

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.

GREATER WORCESTER REGION COMMUNITY HEALTH IMPROVEMENT PLAN

I. Introduction and Background

Improving the health of a community is critical for enhancing residents' quality of life and 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 are leading a comprehensive community health planning effort to measurably improve the health of residents in the Greater Worcester region.

The Community Health Improvement Planning process includes two major components:

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

This report presents the 2013 CHIP Amendment and Annual Report.

MOVING FROM ASSESSMENT TO PLANNING

Similar to the process for the CHA, the CHIP utilized a participatory, community-driven approach guided by the Mobilizing for Action through Planning and Partnerships (MAPP) process.¹ MAPP, a comprehensive planning process for improving health, is a strategic framework that local public

health departments across the country have utilized to help direct their strategic planning efforts (see *Figure 1*). MAPP is comprised of four distinct assessments that are the foundation of the planning process and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs of a community change and evolve, the cyclical nature of the MAPP process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. This framework, which is facilitated by community leaders, helps communities to apply strategic thinking to prioritize public health issues and identify resources to address them.

¹ More information on MAPP can be found at: <http://www.naccho.org/topics/infrastructure/mapp/>

FIGURE 1. MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)



The assessment and planning (CHA-CHIP) process for the Greater Worcester region aimed to serve multiple purposes:

1. Provide a CHA for the basis of regional planning for the District Incentive Grant (DIG) funding provided by the Massachusetts Department of Public Health; and
2. Engage the community in a collaborative health planning process to identify shared priorities, goals, objectives, and strategies for moving forward in a coordinated way; and
3. Provide, engage, serve as the CHA for UMass Memorial Medical Center’s Schedule H/Form 990 IRS mandate; and
4. Achieve compliance with Public Health Accreditation Board (PHAB) Standards 1.1 and 5.2 for WDPH and the CMRPHA.

In order to develop a shared vision and plan for improved community health, and help sustain implementation efforts, the Greater Worcester region assessment and planning process engaged multi-sector organizations, community members, and partners through various avenues:

- In March 2012, the City of Worcester Division of Public Health (lead agency of the Central Massachusetts Regional Public Health Alliance) partnered with UMass Memorial Health Care, Common Pathways, and other community partners to form the CHIP Leadership Team. In May 2012, the team hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a research partner to provide strategic guidance and facilitation of the CHA-CHIP process, to collect and analyze data, and to develop report deliverables.
- A CHIP Advisory Committee was established in May 2012 to guide and offer feedback on the CHA and CHIP processes. The Advisory Committee includes a diverse group of agencies and organizations from across the region. The primary role of the Advisory Committee was to provide input and feedback on the study methodology and data collection instruments and to participate in the two-day strategic planning process. A list of CHIP Advisory Committee members is provided in Appendix A.

During the assessment process, HRiA worked with the Leadership Team and the Advisory Committee and other community partners to collect primary data. Community members were engaged through key informant interviews, focus groups, community dialogues, community festivals, and a region-wide community survey. These various data collection

techniques provided an opportunity for diverse community members to provide their input and feedback on community health-related strengths, needs, and a vision for the future. Information was collected from over 1,700 individuals. This process ensured that the Greater Worcester region was represented in all its diverse aspects including business, civic groups, communications, cultural and linguistic groups, education, faith communities, government, healthcare, immigrant/refugee populations, law enforcement, social services, media, transportation, vulnerable populations (disabled, seniors, etc.), youth, and other organizations and specialized areas. A copy of the community survey is provided in Appendix C.

HRiA also reviewed existing secondary data available for Worcester, Holden, Leicester, Millbury, Shrewsbury, and West Boylston, focusing on all social, economic, health, and health care-related data provided by the City of Worcester Division of Public Health, Massachusetts Department of Public Health UMass Memorial Medical Center, Edward M. Kennedy Community Health Center, Family Health Center of Worcester and Common Pathways, CHNA 8. HRiA also gathered additional data on these six communities to fill any gaps and to ensure the data reflected the information needed to discuss these issues within a social determinants of health framework and with a health equity lens (e.g., ensuring data comprise a range of social and economic indicators as well as are presented for specific population groups). The results of the assessment were synthesized in a CHA report and shared via a presentation to over 125 community stakeholders to provide a comprehensive portrait of the region and set the foundation for the CHIP. The CHA report is available online at www.worcesterma.gov/ocm/public-health or by contacting the Worcester Division of Public Health or UMass Memorial Health Care Department of Community Relations.

II. Overview of the Community Health Improvement Plan

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)?

A CHIP is a long-term, systematic effort to address public health issues on the basis of community health assessment results and the community health improvement planning process. A CHIP is created through a community-wide planning process that engages residents and partners. The plan is then used by health departments, government agencies, hospitals, schools, higher education institutions, human service providers, businesses, and other community partners, to set priorities and coordinate and target resources.

Building upon the key findings and themes identified in the Community Health Assessment (CHA), the CHIP aims to:

- Identify priority issues for action to improve community health;
- Develop and implement a health improvement plan with performance measures for evaluation; and
- Guide future community decision-making and resource allocation to improve population health.

HOW TO USE A CHIP

A CHIP is developed to provide guidance to the health department, city government, hospitals, community health centers, philanthropists, third-party payers, social and community-based organizations, coalitions, and other stakeholders, in improving the health of the population. The plan is critical to developing policies and defining actions to target efforts that promote health. Government agencies, including those related to health, human services, and education, as well as hospitals, can use the CHIP in collaboration with community partners to set priorities and coordinate and target resources.²

A CHIP is designed to be a broad, strategic framework for improving community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors — private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and community residents — can unite to improve the health and quality of life for all people who live, learn, work, and play in the region.

