

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 Five: Health Equity & Health Disparities

While the diversity in the region was described as an asset in the greater Worcester area by nearly all respondents, many also cited dynamics of racism and classism in the region that may influence the health of residents of color and low-income. Reducing racial, ethnic, and socioeconomic health disparities emerged as a particular concern among many interview participants. Quantitative data confirm that there are excess rates of chronic diseases among African Americans, Hispanics, and low-income residents in the greater Worcester area. Participants also explained that populations of color generally had limited access to healthy, affordable food and safe, affordable spaces to engage in physical activity, behaviors they described as linked to these health disparities.

Several participants cited unequal treatment of African American, Hispanic, and immigrant patients at health care facilities and linguistic and cultural dissonance as factors that contributed to poorer quality care for patients of color. While the percentage of

non-White respondents to the survey was low, the Community Health Assessment survey respondents' perceptions of their personal experiences with discrimination when trying to access medical care varied by race and ethnicity. While 28.7% of survey respondents indicated that they had a negative experience with medical staff when trying to receive care, over 38% of Hispanics reported this issue, followed by 31% among Black and Asian respondents. When asked whether respondents felt discriminated against when getting medical care because of their race, ethnicity, or language, nearly 32% of Black survey respondents and 26% of Hispanic respondents replied "true." Income was also considered a source of discrimination when seeking medical care, particularly among non-White respondents.

GOAL 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.

2013 Update. There are no significant revisions to any of the objectives or strategies contained in Domain 5. However, the format of Domain 5 differs slightly from the other domains in that the strategies contained in each objective do not represent stand-alone projects. The strategies are laid out in sequential way, meaning that Strategy 5.1.1 represents the first step toward achieving Objective 5.1.

Rationale. An extensive literature review has revealed a number of studies and articles evidencing the existence of social determinants of health and health disparity. Many articles acknowledge determinants of health include structure of the community (i.e. access to markets, parks/recreation, and employment), access to health care, as well as language/cultural barriers. Also, many journals report that more research is needed to identify “best practice” strategies to reduce health disparity. The literature review revealed successful strategies for improving health equity that are used in developed countries with socialized healthcare systems (i.e. United Kingdom and Australia). These strategies, however, are not generalizable to communities in the United States. Worcester Division of Public Health (WDPH) found a lack of published studies that demonstrate success in reducing health disparities in US communities like those of central Massachusetts. Thus, because reducing health disparities is a new frontier for public health in the US, WDPH selected tools for guidance from the United States Department of Health and Human Services and the US Surgeon General to develop strategies to improve health equity at the local level.

5.1	Objective	Strategies
5.1	By 2015, modify/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.).	5.1.1 Research and identify two public health policies that broadly impact health disparities. 5.1.2 Develop coalitions’ capacity to mobilize communities and implement policy changes. 5.1.3 Develop process to evaluate outcomes of policy implementation and plan for sustainability.

5.2

Objective

Strategies

5.2 By 2015, increase the capacity of over 100 grassroots adult/youth leaders (people who have lived experience in communities with disparities) to effectively influence the development of policies that address health disparities.

- 5.2.1 Asses current funding allocations for grassroots leadership development among local community organizations to establish baseline.
- 5.2.2 Recruit and organize cohort of 100 grassroots leaders, including 25 youth, from key populations and sectors.
- 5.2.3 Enhance and develop training program(s) for grassroots leaders to develop leadership knowledge and skills in community and systems change for public health.
- 5.2.4 Connect trained grassroots leaders to key community leadership roles (e.g. in existing coalitions).
- 5.2.5 Identify and secure resources to support and sustain ongoing community leadership development.
- 5.2.6 Develop support structure (“Learning Community”) for ongoing support, strategy, development, and learning among grassroots leaders engaged in this process.

5.3

Objective

Strategies

5.3 By 2015, develop the capacity and will of 20 cross-sector institutions to address and eliminate institutional oppression in their own organizations.

- 5.3.1 Recruit and organize a cohort of 20 health-related organizational leaders who are best poised to make a substantial impact on addressing institutional oppression in their own organizations.
- 5.3.2 Identify and implement effective, evidence-based training for the cohort of 20 leaders to build the willingness and readiness to change organizational systems, structures, policies and approaches.
- 5.3.3 Identify and facilitate a change process for a subgroup of 5-10 organizational leaders who can commit to addressing institutional oppression within their organizations and affecting organizational policy.
- 5.3.4 Develop a support structure/network to create a learning community among the 20 organizational leaders for ongoing support and strategy development.

5.4

Objective

Strategies

5.4 Ensure that each public health priority area in the CHIP identifies strategies to address oppression and the social determinants of health.

