a total population of 265,899 residents. Additionally, the largest populations that are the primary target areas of CMRPHA are vulnerable, low-income, and immigrant communities.

Partnering with area healthcare providers, academic institutions, community based organizations, and municipalities is key to not only improving upon the services provided to residents, but also strengthening the public health system in Central Massachusetts as a whole.

The Community Health Improvement Planning process includes two major components:

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

The CHIP is not intended to be a static report; rather, it is intended to focus and guide a continuous health improvement process that will monitor and evaluate health priorities and systems changes in an ongoing manner. The Greater Worcester Region CHIP provides an approach that is structured and specific enough to guide decisions, and flexible enough to respond to new health challenges. Its inclusive process represents a common framework for all stakeholders to use when implementing strategies for improving population health.

This full report presents the amended CHIP, which was developed using the key findings from the CHA and a detailed literature review to inform discussions and select the following data-driven priority health issues, goals, objectives, and strategies, and an annual report that details the progress made to date.

DOMAIN AREA 1. HEALTHY EATING & ACTIVE LIVING

Goal	Objective
1. Create an environment and community that support people's ability to make healthy eating and active living choices that promote health and well-being.	1.1 Increase availability of and access to affordable fresh and local fruits and vegetables for low-income residents by 10% by 2015, as measured by walking distance.
	1.2 Identify, prioritize, and implement improvements to increase residents' access to physical activity resources by 10% by 2015 as measured by walking distance.
	1.3 Increase the percentage of children in grade 1 who are a healthy weight by 3% by 2015.

DOMAIN AREA 2. BEHAVIORAL HEALTH

Goal	Objective
2. Foster an accepting community that supports positive mental health; and reduce substance abuse in a comprehensive and holistic way for all who live, learn, work, and play in the Greater Worcester region.	2.1 Reduce the proportion of high school students using tobacco products to below state rates between 2013 and 2020.
	2.2 Reduce the proportion of high school students using alcohol to below state rates between 2013 and 2020.
	2.3 Reduce the proportion of high school students misusing and abusing prescription drugs to below state rates between 2013 and 2020.
	2.4 Prevent an increase in the rate of prescription drug and opiate overdoses between 2013 and 2020.
	2.5 Increase 500 key community members' understanding of mental health issues and improve gatekeepers/systems reaction to common problems by 2015.
	2.6 Improve the assessment of regional mental health needs in order to increase continuity of care among vulnerable populations by 2020.

DOMAIN AREA 3. PRIMARY CARE & WELLNESS

Goal	Objective
3. Create a respectful and culturally responsive environment that encourages prevention of chronic disease, reduction of infant mortality, and access to quality comprehensive care for all.	3.1 Reduce non-urgent or preventable use of the emergency department by 8% by 2015.
	3.2 Reduce the rate of STIs in residents age 15-24 years by 10% by 2015.
	3.3 Reduce the rate of dental caries in residents age 4-19 by 3% by 2015.

DOMAIN AREA 4. VIOLENCE & INJURY PREVENTION

Goal	Objective
4. Improve safety, reduce violence and injury, and inform public perceptions by educating and mobilizing the community around effective, targeted prevention, and intervention strategies.	4.1 Reduce fall-related injuries in children age 10 and under by 5% and in adults age 65 and over by 8% by 2015.
	4.2 Increase public safety by 3% by 2015 as measured by crime rates and perceptions of safety.
	4.3 Reduce the rate of motor vehicle-related pedestrian, cyclist, and occupant injuries by 10% by 2015.

DOMAIN AREA 5. HEALTH EQUITY & HEALTH DISPARITIES

Goal	Objective
5. Improve population health by systematically eliminating institutional racism and the pathology of oppression and discrimination by promoting equitable access to, and use of, health promoting resources in the community, and significantly reducing the structural and environmental factors that contribute to health disparities.	5.1 By 2015, modify or implement two key, city-level public health policies that have the greatest impact on the systems that contribute to health disparities (e.g., zoning changes, housing policies, general education policies, etc.).
	5.2 By 2015, increase the capacity of over 100 grassroots adult and youth leaders (people who have lived experience in communities with disparities) to effectively influence the development of policies that address health disparities.
	5.3 By 2015, develop the capacity and will of 20 cross-sector institutions to address and eliminate institutional oppression in their own organizations.
	5.4 Ensure that each public health priority area in the CHIP identifies strategies to address oppression and the social determinants of health.

