



2025-2027

**Community Health
Improvement Plan**

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Background

Heywood Healthcare – Athol Hospital and Heywood Hospital

Heywood Healthcare is an independent, community owned healthcare system dedicated to providing quality healthcare services to the residents of North Central Massachusetts. Heywood Healthcare is governed by a local community Board of Trustees and employs over 1400 residents of the region. The Medical Staff includes 200+ active, courtesy, and consulting physicians in primary care and a multitude of specialties. Heywood Healthcare is comprised of two hospitals: Athol Hospital and Heywood Hospital.

Athol Hospital is a 21-bed Critical Access, non-profit acute care hospital serving the nine communities of the North Quabbin Region. The hospital's service area includes the towns of Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, and Wendell.

The Athol Hospital campus features acute care treatment facilities, including: 24-hour emergency rooms, and a Swing Bed program, which transitions beds from acute care to sub-acute care to accommodate the rehabilitation needs of recovering patients.

Outpatient Services includes on-site cardiac specialists, high tech laboratory, radiology, cardiopulmonary testing, and a short-stay unit.

Heywood Hospital is a non-profit community-owned hospital licensed for 134 beds located in Gardner, Massachusetts. Heywood Hospital's primary service area includes the City of Gardner and the towns of Ashburnham, Hubbardston, Templeton, Westminster, and Winchendon.

Heywood offers medical surgery, specializing in bariatrics and orthopedics, and services including telemetry and intensive care, emergency care, maternity and pediatrics, geriatric and adult inpatient care, inpatient adult mental health, outpatient oncology and hematology, advanced imaging, special procedures, rehabilitation services and many others on an inpatient and outpatient basis.

Heywood Healthcare also includes Heywood Medical Group, Heywood Rehabilitation, Winchendon Health Center and the Murdock School-based Health Center in Winchendon, and Athol Community Elementary School-based Health Center and Tully Family Medicine and Walk-in in Athol. In addition, the organization includes the Heywood Healthcare Charitable Foundation.

Our Vision: Our vision is to improve the lives of our diverse communities' by providing accessible, affordable, and culturally-sensitive care.

Our Mission: To be our region's first choice for quality, compassionate, patient-centered care.

Our Values:

CHOICE: Compassion, Humanity, Ownership, Integrity, Collaboration, Empowerment

Athol Hospital Website: <http://www.atholhospital.org/>

Heywood Hospital Website: <http://www.heywood.org/>

Community Benefits Mission: Athol Hospital and Heywood Hospital are committed to advancing our community's well-being by working collaboratively with community partners to increase prevention efforts, address social determinants of health, and improve access to care.

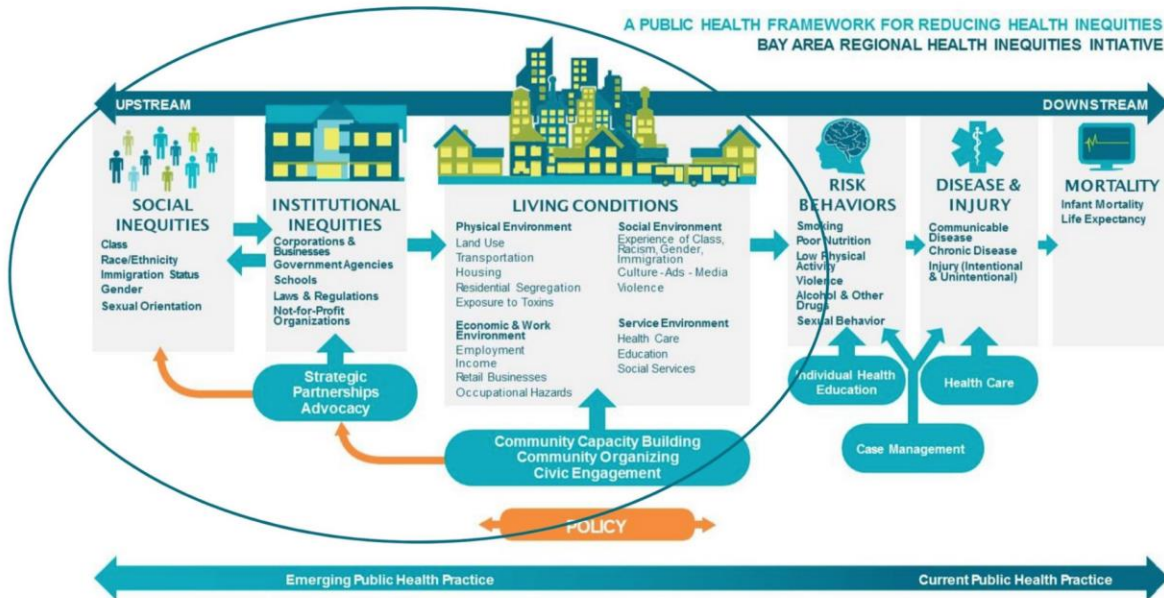
Community Health Improvement Plan Overview:

Community Health Improvement Plan (CHIP) aims to improve the health and well-being of a community by identifying health issues, prioritizing them, and developing strategies to address them.

Community Health Implementation Plan

Heywood Healthcare's 2025-2027 CHIP is a roadmap, illustrating how Heywood plans to meet the health needs of its communities for the next three years (2025-2027). The following pages outline the goals, objectives, strategies, target population, outcome measures, and partners for the four (4) health priority areas outlined in the CHIP. Heywood Healthcare ensures that its work is carried out collaboratively by building and maintaining relationships with partner organizations and community members.

The Bay Area Regional Public Health Framework for Reducing Health Inequities (BARHII) informs Heywood Healthcare's community health improvement work. The BARHII "provides the path to health equity." While downstream interventions, such as education and treatment, are critical, Heywood Healthcare recognizes the importance of moving our community health improvement efforts further upstream to prevent disease. Heywood convenes strategic partnerships across sectors, policy work, and advocacy necessary to implement these upstream strategies.



Strategy Approach

Community Health Needs Assessment and Community Health Improvement Planning Process

The 2025-2027 Community Health Needs Assessment (CHNA) conducted by UMass Memorial Health HealthAlliance-Clinton Hospital and Heywood Healthcare utilized a comprehensive methodology integrating both qualitative and quantitative data. Secondary data were gathered from local, state, and federal sources, including health departments, government agencies, and research institutions. Additionally, qualitative insights were obtained through 18 focus groups facilitated by the CHINA 9 Health Equity Partnership and Three Pyramids, ensuring diverse community representation. The assessment aimed to evaluate acute and chronic health conditions and social determinants of health such as housing, food security, and access to healthcare, with a strong focus on health equity. Data selection was a collaborative effort among key stakeholders, ensuring the most relevant indicators were included to accurately reflect the region’s health landscape.

The assessment process incorporated a rigorous data review, synthesizing existing reports and community assessments to identify key themes, trends, and priority areas for intervention. By integrating quantitative data with lived experiences shared in focus groups, the CHNA provided a holistic view of community health needs. While efforts were made to ensure diverse participation, limitations such as convenience sampling and self-selection bias were acknowledged. Ethical considerations, including confidentiality and informed consent, were prioritized to foster open discussions. The use of the mySidewalk data platform further enhanced the assessment by providing continuously updated health data for strategic planning and resource

allocation. Despite potential discrepancies between manually entered text and auto-updated data, this dynamic tool allows for ongoing refinement of community health initiatives, supporting the long-term goal of improving health outcomes in North Central Massachusetts.

The CHNA provides a comprehensive review of Heywood Healthcare’s Service Area, used to inform the CHIP. The CHNA findings were reported to the hospital leadership and with partners and members at the Community Benefits Advisory committee, the Health Equity Partnership meetings, Schwartz Rounds, and the Heywood Diversity and Equity Committee. Discussions with these groups informed the prioritization of health needs and strategy development. Some of the priority health categories and strategies continue from the previous CHNA-CHIP process, as they represent ongoing, critical needs, especially for key populations, and several initiatives are still in progress to address them.