² Public Health Accreditation Board (PHAB) Standards and Measures, Version 1.0: Standard 5.2.2. p. 127

III. Development of the Community Health Improvement Plan (CHIP)

COMMUNITY ENGAGEMENT

The City of Worcester Division of Public Health (lead agency of the Central Massachusetts Regional Public Health Alliance) and UMass Memorial Health Care oversaw all aspects of the CHIP development. Common Pathways supported planning efforts by coordinating logistics and recruitment for the two CHIP sessions held on October 4 and 19, 2012. Over 125 community leaders participated in these two planning sessions. Planning session agendas can be found in Appendix D and a list of participants can be accessed through the City of Worcester Division of Public Health.

DEVELOPMENT OF DATA-DRIVEN, COMMUNITY IDENTIFIED HEALTH PRIORITIES

A summary of the CHA findings was presented to a large group of community stakeholders at a four-hour planning session on October 4, 2012. Participants were asked to reflect and offer input on the themes identified from the CHA.

The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

- Obesity, active living, physical activity
- Mental health
- Substance abuse



- Smoking
- Chronic disease (diabetes, heart disease, cancer)
- Asthma
- Oral health
- Sexual health/teen pregnancy
- Health care access
- Health equity/disparities
- Transportation/built environment
- Public safety/violence
- Focus on priority populations: elderly, youth, immigrants/refugees

The group was invited to offer feedback on the priorities listed above. These items are noted in *italics* in Table 1. In addition, during this discussion, participants added additional priority areas and agreed that several themes were more appropriate as cross-cutting strategies (*see Table 2*).

TABLE 1. THEMES FROM THE COMMUNITY HEALTH ASSESSMENT CHA

Themes:	
• Obesity, active living, physical activity	• Sexual health/teen pregnancy
• Mental health <i>and post-traumatic stress disorder (PTSD)</i>	• Health care access
• Substance abuse: <i>harm reduction and overdose</i>	• Health equity/disparities
• Smoking	• Transportation/built environment
• Chronic disease (diabetes, heart disease, cancer)	• Public safety/violence/ <i>domestic violence</i>
• Asthma	• Focus on priority populations: elderly, youth, immigrants/refugees
• Oral health	

(italics = items added by participants)

TABLE 2. THEMES ADDED BY PARTICIPANTS

Themes:	
• Priority population: elderly	• Environment
• Priority population: youth	• Community involvement**
• Priority population: immigrants, refugees, people of color	• Stages of development
• Recreation	• Workplace wellness**
• Racism	• Pneumonia
• Infant mortality/maternal health/pre-maternity/birth defects	• Immunization
• Nutrition/food insecurity	• Collaboration**
• Primary care	• West Nile/Triple E
• Health education/promotion	• Ability/disability
• Housing	• Health care costs
• Education	• Green space
• Financial security: under and unemployment/ livable wage/home economics	• Health literacy
• Stress	• Cultural differences
• Classism	• Employment discrimination
• Gambling	• Housing discrimination
	• Media influences and perceptions

*(** = Denotes cross-cutting strategy)*

Facilitators used a voting process to identify priority public health issues for the Greater Worcester region from the list of major themes identified from the CHA. Each participant identified their top four public health priorities, after reviewing, discussing, and agreeing upon a common set of selection criteria. These included:

- Community need (based on data)
- Achievable short term wins
- Measurable outcomes
- Impact
- Available resources
- Political will exists to support change

The results of the voting process are listed in Table 3:

TABLE 3. PRIORITIES: COMBINED THEMES

Combined Themes:	# of Votes
Behavioral health, mental health, PTSD, substance abuse, tobacco, stress, alcohol, gambling, stages of development, cultural competency	50
Obesity, active living, physical activity, nutrition, green space, workplace wellness, built environment, home economics, recreation, food insecurity, access, public safety	45
Public safety, violence, domestic violence, unemployment	37
Primary care, oral health, health education, preventive medicine, immunization, sexual health, teen pregnancy, access, maternal health, pre-maternity, infant mortality, early pregnancy, birth defects, housing security	33
Chronic disease (diabetes, heart, cancer, asthma, HIV/AIDS), pneumonia, stages of development, environment	24
Financial security, unemployment, under-employment, livable wage, employment discrimination, access to vocational/technical	19
Housing, housing discrimination, homelessness, healthy homes, affordability, housing security	17
Education, language barriers	16
Environment, West Nile, Triple E, air quality	5
Health equity, health disparity, racism, classism, cultural competence, ability/disability, education, language barriers	*

* Determined by CHIP participants to be a standalone Priority Area rather than a cross-cutting theme. See next page.

Based on a group discussion, planning participants combined, organized, and ultimately agreed upon five health priority areas for the CHIP (see Table 4).

The group also suggested several cross-cutting strategies for each of the CHIP priorities, as appropriate (see Table 5):

TABLE 4. FINAL PRIORITY AREAS

Priority Areas	# of Votes
Behavioral Health	50
Obesity/Active Living	45
Public Safety/Violence	37
Primary Care/Oral Health	33
Healthy Equity/Racism	Chosen as additional priority following voting exercise due to its importance

DEVELOPMENT OF THE CHIP STRATEGIC COMPONENTS

During the two, half-day planning sessions held on October 4 and October 19, 2012, a team from HRiA facilitated priority area working groups to develop draft goals, objectives, strategies, and Outcome Measures.