Domain Area Three: Primary Care & Wellness

During the Community Health Assessment (CHA) process, many interview participants cited chronic diseases, including cardiovascular disease, diabetes, and oral health as major health concerns for the region. Other participants noted that asthma and chronic lung disease were also of particular concern. It was also a concern among respondents at these conditions are disproportionately concentrated among low-income residents, racial and ethnic minorities, and immigrant communities. Quantitative data indicate that the chronic diseases cited by respondents are prevalent in the Greater Worcester area. According to the BRFSS, in 2009, 36% of persons aged 18 and older in Worcester County have been diagnosed with high cholesterol in their lifetime, and 25% have been diagnosed with hypertension in their lifetime.[1] Approximately 11% of persons aged 18 and older have asthma and 8% have diabetes.[2] In Worcester County, Hispanics (23% of the population) have the highest prevalence of asthma, followed by non-Hispanic Whites (14% of the total population) and non-Hispanic Blacks (11% of the population).[5] Prevalence of asthma for Hispanics in Worcester County is greater than that for Hispanics in the State.[6]

Infant mortality, inadequate prenatal care and teenage pregnancy among vulnerable populations, particularly populations of color, emerged as concerns pertaining to reproductive and maternal health. Chlamydia and gonorrhea were the two most common communicable diseases among residents of Worcester County from 2008 to 2010.[7] Respondents to the Community Health Assessment Survey expressed mixed satisfaction for birth control and sexual health services for youth. Approximately

22.4% of respondents indicated that they are very satisfied with services, but 28.6% expressed that they are not at all satisfied with the availability of these services for youth.

Oral health and access to oral health services emerged as a concern among respondents, particularly because several participants noted that the water in the greater Worcester region is not fluoridated. The proportion of persons in Worcester County who have seen a dentist in the past year and who have lost six or more teeth due to tooth decay is patterned by socioeconomic status. Only 57% of residents of Worcester County who have less than a high school education have seen a dentist in the past year, followed by 69% of residents with a high school education, 81% of persons with some college education, and 86% of residents with a college education or higher.[8] Approximately 46% of Worcester County residents with less than a high school education have lost six or more teeth due to tooth decay, followed by residents with a high school education (21%), those with some college education (15%), and residents with a college education or higher (5%).[9] The proportion of children in Worcester County with tooth caries exceeds that for the State. Approximately 39% of children in kindergarten in Worcester County have tooth caries, while only 28% of children in Massachusetts have tooth carries.[10]

Interviews with respondents indicated a perception that health care services in the area are of excellent quality and high in number. However, several challenges related to access for more vulnerable populations emerged as a key theme. Challenges discussed include; transportation limitations, long waiting lists to get an appointment, long wait times when at the health facility, complexities navigating

the health system, cultural competency of providers and office staff, and a lack of coordination of care for low-income residents.

Respondents also described several structural factors that contributed to these challenges in accessing health care services. A lack of providers practicing primary care, conflicts between business hours during which health facilities are open and the work schedules of vulnerable populations seeking care, and inadequate public transportation were described by respondents as barriers to obtaining and attending appointments for low-income residents. In addition, several respondents noted a need for assistance in navigating complex and fragmented health systems. An indicator of barriers to accessing health care is the use of hospital emergency departments for non-emergent issues. The leading cause of visiting the emergency department in Worcester was due to diseases of the respiratory system. Rates for this condition were particularly high among children in the City of Worcester (58.0 per 1000).[11] A few participants explained that limited access to necessary health care contributed to use of emergency departments for management of chronic illnesses.

Given this qualitative and quantitative evidence, reducing the prevalence of chronic diseases, improving oral health, improving sexual health, decreasing emergency room utilization, reducing infant mortality, and reducing preventable hospitalizations and readmissions emerged as key issues to address in an effort to promote wellness and improve access to quality care in the greater Worcester area.

[1] MDPH, BRFSS, 2009.

[2] MDPH, BRFSS, 2009.

[3] MDPH, “A Profile of Health Among Massachusetts Adults” 2010.

[4] MDPH MassCHIP Massachusetts Community Health Information Profile – BRFSS.

[5] Asthma Reports for Worcester County, BRFSS 2003-2008.

[6] Asthma Reports for Worcester County, BRFSS 2003-2008.

[7] MDPH, Health Status Indicators Report for Worcester County, 2008-2010.

