Community Benefits
Strategic Implementation Plan
FY' 2014 – 2016
Milford Regional Medical Center

This report was prepared by:

Health Resources in Action
Advancing Public Health and Medical Research

Milford Regional
Medical Center
14 Prospect Street • Milford, MA 01757

Milford Regional Medical Center (MRMC)
Community Benefits Strategic Implementation Plan
February 2014

Priority Areas and Goals

Community Benefits Priority Areas	Goal
Access to Care: Insurance, cost, transportation, primary care and navigating the health care system	Goal 1: Reduce health disparities by improving access to care for vulnerable populations in the MRMC service area.
Health Promotion & Disease Prevention: Screening, access and focus on vulnerable populations	Goal 2: Improve chronic disease management and related health outcomes.
Behavioral Health/Substance Abuse: Resources to address the need for behavioral health and substance abuse services across the lifespan	Goal 3: Integrate and promote behavioral health/substance abuse prevention into health care delivery systems and schools.
Healthy Weight for Youth: Time, cost and education in preparing healthy meals, access to healthy food and increasing physical activity	Goal 4: Reduce the number of overweight and obese youth and adolescents in the Greater Milford area.

Priority 1: Access to Care Goal: Reduce health disparities by improving access to care for vulnerable populations in the MRMC service area.		
Objective 1.1: By September 2016, increase the number of residents/patients from vulnerable populations who have access to health care.		
Outcome Indicators:	**Target**	**Stretch**
• Number of residents who receive insurance-enrollment assistance service through Milford Regional Medical Center (MRMC)	220	280
• Number of patients who are connected to primary care at Edward M Kennedy Community Health Center (EMKCHC) and receive insurance-enrollment assistance service through Community Health Workers and care management	Just opened	TBD
• Number of key stakeholders and providers who collaborate to support the care of vulnerable populations in the MRMC service area	15%	40%
• Number of newly arrived Milford Schools students connected to primary care	100%	100%
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
1.1.1: Facilitate enrollment of uninsured and underinsured residents for health Benefits	1, 2, 3	MA EOHHS grant, MRMC Patient Accounts,
1.1.2: Utilize MRMC Community Health Workers and Care Managers to connect Emergency Department patients to primary care at EMKCHC	1, 2, 3	EOHHS grant, Care Management
1.1.3: Align with provider practices (e.g. Primary/Specialty Care) in MRMC area	1, 2, 3	Tri-County Medical Associates (TCMA), Tri-River Family Health Center, and other provider practices
1.1.4: Collaborate with the Family Resource Center and Milford Public Schools to ensure that newly arrived populations of students are connected to primary care	1, 2, 3	Community Benefits
1.1.5: Provide support services for doctors volunteering at monthly free medical program in Whitinsville	1, 2, 3	MRMC Medical and Support staff
Monitoring/Evaluation Approach: • Tracking/Reporting/Patient Services/School Records • End of year reports		

Priority 1: Access to Care Goal: Reduce health disparities by improving access to care for vulnerable populations in the MRMC service area.		
Objective 1. 2: By September 2016, provide education on programs, services, and resources to improve health and increase access to care for vulnerable populations.		
Outcome Indicators:	**Target**	**Stretch**
• Number of community agency linkages to support EMKCHC	50	75
• Number of individual stakeholders and community partners and providers who buy-in to MRMC Strategic Implementation Plan	40	80
• Number of provider practices who serve vulnerable populations in the MRMC service area	25%	50%
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
1.2.1: Foster and integrate community linkages to support EMKCHC in Milford	1,2,3	Community Benefits, MRMC Interpreter Services Medical Staff
1.2.2: Disseminate and promote Strategic Implementation Plan based on MRMC Community Health Assessment	1,2,3	Community Benefits, Hospital Management
1.2.3: Outreach to and increase the participation of key stakeholders and providers who provide care for vulnerable populations in the MRMC service area	1,2,3	TCMA and other provider practices, Hospital Management
1.2.4: Outreach to and provide education to vulnerable populations on culturally competent programs, services, and resources	1,2,3	Care Management, Medical Staff
Monitoring/Evaluation Approach: • End of year reports/Tracking/ • Participant Lists		