- 5.4.1 Convene a forum for all priority area work groups to learn about/discuss institutional racism in the early planning stages for the CHIP, including training on race relations.
- 5.4.2 Ensure that each priority area work group identifies one to two strategies, including resource strategies for implementation, to address institutional oppression/ racism in their priority area.
- 5.4.3 Develop monitoring and evaluation plan to ensure each priority area’s strategies are reported on bi-annually at minimum.
- 5.4.4 During CHIP implementation, convene annual forum of partners in each priority area (learning community) to identify and share best practices for addressing institutional oppression as a root cause of health disparities.

GOAL 5. Improve safety, reduce violence and injury, and inform public perceptions by educating and mobilizing the community around effective, targeted prevention, and intervention strategies.

5.1

By 2015, modify/implement two key, city-level public health policies that have the greatest impact the systems that contribute to health disparities (e.g. zoning changes, housing policies, general education policies, etc.).

Rationale. Health equity can be greatly impacted and improved by policy and policy changes. The Guide to Community Preventive Services contains several policies that are recommended for improving health equity such as full day kindergarten. Although some recommended policy changes may not be feasible in the region, the CHIP planning committee decided it was appropriate to incorporate a policy change approach into the domain. A literature review revealed that it is widely recommended that that potential policy changes for improving health equity be comprehensive, coordinated policies spanning multiple sectors. Furthermore, the National Prevention Strategy recommends that the potential interventions be “grounded in the unique historical and cultural contexts of communities.” The CHIP planning committee considered these factors when selecting this objective and the strategies contained within it.

Lead Agencies: Worcester Health Equity Partnership, Worcester Division of Public Health

Current Partners: Mass in Motion, Massachusetts Department of Public Health Office of Community Design, Clark University, Fallon Health

5.1.1 Research and identify two public health policies that broadly impact health disparities.

Outcome Measures. Completed report identifying policies and priority selection process

5.1.2 Develop coalitions’ capacity to mobilize communities and implement policy changes.

Outcome Measures. Number of trainings held; Number of participants

5.1.3 Develop process to evaluate outcomes of policy implementation and plan for sustainability.

Outcome Measures. Completed implementation and evaluation plan

Current Status. A preliminary literature review was started by a WDPH intern, and Mass in Motion Worcester (MIM) has reached out to other MIM communities who have done thorough evaluations of local policy and its impact on health equity. Additionally, WDPH completed its first Health Impact Assessment to evaluate the health impacts of an inter-departmental neighborhood revitalization effort in an underserved neighborhood in Worcester. Health Impact Assessment is considered a best practice in improving health equity.

2014 Plans. In 2014, WDPH will allocate specific resources to do an assessment of local school, housing, and zoning policies to determine areas for improvement. Results of that assessment will be provided to the Worcester Health Equity Partnership, with an opportunity for Partnership members to provide recommendations for policy change as well.

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.

Rationale. The CHIP planning committee recognized that reducing health disparities is a complex process that will require strong leaders to affect change. This is the rationale for including an objective devoted to improving the capacity of local leaders to influence health equity. Available research is sparse, however, national agencies such as the Department of Health and Human Services’ Office of Minority Health and the National Prevention Council recommend increasing access to education and training surrounding health equity for local leaders, to improve program planning and engagement of stakeholders.

Lead Agencies: Worcester Health Equity Partnership, Worcester Division of Public Health

Current Partners: Black Legacy, Boys & Girls Club of Worcester, YouthConnect, Edward M. Kennedy Community Health Center, UMass Memorial Health Care, UMass Medical School, Regional Environmental Council, Worcester Division of Public Health, Mosaic Cultural Complex, Institute for Global Leadership, Common Pathways CNHA-8, Health Foundation of Central MA, United Way of Central MA, Mass College of Pharmacy and Health Sciences, MA Department of Public Health, Worcester Office of Human Rights and Disability, Fallon Health

5.2.1 Assess current funding allocations for grassroots leadership development among local community organizations to establish baseline.

Outcome Measures. Completed report outlining current funding allocations and additional funding opportunities

5.2.2 Recruit and organize cohort of 100 grassroots leaders, including 25 youth, from key populations and sectors.

Outcome Measures. Number of leaders identified and recruited

5.2.3 Enhance and develop training program(s) for grassroots leaders to develop leadership knowledge and skills in community and systems change for public health.

Outcome Measures. Completed training curriculum

5.2.4 Connect trained grassroots leaders to key community leadership roles (e.g. in existing coalitions).

Outcome Measures. Number of trained leaders holding leadership positions

5.2.5 Identify and secure resources to support and sustain ongoing community leadership development.

Outcome Measures. Secured resources

5.2.6 Develop support structure (“Learning Community”) for ongoing support, strategy, development, and learning among grassroots leaders engaged in this process.