[8] MDPH, “A Profile of Health Among Massachusetts Adults”, 2010 – BRFSS.

[9] MDPH, “A Profile of Health Among Massachusetts Adults”, 2010 – BRFSS.

[10] The Catalyst Institute, “The Oral Health of Massachusetts’ Children” January 2008 report.

[11] UMASS data for Worcester Community Health Assessment, Emergency Department data, 2011.

GOAL 3. Create a respectful and culturally responsive environment which encourages prevention of chronic disease, reduction in infant mortality, and access to quality comprehensive care for all.

2013 Update. Goal 3 has been edited to better reflect the aims of the partners who have prioritized reducing infant mortality and chronic disease burden through implementation of the strategies contained herein.

Health equity considerations. The work of Domain 3 centers around the prevention of chronic disease by increasing access to quality care and preventive services. While this work inherently requires a consideration of the social determinants of health, the workgroup continues to prioritize health equality in its implementation. For example, the asthma control pilot program has prioritized high risk asthmatics because this group is often children that are from low income families, or face language/cultural barriers.

3.1 Objective Strategies

3.1 Reduce non-urgent or preventable use of the emergency department by 8% by 2015.

- 3.1.1 Facilitate linkages between health care systems to encourage individuals to seek a source for on-going care.
- 3.1.2 Increase the number of navigators, advocates, and community health workers as a mechanism to improve culturally competent access to care.
- 3.1.3 Support providers and health centers in addressing reported barriers to care such as cross-cultural barriers, transportation, office hours, etc.

3.2 Objective Strategies

3.2 Reduce the rate of Sexually Transmitted Infections (STI's) in residents age 15-24 years by 10% by 2015

- 3.2.1 Develop and implement a mass media education campaign to increase knowledge about risky sexual behaviors, HIV and HIV testing, and STI's, including advertising of available resources in the community.
- 3.2.2 Introduce amendments to current school policy to enable school-based health providers to offer, with parental consent, reproductive health education and STI education, screening and treatment.

3.3 Objective Strategies

3.3 Reduce the rate of dental caries in residents age 4-19 by 3% by 2015.

- 3.3.1 Introduce and pass policy requiring school-based dental programs to provide a minimum of one screening per child per year, pre-K through 12th grade.
- 3.3.2 Develop and implement a comprehensive public education campaign on the benefits of good oral health practices.
- 3.3.3 Advocate for policies that decrease consumption of sugary drinks in schools, after-school programs, and youth programs.

GOAL 3. Create a respectful and culturally responsive environment which encourages prevention of chronic disease, reduction in infant mortality, and access to quality comprehensive care for all.

3.1 Reduce non-urgent or preventable use of the emergency department by 8% by 2015.

2013 Update. Over the past year, the workgroup has focused on the strategies supporting Objective 3.1. However, a review of data collected led to the decision to refocus the objective on reducing emergency department visits for preventable conditions, such as acute asthma attacks, and non-urgent conditions that could be treated by a primary care physician. This decision is supported by locally collected data that reveals frequent use of the free clinic system and emergency departments by residents that have both insurance and a primary care physician. The new objective will more accurately capture information reflecting the improvements achieved through the implementation of the strategies below.

In addition, the original Strategy 3.1.3 has been removed. While the goal to improve informed decision making is valuable, the group determined that there is not yet enough evidence in this area to guide the implementation of an effective program for the region.

Lead Agency: UMass Memorial Healthcare

Current Partners: Worcester Division of Public Health, Edward M. Kennedy Community Health Center, Family Health Center, Worcester Free Clinics System, Fallon Health

3.1.1 Facilitate linkages between health care systems to encourage individuals to seek a source for on-going care.

Rationale. Improving access to high quality care is an overarching goal of Healthy People 2020. Specific objectives include increasing the proportion of the population who have a source for on-going primary care by 10% and increasing the proportions of persons with a usual primary care physician by 10%. In addition, the National Prevention Strategy highlights the lack of access to health services and the high proportion of adults that are not receiving routine prevention services such as vaccinations and cancer screenings. The strategy recommends several interventions in this regard: 1) support implementation of community-based preventive services and enhance linkages with clinical care 2) reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk 3) enhance coordination and integration of clinical, behavioral, and complementary health strategies.

A literature review revealed that the evidence for the strategy of linking clinical services to community organizations to increase access to preventive services is not conclusive. However, research in this area is limited, as it is a newly emerged field of interest. Available evidence strongly suggests that linkages between clinical and community services can be particularly effective in the management of chronic conditions.