The 2024 CHNA is accessible at:

<https://www.heywood.org/about-us/community-benefit>

“Steps in Community Health Improvement Processes

- | | |
|--|--|
| <i>1. Reflect and strategize</i> | <i>2. Identify and Engage Stakeholders</i> |
| <i>3. Define the Community</i> | <i>4. Collect and Analyze Data</i> |
| <i>5. Prioritize Community Health Issues</i> | <i>6. Document and Communicate Results</i> |
| <i>7. Plan Implementation Strategies</i> | <i>8. Implementation Strategies</i> |
| <i>9. Evaluate Progress”.</i> | |

CHNA KEY FINDINGS: Priority Health Issues

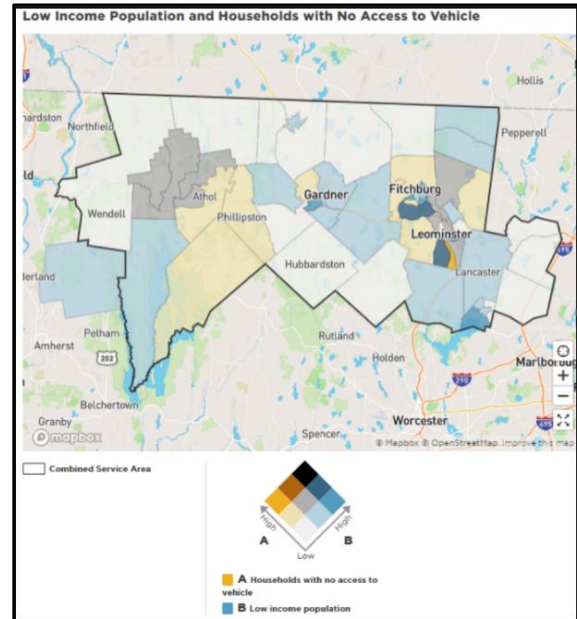
EQUITABLE ACCESS TO CARE

Workforce Shortages

The area faces significant challenges related to equitable access to healthcare, largely due to a low provider-to-patient ratio. Healthcare facilities are concentrated in just a few communities, primarily Athol and Gardner, limiting access for individuals in other parts of the service area. This shortage of providers makes it difficult for residents to receive timely medical care, worsening existing health disparities.

Transportation Barriers

A lack of transportation infrastructure further exacerbates healthcare access issues. Many individuals struggle to reach employment opportunities, access healthy food, or receive medical care due to transportation barriers. These challenges contribute to social isolation and negatively impact overall well-being. The areas with the darkest shading on the map indicate regions with lower income and limited vehicle access, highlighting communities where healthcare disparities are most pronounced.



Language and Race

Language barriers also play a significant role in limiting healthcare access. Approximately one-third (33.4%) of individuals who speak a language other than English report speaking English "less than very well," making it difficult to navigate the healthcare system. Providing language-concordant care and addressing cultural factors can significantly improve health outcomes. The region's population is becoming increasingly diverse, with about 20% identifying as people of color, including a growing number of international migrants, primarily from Haiti. Unfortunately, people of color in the area experience significantly higher poverty rates compared to their White, non-Hispanic counterparts. These economic disparities are closely linked to poor health outcomes, including limited access to care, increased stress, and higher rates of chronic conditions, all of which further hinder individuals' ability to achieve optimal health.