During this process, sample evidence-based strategies and outcome measures were provided that were identified from the *Guide to Community Preventive Services*, *County Health Rankings*, *Healthy People 2020*, and the *National Prevention Strategy* prior to and during the strategy setting session.

TABLE 5. CROSS-CUTTING STRATEGIES

Strategies
Priority populations <ul style="list-style-type: none"> • Elderly • Youth • Immigrants/refugees • People of color • GLBTQ • Child-bearing women • People with disabilities
Community involvement
Collaboration
Media influences and perceptions
Policy and systems change
Transportation
Health equity, health disparity, racism, classism, cultural competence and differences, ability/disability, education, language barriers
Health literacy
Health education/promotion
Health care costs



The Advisory Committee and HRiA reviewed the draft output from the planning sessions and edited material for clarity, consistency, and inclusion of evidence-based strategies. Following the planning sessions, workgroup participants were invited to provide feedback on draft plan components via email and a region-wide survey. Sixteen workgroup participants provided additional input. Their feedback on strategies, Outcome Measures, and potential partners was incorporated into the final versions of the CHIP (*see Appendix E for CHIP Feedback Survey*).

After one year of implementation, CHIP partners reviewed each goal, objective, and strategy to assess feasibility, coalesce data, and better focus the work. As a result, several of the initially identified objectives and strategies were edited. Results of a literature review were added for reference to support implementation.

RELATIONSHIP BETWEEN THE CHIP AND OTHER GUIDING DOCUMENTS AND INITIATIVES

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalition work already in place to improve the public health of the Greater Worcester region. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, CHIP participants identified potential partners and resources wherever possible.

In addition to guiding future services, programs, policies, and potential resource allocation for participating agencies and the area overall, the CHIP meets the requirements for hospitals as per the section 501(r)(3)(B) of the Internal Revenue Code³, and fulfills the required prerequisites for local public health departments to earn accreditation, which indicates that the agency is meeting national Public Health Accreditation Board (PHAB)⁴ standards. Following the guidelines of the National Association of County and City Health Officials (NACCHO)⁵, the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact.

³ Public Health Accreditation Board (PHAB) Standards and Measures, Version 1.0: Standard 5.2.2. p. 127 Hospitals-Under-the-Affordable-Care-Act

⁴ <http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/>

⁵ <http://www.naccho.org/topics/infrastructure/CHAIP/accreditation-preparation.cfm>

IV. Regional Demographic and Health Profile

Tables 6 and 7 and Figure 2 provide context for implementing the goals of the CHIP in the communities of the Greater Worcester region.

TABLE 6. DEMOGRAPHIC QUALITIES OF ALLIANCE COMMUNITIES

	CMRPHA total	Holden	Leicester	Millbury	Shrewsbury	West Boylston	Worcester	Massachusetts
Population	265,889	17,346	10,970	13,261	35,608	7,669	181,045	6,547,629
Median Household income	\$57,464	\$85,095	\$72,843	\$68,046	\$85,016	\$71,172	\$47,415	\$65,981
% below poverty	13.8%	3.5%	4.8%	2.9%	3.9%	3.6%	19%	11%
Median age	36.1	41.4	39.7	41.8	38.8	40.4	34.3	38.9
% unemployed	5.6%	5.6%	6.9%	5.6%	4.1%	3.6%	6%	6%

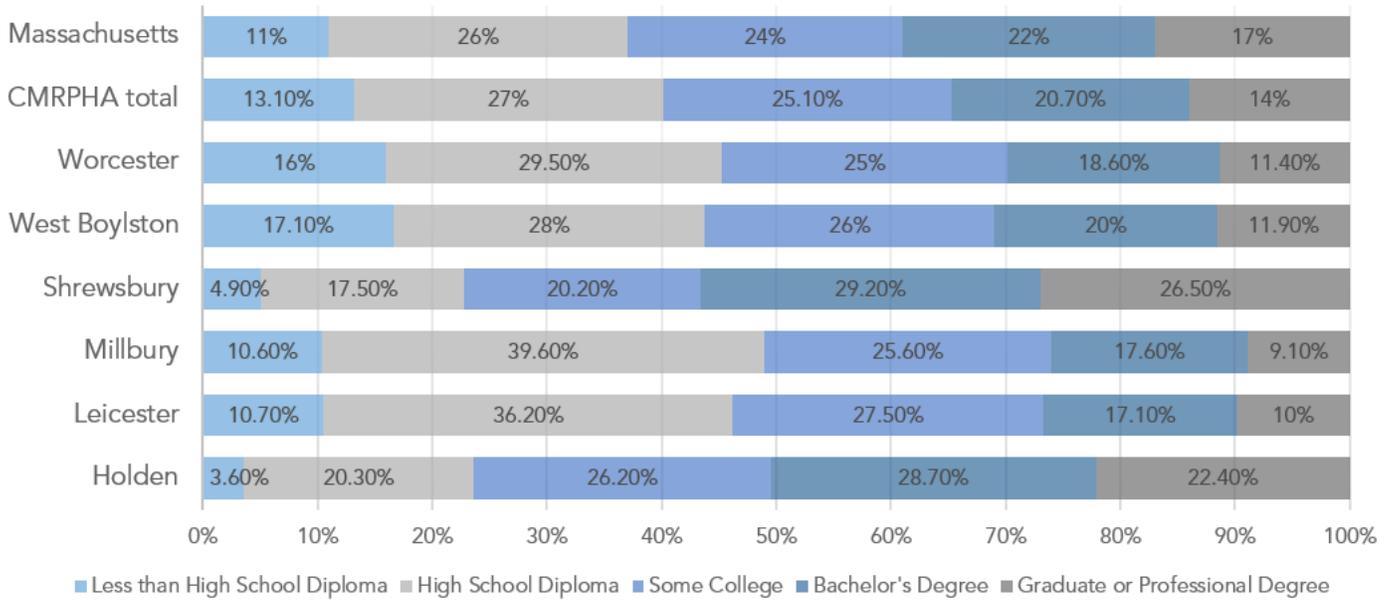
Source: US Census Bureau, American Community Survey (2007-2011)