Current Status. Strategy 3.1.1 has been rewritten in this report to better reflect the goals of the Domain working group and the needs of the community, based on data that was not previously available. However, some related work has been completed. First, a “point in time” report was completed by the Worcester Free Clinic Coalition to identify who is accessing the system and why. In addition, an ongoing media outreach project is being conducted to raise local awareness of access to health care issues in the region.

2014 Plans. The media outreach project will identify and secure funding in 2014. The workgroup will come together to discuss and create an implementation plan for the strategy.

Outcome Measures. Proportion of individuals reporting that they have a source of on-going care

Changes to the language of this strategy were made to create a more feasible plan for partners to implement as Domain 3 partners recognized that barriers to access to care such as cost would be difficult to change. The strategy as written in this report allows partners to make specific changes to increase access to care by more efficiently connecting existing resources.

3.1.2 Increase the number of navigators, advocates, and community health workers as a mechanism to improve culturally competent access to care.

Rationale. The National Prevention Strategy promotes the use of community health workers to support clinical care outside of traditional health care settings. Community health workers can provide a link between clinical and community services and increase access to care by helping patients overcome barriers such as difficulty navigating the healthcare system. The MA Department of Public Health has also recognized the value of community health workers and has demonstrated support through capacity building projects and other programmatic supports.

Literature review has revealed strong evidence that community health workers can reduce non-financial barriers to care by increasing linkages between clinical providers and the community. Community health workers also contribute to higher quality of care by improving continuity of care, providing health education, and easing navigation of the healthcare system for patients.

Current status. Significant progress has been made on Strategy 3.1.2 over the past year. Pediatric asthma has been identified as priority area and an intervention has been initiated utilizing community health workers to provide support and education to high risk asthma patients and their families. An asthma task force is being organized, and a pilot project of the community health worker home-visit intervention will launch in December 2013 in the Bell Hill and Plumley Village neighborhoods of Worcester. Finally, the group has submitted an application for the MA Prevention and Wellness Trust Fund. If awarded, the grant would fund community health worker interventions for hypertension and pediatric asthma.

The MA Prevention and Wellness Trust Fund, a \$60 million endowment, represents significant investment in and prioritization of the prevention of four health conditions: tobacco use, hypertension, falls, and asthma. Managed by the MA Department of Public Health, the Fund seeks reduce health care spending and the burden of disease.

2014 Plans. Plans for the upcoming year include expansion of the pediatric asthma intervention, contingent on the availability of grant funding. The asthma task force will meet in January 2014 and work to further engage local community health workers and other stakeholders.

Outcome Measures. Number of patients served by navigators, advocates, community health workers

This strategy has been edited to establish a more actionable plan for partners to implement by changing the focus from policy advocacy to implementation.

3.1.3 Support providers and health centers in addressing reported barriers to care such as cross-cultural barriers, transportation, office hours, etc.

Rationale. The Healthy People objectives relating to access to care are mainly focused around increasing health insurance coverage and the number of people who have a primary care physician. However, due to the passing of “An Act Providing Access to Affordable, Quality, Accountable Health Care” in Massachusetts, in 2006, almost all residents of the state have health insurance coverage. Therefore, the CHIP planning participants focused on other barriers to accessing care.

Current status. During year one of implementation the Domain 3 workgroup has focused their work surrounding access to care on maternal and child health for vulnerable populations. Worcester consistently reports infant mortality rates higher than the state average, particularly among minority groups. The workgroup has collaborated closely with the March of Dimes, UMass Medical School, and Clark University. A grant application is in process for funds to address access to care issues relating to maternal and child health. In addition, the group has been working to reach out to the Ghanaian community in Worcester, a large community in the area that has been identified as being at an increased risk for infant mortality. The group is identifying barriers to care in this population by conducting focus groups to collect additional data and inform intervention planning. In addition, Dr. Sarkis of Clark University will be hosting a discussion group with African, Vietnamese, and Latino women to continue to identify barriers to care, focusing on prenatal care. Finally, a member of the workgroup, Dr. Sheils, held a meeting with the Infant Mortality Subcommittee of Worcester’s city council and will also meet with other elected officials.

2014 Plans. Over the next year, the group will be focusing on the design of an intervention to improve access to prenatal care for high risk groups.