Outcome Measures. Completed Learning Community charter and structure; Number of leaders participating

Current status. The Partnership once again held an Undoing Racism training with the People’s Institute for Survival and Beyond in March 2013, at the Massachusetts College of Pharmacy and Health Sciences. Thirty-two community leaders, including seven top-level individuals, went through the intensive two day training that taught the trainees about institutional racism and established a common language for all to use. The training also included several follow-up discussions with the White Caucus and the People of Color Caucus.

2014 Plans. Development of a grassroots/youth leader specific training will begin following the completion of Undoing Racism 2014. The training subcommittee of the Partnership has set a goal to host a new training, specific to grassroots leaders in fall 2014. A priority of the group is to set a definition for “grassroots leader” in order to properly target the training.

5.3

By 2015, develop the capacity and will of 20 cross-sector institutions to address and eliminate institutional oppression in their own organizations.

Rationale. The Community Health Assessment revealed disparities in quality of interactions with health care providers. Blacks, Latinos, and Asians more frequently reported negative interactions with providers. This is consistent with research compiled by the Department of Health and Human Services' Office of Minority Health found that Hispanics and African Americans report "low" quality of communication with their physicians. As part of the strategies to reduce health disparities, the National Prevention Council recommends fostering cultural competence in the workplace by considering the language, age, culture, and preferred communication styles of patients. Research also suggests that specific provider behaviors, such as, encouraging participatory decision making, can promote patient satisfaction with the healthcare system.

Lead Agency: Worcester Health Equity Partnership

Current Partners: Black Legacy, Boys & Girls Club of Worcester, YouthConnect, Edward M. Kennedy Community Health Center, UMass Memorial Health Care, UMass Medical School, Regional Environmental Council, Worcester Division of Public Health, Mosaic Cultural Complex, Institute for Global Leadership, Common Pathways CNHA-8, Health Foundation of Central MA, United Way of Central MA, Mass College of Pharmacy and Health Sciences, MA Department of Public Health, Worcester Office of Human Rights and Disability, Fallon Health

5.3.1 Recruit and organize a cohort of 20 health-related organizational leaders who are best poised to make a substantial impact on addressing institutional oppression in their own organizations.

Outcome Measures. Number of organizational leaders identified and recruited

5.3.2 Identify and implement effective, evidence-based training for the cohort of 20 leaders to build the willingness and readiness to change organizational systems, structures, policies and approaches.

Outcome Measures. Completed training curriculum

5.3.3 Identify and facilitate a change process for a subgroup of 5-10 organizational leaders who can commit to addressing institutional oppression within their organizations and affecting organizational policy.

Outcome Measures. Number of leaders recruited; Number of leaders participating in a change process; Number of organizations implementing policy changes

5.3.4 Develop a support structure/network to create a learning community among the 20 organizational leaders for ongoing support and strategy development.

Outcome Measures. Completed Learning Community charter and structure; Number of leaders participating

Current status. The Partnership held an Undoing Racism training with the People's Institute for Survival and Beyond in March 2013, at the Massachusetts College of Pharmacy and Health Sciences. Thirty-two community leaders, including seven top-level individuals, went through the intensive two day training that taught the trainees about institutional racism and established a common language for all to use. The training also included several follow-up discussions with the White Caucus and the People of Color Caucus.

2014 Plans. The Partnership training subcommittee will work to host another Undoing Racism training provided by the Peoples Institute for Survival and Beyond. The attendees this year will be institutional leaders who are poised to make a change within their organizations and in the community at large. The training will be held in early April.

5.4

Ensure that each public health priority area in the CHIP identifies strategies to address oppression and the social determinants of health.

Rationale. Because the priority health areas contained in the CHIP affect different populations disproportionately, it is crucial that health equity is considered in terms of each individual priority area to identify the most vulnerable populations and the barriers associated with poor health outcomes. Research supports this approach, with the National Prevention Council recommending community-based solutions to reducing disparities for populations at the greatest risk. The Domain 5 work group's role is to facilitate conversations with the partners of the other domains to ensure that the health equity conversations and approaches are shared.

Lead Agency: Worcester Health Equity Partnership

Current Partners: Worcester Division of Public Health, Commonwealth Medicine, Fallon Health

5.4.1 Convene a forum for all priority area work groups to learn about/discuss institutional racism in the early planning stages for the CHIP, including training on race relations.

Outcome Measures. Number of CHIP partners participating in forum and trainings

5.4.2 Ensure that each priority area work group identifies one to two strategies, including resource strategies for implementation, to address institutional oppression/racism in their priority area.

Outcome Measures. Completed report outlining health equity considerations for each Domain

5.4.3 Develop monitoring and evaluation plan to ensure each priority area's strategies are reported on biannually at minimum.

Outcome Measures. Completed report outlining evaluation plan for health equity efforts by each Domain workgroup

5.4.4 During CHIP implementation, convene annual forum of partners in each priority area (learning community) to identify and share best practices for addressing institutional oppression as a root cause of health disparities.