TABLE 7. RACIAL AND ETHNIC BACKGROUND OF ALLIANCE COMMUNITIES

	CMRPHA total	Holden	Leicester	Millbury	Shrewsbury	West Boylston	Worcester	Massachusetts
White, Not Hispanic	70.4%	92.7%	90.8%	92.8%	77.3%	88.9%	59.6%	76.1%
Black or African-American, Not Hispanic	7.1%	0.9%	1.0%	1.2%	2.0%	4.2%	10.2%	6.0%
Hispanic or Latino	14.1%	2.2%	3.8%	2.3%	2.7%	5.3%	20.9%	9.6%
Asian	6.3%	3.0%	1.6%	1.0%	15.3%	0.7%	6.0%	5.3%
Some Other Race	0.5%	0.2%	0.6%	0.5%	1.0%	0.4%	0.9%	11.0%
Two or More Races	1.6%	1.0%	1.3%	1.3%	1.6%	0.6%	2.3%	1.9%

Source: US Census Bureau, American Community Survey (2007-2011)

FIGURE 2. EDUCATIONAL ATTAINMENT OF ALLIANCE COMMUNITIES



Source: US Census Bureau, American Community Survey (2007-2011)

Health Profile

According to data from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS) (Table 8), Worcester adults are more likely to report poorer general health and mental health and higher rates of overweight/obesity, asthma and diabetes than are Massachusetts residents overall. They are more likely to report smoking and to report lower rates of consumption of fruits and vegetables and regular physical activity. Based on Worcester's demographic information and the literature, it is reasonable to expect poorer general health and mental health status, as well as worse chronic disease and health behavior rates as compared to the state.