Outcome Measures. Completed policy brief educating providers on potential impacts of organizational changes

This strategy has been edited for clarity. The original language required partner organizations to identify barriers to care in the region. However, the workgroup recognizes that the bulk of this information is outlined in the CHA. The new objective allows partners to act on available data and make concrete changes to improve access.

Key Sources

- 3.1.1 Porterfield DS, Hinnant LW, Kane H, Horne J, McAleer K, Roussel A. Linkages between clinical practices and community organizations for prevention: a literature review and environmental scan. *American Journal of Preventive Medicine*. 2012 Jun;42(6 Suppl 2):S163-71.
- 3.1.2 Witmer A, Seifer SD, Finocchio L, Leslie J, O’Neil EH. Community health workers: integral members of the health care work force. *American journal of public health*. 1995 Aug;85(8 Pt 1):1055-8.

3.2 Reduce the rate of STIs in residents age 15-24 years by 10% by 2015.

2013 Update. Objective 3.2 has been edited after year one of implementation to better reflect the goals of the strategies supporting it and to conform to the structure of the other domains. The 10% value was chosen based on a review of Healthy People 2020 goals and objectives and the age range chosen based on the high STI rates in this age group and the target population of the strategies.

In addition, the original Strategy 3.2.1 has been removed. It was determined that a health literacy effort specific to STI prevention was not necessary because the objective also includes a public education campaign strategy and because Domain 2 includes a health literacy strategy. It was also decided that improving health literacy may not relate directly to the prevention of STI infections.

Lead Agency: Planned Parenthood

Current Partners: Worcester Division of Public Health, Worcester Public Schools, Edward M. Kennedy Community Health Center, Family Health Center of Worcester, Worcester Free Clinics Coalition, UMass Memorial Healthcare, Fallon Health

3.2.1 Develop and implement an education campaign to increase knowledge about risky sexual behaviors, HIV, and STIs, including advertising of available resources in the community.

Rationale. Healthy People 2020 objectives aim to reduce STI infection rates, specifically, gonorrhea, syphilis, and HPV by 10%. The goals also include increasing the proportion of women that receive routine screenings and decreasing the prevalence of pelvic inflammatory disease resulting from undiagnosed STIs. The National Prevention Strategy similarly supports these goals and recommends expansion of sexual health education.

Studies have demonstrated that mass media campaigns can support positive sexual decision making among youth. Reported outcomes include increased contraceptive usage and increased condom usage between casual partners.

Current status. Year one of implementation did not focus a lot of effort on the Strategy 3.2.1 (formerly 3.2.2). However, the group did identify AIDS Project Worcester as a key stakeholder in the implementation of this strategy.

2014 Plans. Year two work on Strategy 3.2.1 will include recruiting AIDS Project Worcester to help the domain workgroup support and implement the strategy.

Outcome Measures. Number of individuals reached by a public education campaign or outreach initiative

3.2.2 Introduce amendments to current school policy to enable school-based health providers to offer students reproductive health education and STI education, screening, and treatment.

Rationale. The Healthy People 2020 goals relating to reducing STI infections also aim to increase access to screening and treatment services. The National Prevention Strategy recommends expanding access to screening and treatment services. In addition, the Guide to Community Preventive Services recommends comprehensive sexual health education in schools as a way to reduce STI transmission.

A review of the literature supports the implementation of school-based education, screening, and treatment for STIs. Studies have shown that the comprehensive education and school based screening do not increase sexual activity among youth and can reduce the prevalence of STIs.

Current status. Over the past year, the Domain 3 workgroup has focused on conducting an assessment of what work has been done in this area by other groups in the area such as the public schools and Planned Parenthood.

2014 Plans. The goal for the upcoming year is to formulate a plan for introducing a screening and treatment program within the 12 established school-based health centers in Worcester.

Outcome Measures. Number of students educated about, screened for, or treated for STIs

Key Sources

- 3.2.1 Keller SN, Brown JD. Media interventions to promote responsible sexual behavior. *Journal of sex research.* 2002 Feb;39(1):67-72. PubMed PMID: 12476260.
- 3.2.2 Kirb D. The impact of schools and school programs upon adolescent sexual behavior, *Journal of Sex Research.* 2002;39:1, 27-33.