Priority 2: Health Promotion and Disease Prevention Goal: Improve chronic disease management and related health outcomes.		
Objective 2.1: By September 2016, improve health outcomes related to chronic disease through health promotion and prevention strategies/programs.		
Outcome Indicators:	**Target**	**Stretch**
• Number of educational programs	12	20
• Number of Latina women screened for breast cancer	40	-
• Number of at-risk diabetic patients in the YMCA Diabetes Prevention Program (YDPP) finishing program	15	60
• Number of providers referring to YDPP	15	30
• Number of health insurance providers reimbursing for YDPP	1	4
• Number of walking groups/worksites using walking maps and trails in Milford	5	15
• Number of patients screened for TB.	TBD	TBD
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
2.1.1: Provide education programs, screenings, and CPR training	1,2,3	Marketing
2.1.2: Increase access to screening for breast cancer and provide outreach to Latina women through mammography screening and health insurance enrollment	1	Community Benefits
2.1.3: Refer adults at risk for diabetes to 12-month YDPP	1,2,3	Community Benefits, Medical Staff
2.1.4: Promote walking and worksite wellness programs	1,2,3	Community Benefits, Healthy Balance (Wellness Committee)
2.1.5: Increase access to TB testing by partnering with EMKCHC and other community organizations	1,2,3	Care Management, Medical Staff
2.1.6: Improve chronic disease self-management by promoting services and resources in multiple languages to both patients and providers	1,2,3	Care Management, Medical Staff, Community Benefits, Marketing

Priority 2: **Health Promotion and Disease Prevention** **Goal: Improve chronic disease management and related health outcomes.**	
Objective 2.1:	**By September 2016, improve health outcomes related to chronic disease through health promotion and prevention strategies/programs.**
Monitoring/Evaluation Approach: • Attendance and participation records • Tracking/Reporting/Patient services • YMCA YDPP data • Screening data	

Priority 3: Behavioral Health and Substance Abuse Prevention Goal: Integrate and promote behavioral health/substance abuse prevention into health care delivery systems and schools.		
Objective 3.1: By September 2016, increase the number of health care/schools that integrate behavioral health and substance abuse prevention services.		
Outcome Indicators:	**Target**	**Stretch**
• Number of behavioral health nurses hired in the MRMC Emergency Department	4	6
• Number of ED Behavioral health patients provided with Individual Management Plans (IMP) by the multidisciplinary team	20	60
• Percent of area primary care practices integrating behavioral health	10%	30%
• Number of visits for mental health counseling at Blackstone Valley Regional Vocational Technical (BVT) High School	247	300
• Number of school-based sites developing behavioral health model	2	5
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
3.1.1: Develop a multidisciplinary team to improve and integrate care for patients with behavioral health needs in the MRMC Emergency Department	1	EOHHS grant, MRMC ED, Community Benefits and Care Management, Riverside (contracted), PFAC
3.1.2: Integrate behavioral health in area primary care practices	1,2,3	PFAC, TCMA, Tri-River, MRMC Community Benefits
3.1.3: Expand and sustain mental health counseling at BVT High School	1,2,3	MRMC Patient Care Services, BVT, Riverside,
3.1.4: Support development of school based behavioral health services	1,2,3	MRMC, Community Benefits