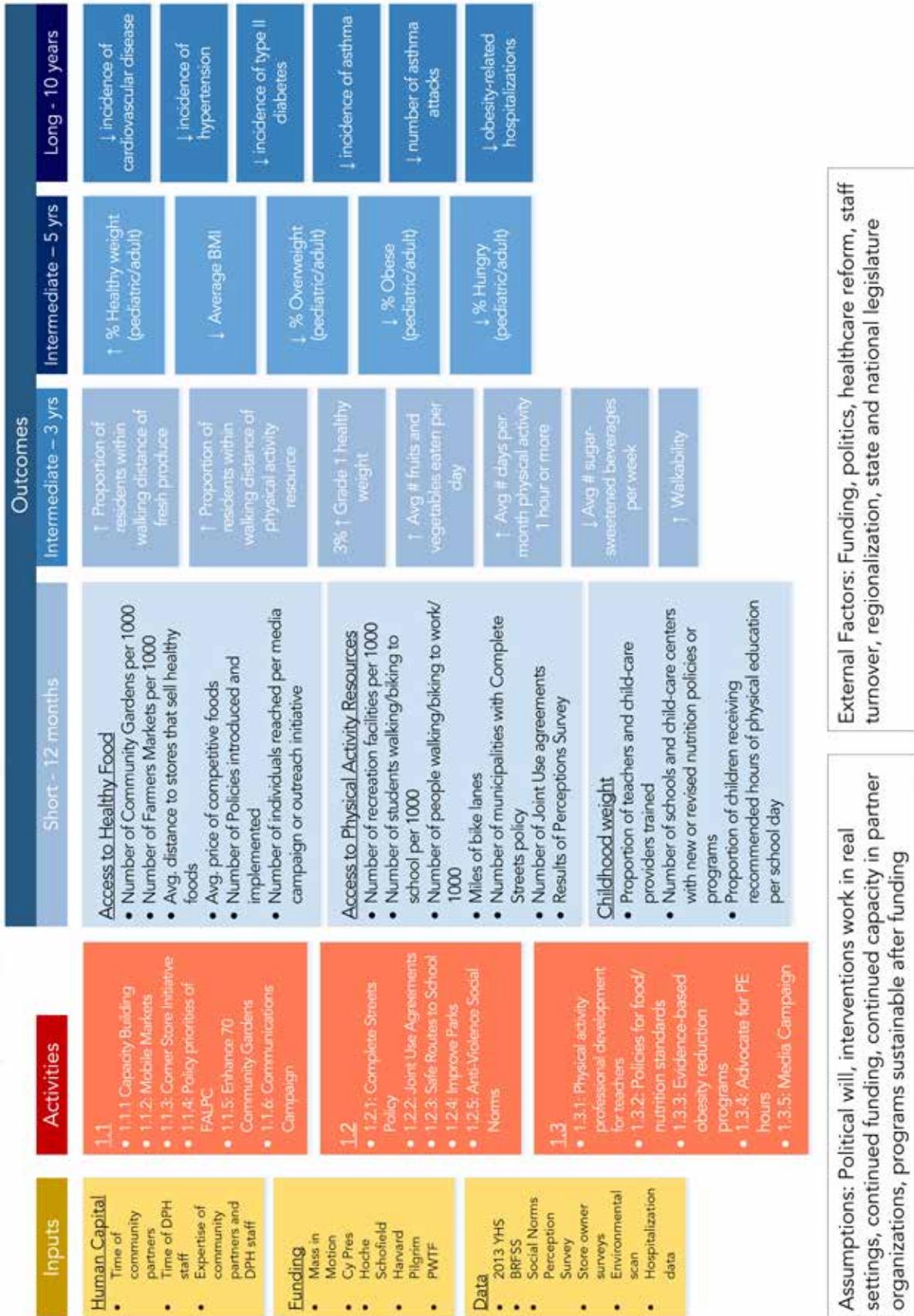
TABLE 8. STATE BRFSS DATA FOR WORCESTER, MASSACHUSETTS

	Worcester	Massachusetts
General		
Prevalence of fair or poor health	15.7%	11.9%
Number of days in past 30 days physical health not good	10.1 days	8.5 days
Prevalence of having a disability and needing help	8.4%	5.4%
Physical / Disease-related		
Prevalence of coronary heart disease	6.0%	5.9%
Prevalence of ever diagnosed with Stroke among adults (35+)	1.8%	2.0%
Prevalence of asthma	12.7%	10.3%
Prevalence of diabetes	8.6%	7.5%
Prevalence of obesity	25.1%	23.0%
Prevalence of overweight/obesity	61.4%	58.9%
Mental		
Number of days in past 30 days mental health not good*	12.1 days	8.9 days
Prevalence of symptoms of depression in past two weeks	11.0%	7.4%
Behavioral		
Prevalence of consumption of 5 or more fruits and vegetables per day	24.3%	27.4%
Prevalence of regular physical activity**	46.6%	52.2%
Prevalence of current smoker***	23.1%	15.9%

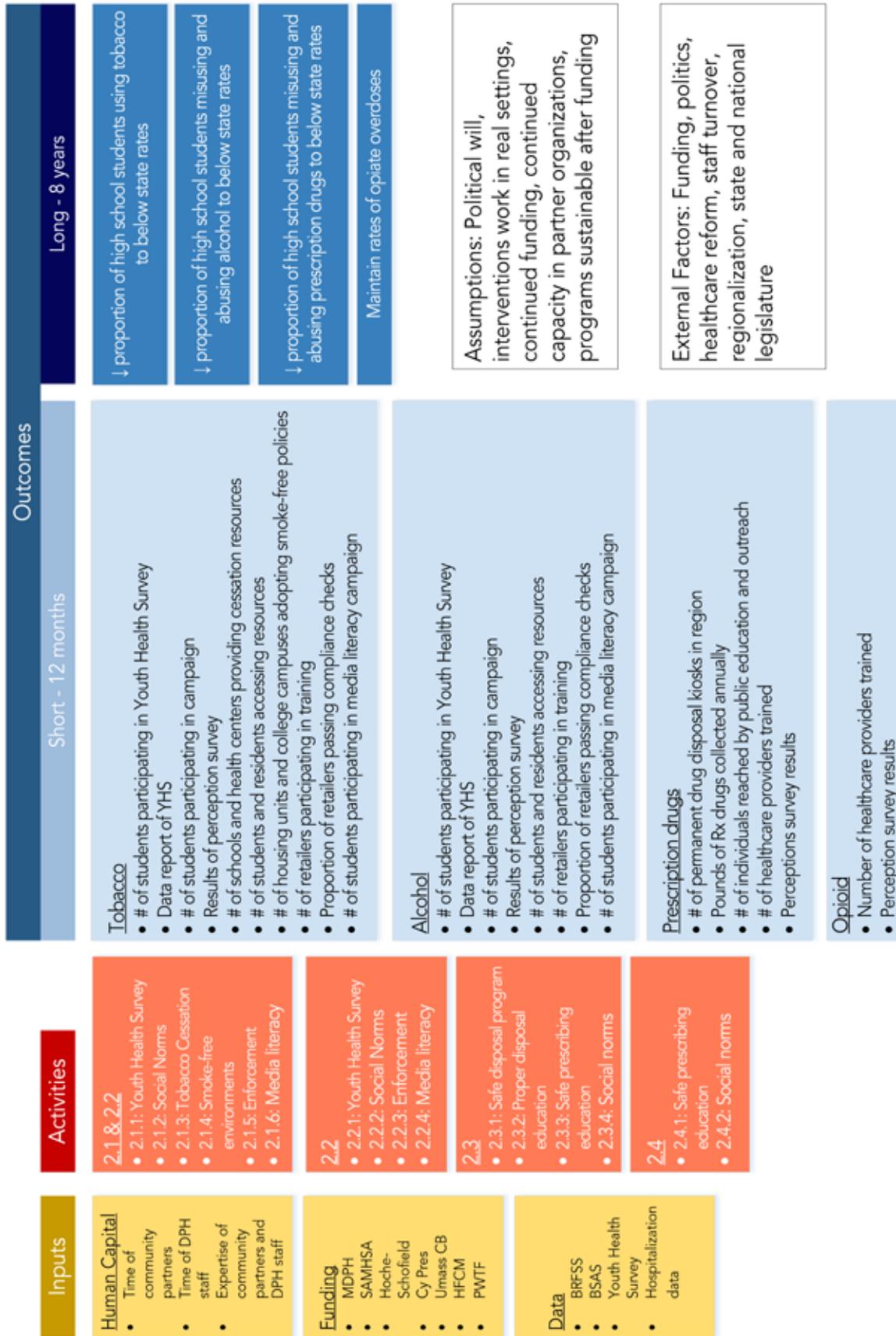
Source: Massachusetts Department of Public Health, Behavioral Risk Factor Surveillance System CY 2008-2011. *CY 2007-2011. **CY 2001, 2003, 2005, 2007, 2009. ***CY 2006-2010.