SOCIOECONOMICS

Challenges in Workforce Development

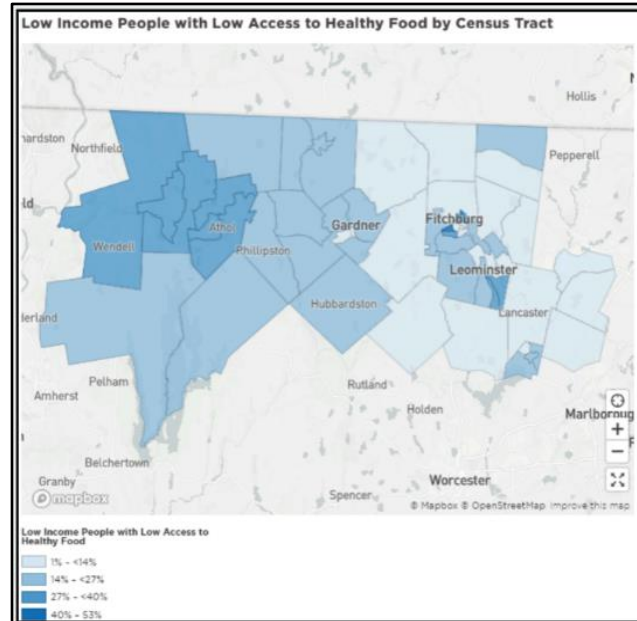
Financial stability in the area is significantly impacted by limited employment opportunities, a low-skilled workforce, and a prevalence of jobs that do not pay a living wage. These factors contribute to ongoing economic hardship, particularly for vulnerable populations. People of color

and veterans face disproportionately higher unemployment rates, further deepening economic disparities.

The largest employers in the region are in education and healthcare, but these sectors may not provide sufficient opportunities for everyone. Individuals with lower skill levels or those unable to meet the qualifications for these positions often struggle to find stable employment, leaving them with few options for financial advancement.

Income and Poverty Disparities

Economic hardship is widespread, with 22.8% of the population in the Combined Service Area living with low incomes and 9.3% living in poverty. Certain populations face even higher poverty rates:



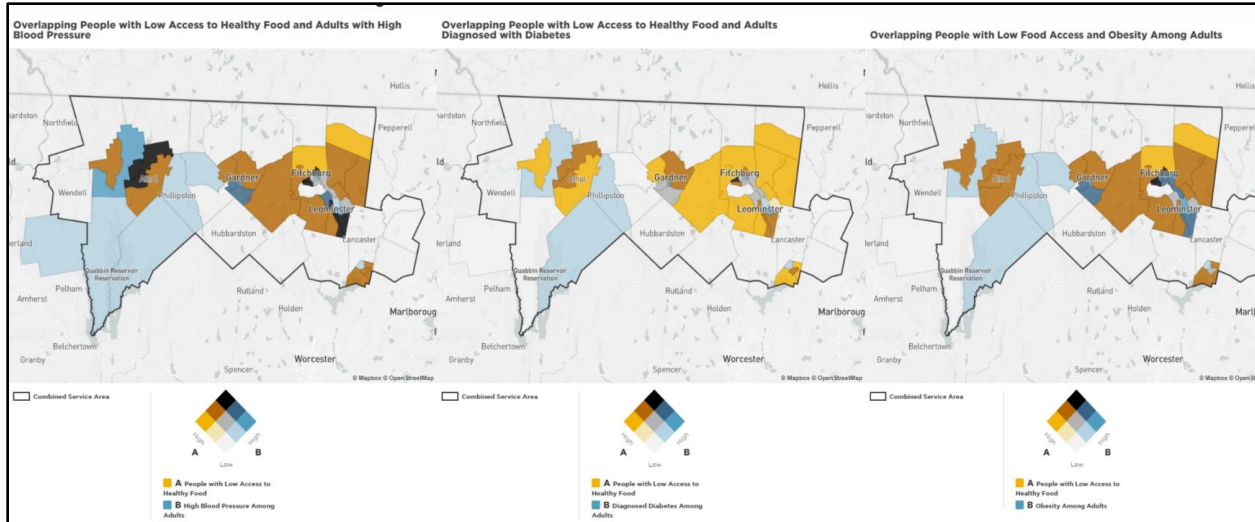
- **Children:** 12.0%
- **Older adults:** 7.2%
- **People of color:** 15.2%
- **Workers:** 12.0%
- **Single mothers:** 13.6%

The Economic Policy Institute estimates that a two-parent, two-child family in North Central MA needs \$9,812 per month or \$117,742 per year to maintain a modest yet adequate standard of living. However, the median wage in the area is \$53,488, and the median household income is \$90,630, creating a significant gap between earnings and the cost of living. This disparity underscores the urgent need for better employment opportunities and higher wages to improve financial stability across the region.