3.3 Reduce the rate of dental caries in residents age 4-19 by 3% by 2015.

2013 Update. The decision to edit Objective 3.3 after year one of implementation is intended to better reflect the goals of the group and conform to the format of the other CHIP domains. The original objective was not a measure capable of incorporating the results of the implementation of the strategies below. The current objective represents a unified goal for the strategies. The decision to define the target population age was made because this age range not only has the highest rate of dental caries, but also because the strategies are focused on improving oral health via interventions in the school systems. The target goal of 3% was chosen after a review of Healthy People 2020.

In addition, the original Strategy 3.3.3 has been removed. The group agreed that the strategy was too broad to be implemented and hinged the responsibility for successful implementation on the political will of the state and local legislatures. It has been replaced by a more practical strategy with a stronger evidence base: reducing children's intake of sugary drinks.

Lead Agencies: Central MA Oral Health Initiative

Current Partners: Worcester Division of Public Health, Edward M. Kennedy Community Health Center, Family Health Center, Worcester Free Clinic Coalition, UMass Memorial Healthcare, Fallon Health

3.3.1 Introduce and pass policy requiring school-based dental programs to provide a minimum of one screening per child per year, pre-K through 12th grade.

Rationale. Healthy People 2020 places oral health into an independent goal with multiple objectives. These include increasing the proportion of people who have accessed oral health services in the past year by 10% and reducing the prevalence of dental caries across all ages by 10%. The Guide to Community Preventive Services also recommends school based oral health programs as an effective strategy for reducing dental caries among children and youth.

Review of the literature supports the implementation of a school-based screening program. These programs are particularly effective when school-based programs are also providing preventive services, such as sealants.

Current status. During year one of implementation, the workgroup began discussions with the Worcester Public Schools to ensure that access to oral health services is available through the schools to all students. This has led to the design of a potential pilot program for the 2014-2015 school year, which will begin in one Worcester public school. The program will require all students in the school to receive a dental health screening. If implemented, there would be an opt-out policy available for parents that do not want their children to participate. The Central Massachusetts Oral Health Initiative, a group of dental providers working with Worcester Public Schools, has taken on the leadership role in this work.

2014 Plans. In the upcoming year, the Domain workgroup plans to complete the implementation of the Worcester Public Schools pilot program. This will also include establishing data collection and evaluation plans.

Outcome Measures. Number of students in the region receiving an annual oral health screening through school-based providers

3.3.2 Develop and implement a comprehensive public education campaign on the benefits of good oral health practices.

Rationale. The Healthy People 2020 oral health objectives focus on increasing access to oral health services. Because the 2012 Greater Worcester Community Health Assessment informants frequently cited lack of access to oral health services, rather than lack of availability of services, it is logical to implement a strategy that encourages residents to engage in good oral health practices, including seeking preventive dental services.

Current status. The Central Massachusetts Oral Health Initiative has taken a leadership role in the implementation of this strategy. While year one did not see extensive work in this area, the group has determined that additional stakeholders need to be recruited and funding secured in order to implement the strategy.

2014 Plans. Year two of implementation will focus on convening stakeholders to design a plan for the launch of an education campaign. This will minimally include: material to be included in campaign messages, funding sources, and potential distribution outlets, as well as an evaluation plan.

Outcome Measures. Number of individuals reached by a public education campaign

3.3.3 Advocate for policies that decrease consumption of sugary drinks in schools, after-school programs, and youth programs.

Rationale. Healthy People 2020 includes an objective to decrease the intake of foods containing added sugars. Although this objective is categorized in the nutrition and weight control topic section, it is also applicable to reducing dental caries.

Literature strongly supports the link between sugar consumption and the prevalence of dental caries in children. Children that frequently consume sugar-sweetened beverages are more likely to have dental caries and tooth decay. Therefore, reducing intake of these beverages among children will greatly reduce the risk of caries and reduce the overall prevalence of caries in children of the region.

Current status. As Strategy 3.3.3 is new as of this report, no work has been completed relating to this strategy within the Domain 3 workgroup. The Domain 1 workgroup has undertaken similar efforts through Strategy 1.3.2.

2014 Plans. Next steps relating to Strategy 3.3.3 have yet to be determined. However, they will include connecting with the Domain 1 workgroup to explore collaboration.

Outcome Measures. Number of schools and programs that enforce sugary drink policies.