Domain Logic Models

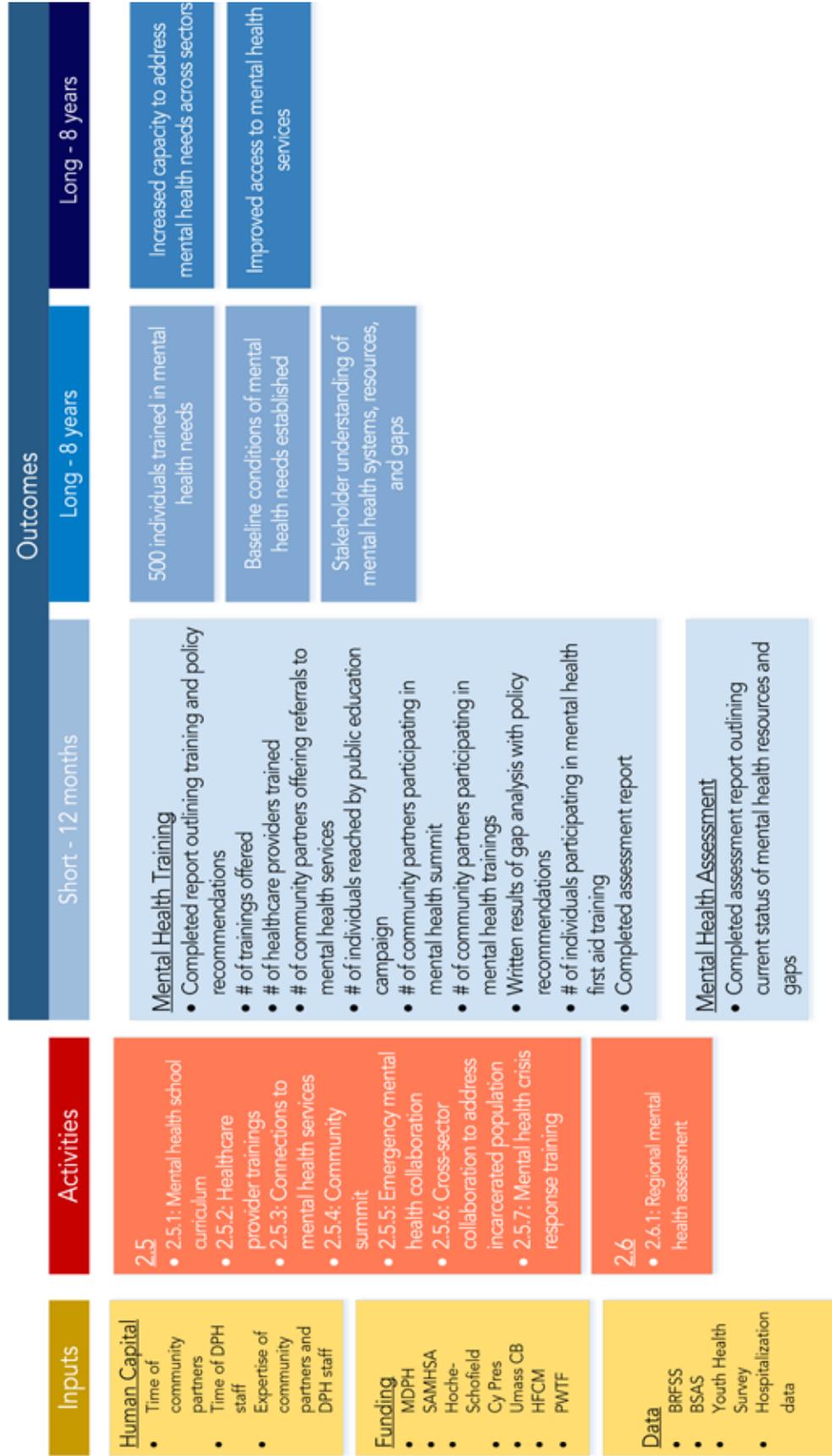
Domain 1: Healthy Eating, Active Living



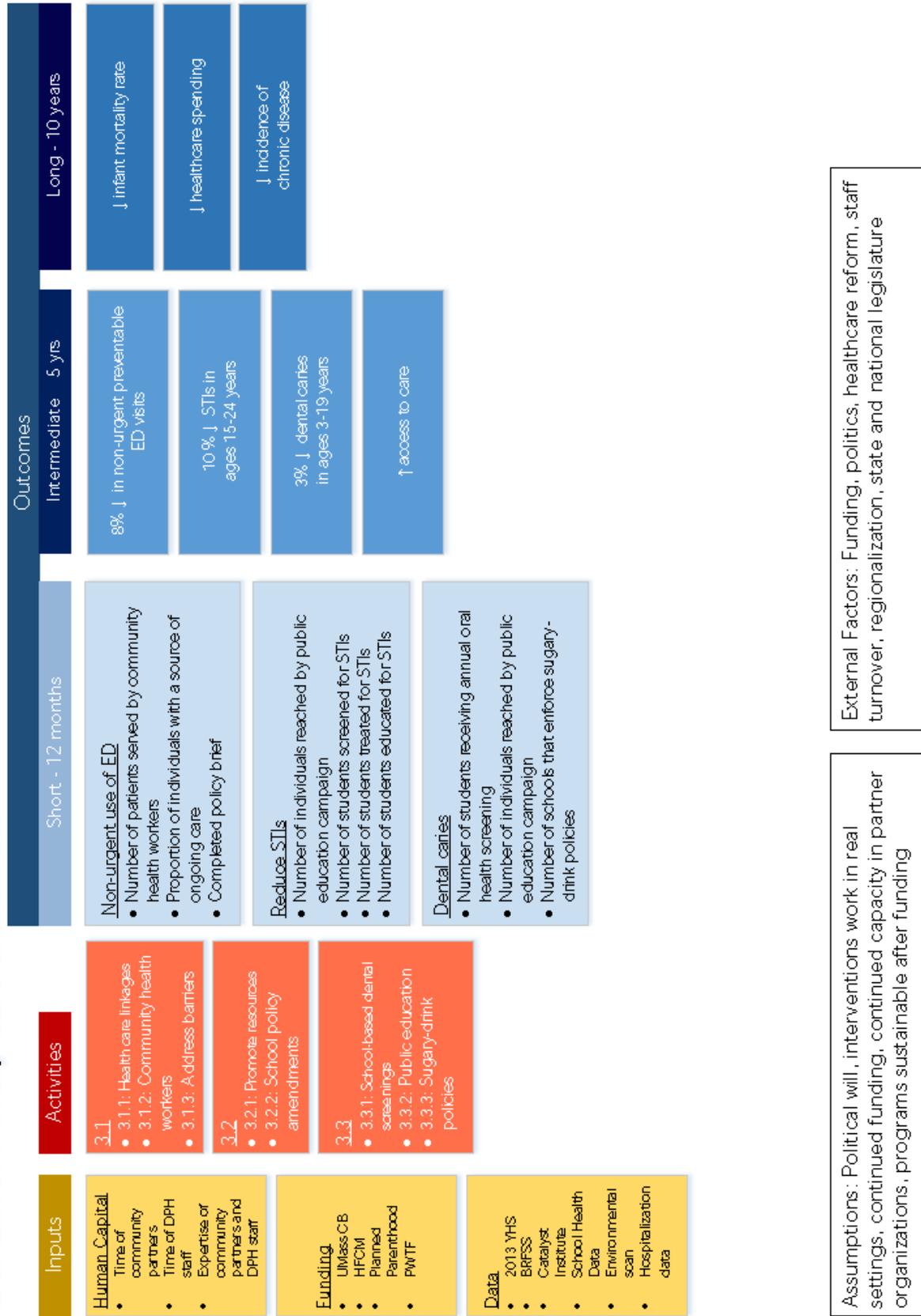