Priority 3: Behavioral Health and Substance Abuse Prevention Goal: Integrate and promote behavioral health/substance abuse prevention into health care delivery systems and schools.		
Objective 3.2: By September 2016, increase community linkages to connect and advocate for families/individuals to access behavioral health and substance abuse prevention services.		
Outcome Indicators:	**Target**	**Stretch**
• Number of community agencies/medical offices linked to behavioral health/substance abuse providers/services	50	75
• Number of individual stakeholders and providers attending Annual Mental Health Networking Breakfast	100	120
• Percent of area primary care practices integrating behavioral health	10%	30%
• Number of people accessing Yourteen.org annually	1200	1800
• Number of referrals to Interface program annually	120	200
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
3.2.1: Develop community linkages to behavioral health/substance abuse providers	1,2,3	Community Benefits, PFAC
3.2.2: Advocate for integrating behavioral health/substance abuse with medical care	1,2,3	PFAC Behavioral Health Task Force (BHTF), MRMC ED, Community Benefits
3.2.3: Plan, promote and sponsor Annual Mental Health Networking Breakfast to educate providers and community partners	1,2,3	PFAC, Center for Adolescent and Young Adult Health (CAYAH),Community Benefits
3.2.4: Broaden community partnerships and oversee expansion of resources for behavioral health and substance abuse prevention services	1,2,3	PFAC BHTF, Community Benefits
3.2.5: Educate parents through website yourteen.org	1,2,3	Center for Adolescent and Young Adult Health (CAYAH)
3.2.6: Connect youth and families to behavioral health providers through MSPP Interface Resource and Referral Service and through MRMC case management	1,2	PFAC BHTF, Care Management, Community Benefits
Monitoring/Evaluation Approach: • Tracking/Reporting/Patient Services • Attendance sheets • Website traffic • Referrals and reports from Interface • Attendance and evaluation at networking breakfast • Data for BH patients in ED		

Priority 4: Healthy Weight for Youth Goal: Reduce the number of overweight and obese youth and adolescents in Greater Milford.		
Objective 4.1: By September 2016, increase physical fitness and healthy eating for birth through high school aged youth in the Greater Milford area.		
Outcome Indicators:	**Target**	**Stretch**
• Number of community agencies who participate in Healthy Futures coalition	20	30
• Number of Milford schools receiving grants for before and after school physical activity and nutrition programs	2	4
• Number of schools receiving Healthier US School Challenge distinction to promote access to healthy foods	2	3
• Resources (e.g. grants, in-kind services, collaborations) applied to for support	3	6
• Number of food pantries (e.g. Daily Bread Food Pantry) signed on for "Healthy Food Donations"	2	6
• Number of participants in the 'Rethink Your Drink' campaign	100	400
• Percent decrease of middle school youth who consume sugar sweetened beverages	5%	10%
• Number of youth participating in annual Healthy Kids Day with Hockomock Area YMCA	2000	2500
Strategies:	**Timeline: Year 1,2,3**	**MRMC Resources**
4.1.1: Assist Milford schools in providing before and after school physical activity and nutrition education and programs through YMCA, Healthy Futures, and community partners.	1,2,3	MRMC Dietary, Community Benefits
4.1.2: Partner with schools and participate in Milford Public Schools Wellness Council to increase access to healthy foods and promote physical activity	1,2,3	Community Benefits
4.1.3: Leverage community and state resources to sustain work	1,2,3	MRMC Dietary, Community Benefits
4.1.4: Promote nutrition programs and policies at area schools	1,2,3	Community Benefits
4.1.5: Improve healthy food items at food pantries (e.g. Daily Bread Food Pantry)	1,2,3	MRMC Patient Care Services, BVT, CAYAH
4.1.6: Decrease consumption of sugar sweetened beverages for youth in Greater Milford through 'Rethink Your Drink' program	1,2,3	Community Benefits, MRMC Dietary

Priority 4: Healthy Weight for Youth Goal: Reduce the number of overweight and obese youth and adolescents in Greater Milford.		
Objective 4.1: By September 2016, increase physical fitness and healthy eating for birth through high school aged youth in the Greater Milford area.		
Monitoring/Evaluation Approach: • End of year reports • Attendance records • Grant funding • Metro West Adolescent Health Survey		

Requests for additional information may be directed to:

Ellen Freedman
Office of Community Benefits
Milford Regional Healthcare Foundation
Milford Regional Medical Center
508-422-2627
efreedman@milreg.org