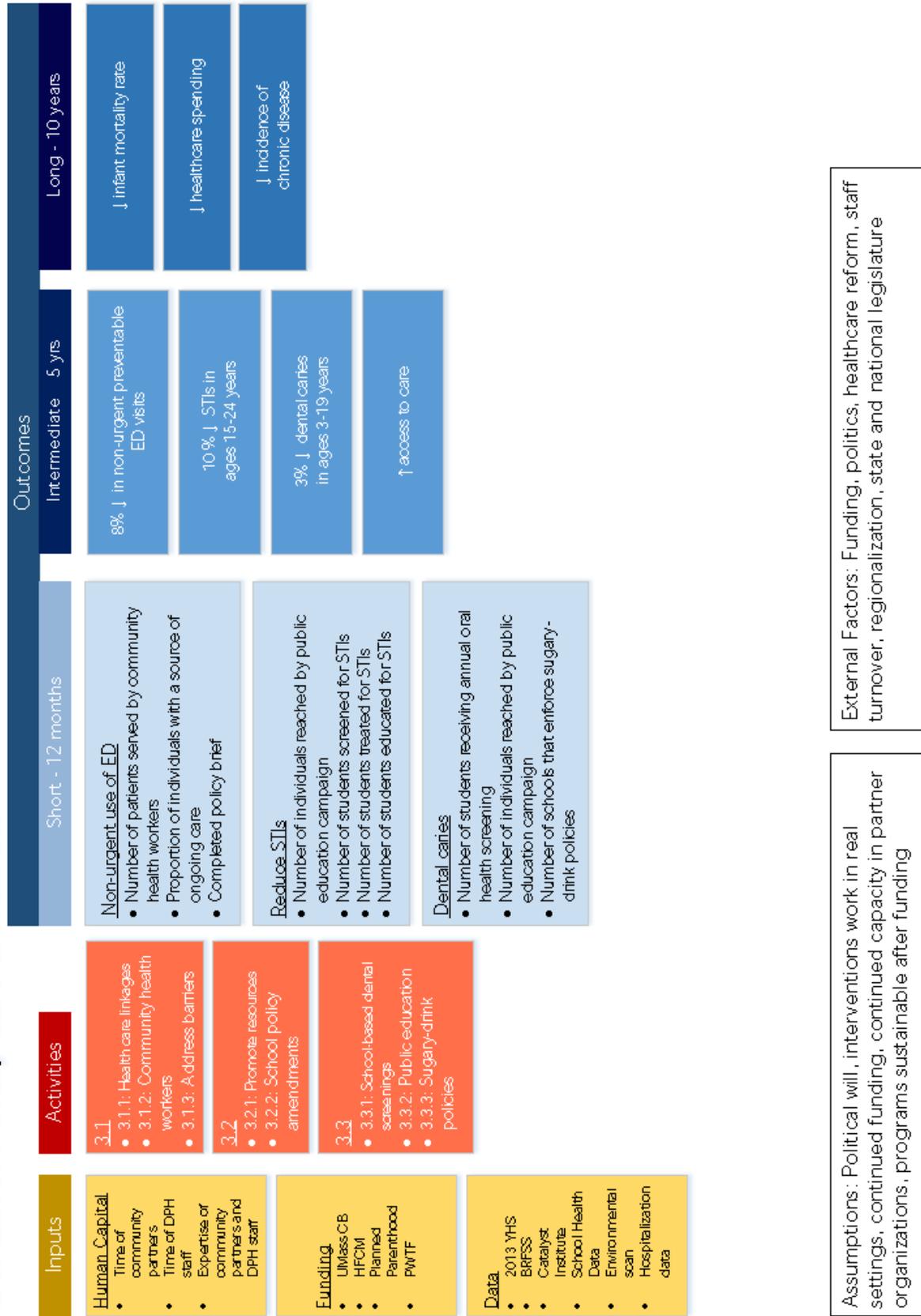
This strategy has been added as of this report to replace the former 3.3.3. This strategy represents a stronger evidence-base and more concise implementation plan for partners.

Key Sources

3.3.1 Gooch BF, Griffin SO, Gray SK, Kohn WG, Rozier RG, Siegal M, et al. Preventing dental caries through school-based sealant programs: updated recommendations and reviews of evidence. *Journal of the American Dental Association.* 2009 Nov;140(11):1356-65.

3.3.3 Shenkin JD, Heller KE, Warren JJ, Marshall TA. Soft drink consumption and caries risk in children and adolescents. *General dentistry.* 2003 Jan-Feb;51(1):30-6.

Domain 3: Primary Care & Wellness





Public Health
Prevent. Promote. Protect.

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