Domain 2: Behavioral Health – Substance Abuse



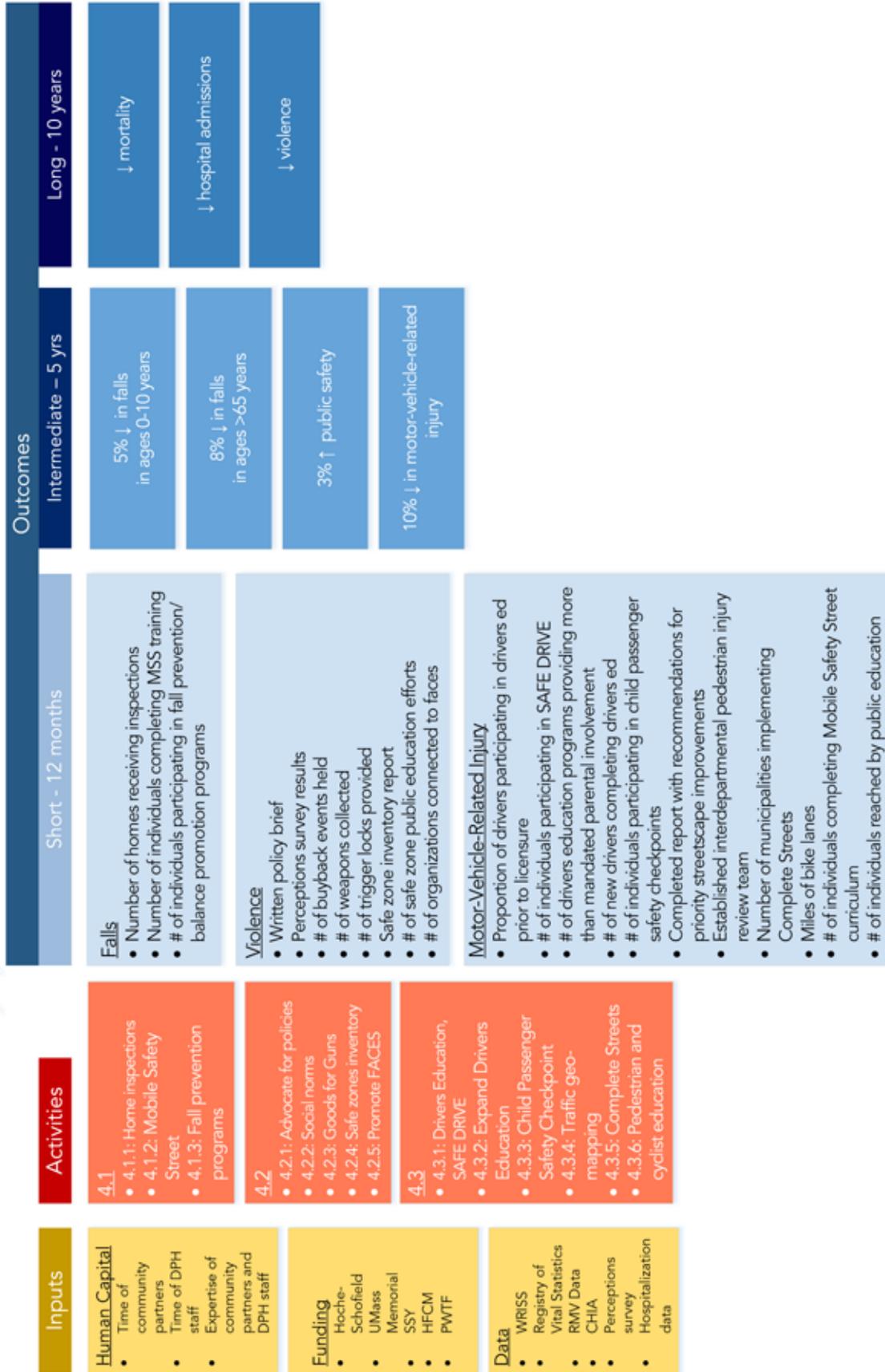
Domain 2: Behavioral Health – Mental Health