Outcome Measures: Number of CHIP partners participating in forum and trainings

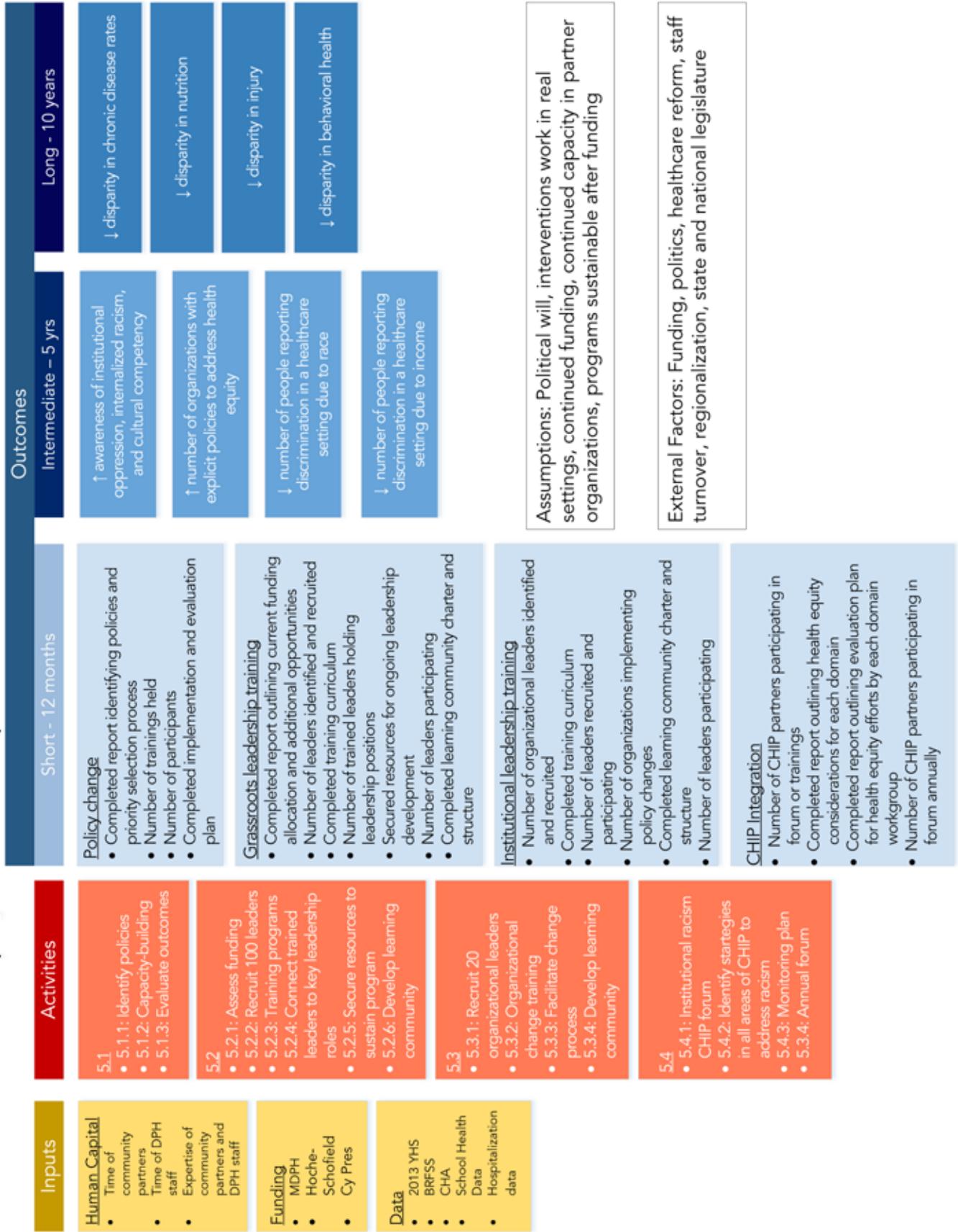
Current status. A formal process to monitor and evaluate the domain work groups' consideration of health equity has not been established as of this time, but an action plan for 2014 has been written. Work group conveners are required to provide quarterly updates on challenges and progress in addressing health equity.

2014 Plans. Each domain work group will develop a training plan to receive training on health equity, cultural competency, and oppression in order to develop a common language for an annual forum that will coincide with the partners' conference in December 2014. Prior to the conference, each domain working group will be charged with identifying one to two strategies that will include specific efforts to reduce health disparities. The evaluation subcommittee of the Worcester Partnership will establish a plan for each workgroup to monitor and report on progress of those strategies.

Key Sources

- 5.1 National Partnership for Action to End Health Disparities. National Stakeholder Strategy for Achieving Health Equity. Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health; 2011 April. 228 p.
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Domain 5: Health Equity & Health Disparities





Public Health
Prevent. Promote. Protect.

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