Domain 3: Primary Care & Wellness



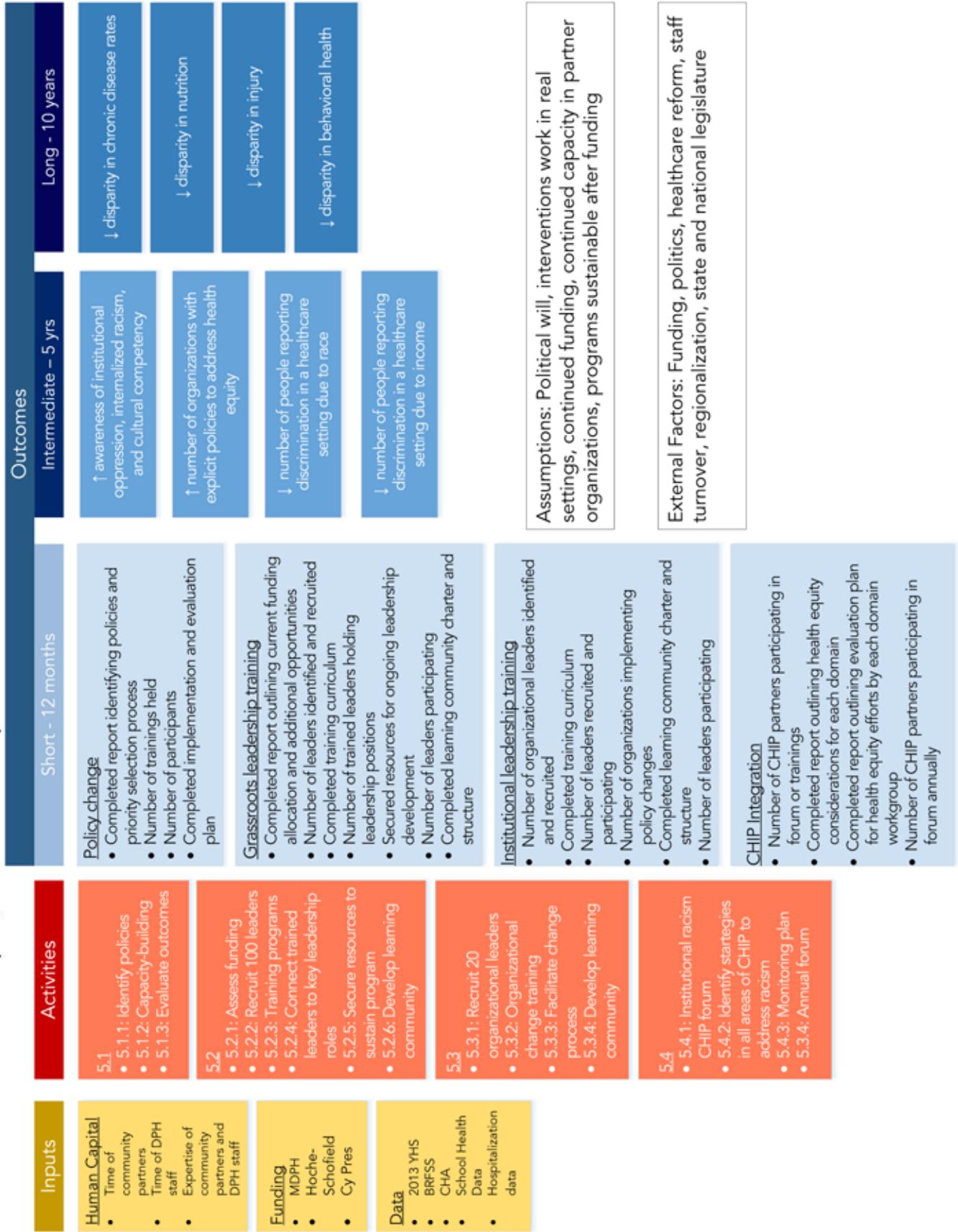
Domain 4: Violence & Injury Prevention



Assumptions: Political will, interventions work in real settings, continued funding, continued capacity in partner organizations, programs sustainable after funding

External Factors: Funding, politics, healthcare reform, staff turnover, regionalization, state and national legislature

Domain 5: Health Equity & Health Disparities



Assumptions: Political will, interventions work in real settings, continued funding, continued capacity in partner organizations, programs sustainable after funding

External Factors: Funding, politics, healthcare reform, staff turnover, regionalization, state and national legislature



Public Health
Prevent. Promote. Protect.

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