NUTRITION RELATED CHRONIC CONDITIONS

Food insecurity is a significant issue in the region, with approximately 1 in 10 residents experiencing limited access to adequate food. The darker blue shadings in the map are census tracts in our service area with a high percentage of low-income people and areas with low access to healthy foods. This problem is even more pronounced among certain populations, with 2 in 10 Black and Hispanic residents facing food insecurity, and 3 in 10 low-income residents affected. The relationship between food insecurity and chronic health conditions is well-documented, as individuals who struggle with access to nutritious food are more likely to experience a range of health issues, including diabetes, heart disease, and obesity.

Addressing food insecurity requires targeted interventions focusing on areas where poverty is most concentrated. By improving food access in these communities, it is possible to alleviate hunger and promote better overall health outcomes, ultimately reducing the burden of chronic diseases in the service area.



MENTAL HEALTH

Prevalence of Mental Health Issues

Mental health is a significant concern in the Service Area, with over 17% of adults reporting poor mental health for 14 or more days in the past month. Additionally, more than 23% of adult residents have been diagnosed with depression by a healthcare professional. These figures highlight the widespread nature of mental health challenges in the community and indicate a strong need for increased access to mental health support and services.

Substance Use and High-Risk Behaviors

The region also faces concerning substance use trends, with residents in the Heywood and Athol Service Area reporting higher rates of binge drinking and smoking compared to state and county averages. Among high school-aged individuals, females are more likely to engage in risky behaviors such as smoking, vaping, and drinking.

Additionally, LGBTQIA+ youth show the highest likelihood of participating in these behaviors. These trends underscore the need for targeted mental health and substance use prevention programs, particularly for vulnerable populations such as youth and LGBTQIA+ individuals, to address the growing mental health and substance use challenges in the community.

Community	Percentage of Adults Age 18+ Binge Drinking in the Past 30 Days (Crude)	Percentage of Adults that are Current Smokers	Opioid Related Overdose Deaths (per 100,000)
Heywood Hospital	17.40%	15.30%	47.85
Athol Hospital	17.00%	17.00%	56.30
Worcester Counts	16.00%	13.20%	303.41
Franklin County	16.10%	13.80%	38.04
Massachusetts	16.80%	12.10%	291.27

MATERNAL HEALTH

Shortage of Maternal Healthcare Providers

Maternal health in the Service Area faces significant challenges due to a shortage of healthcare providers. The provider-to-patient ratios in the region are only 60-70% of the state average, with the most severe gap among OB-GYN providers, where the ratio is just 30% of the Massachusetts average. This shortage has been further exacerbated by the closure of the HAC Maternity Unit, which has led to a 30% increase in births at Heywood Hospital.

Rising Diversity and Maternal Health Disparities

The region has seen an increase in the diversity of birthing patients, reflecting demographic shifts driven by new arrivals in our community from Haiti and more patients from Fitchburg and Leominster who have greater diversity.

Health data shows significant disparities in maternal and infant health outcomes among racial and ethnic minority groups. The Community Health Needs Assessment (CHNA) report highlights disproportionately high infant mortality rates among Black and African American populations, as well as elevated rates of neonatal abstinence syndrome. Additionally, there is a clear lack of support services for new parents, which further exacerbates these health challenges. Addressing these disparities requires comprehensive maternal healthcare improvements to ensure equitable access to quality care for all birthing individuals.

Work Plan Overview

Priority Areas
Equitable Access to Care
<p>Goals: Improve healthcare accessibility by addressing barriers such as provider shortages, transportation, language, and cultural differences while ensuring that all individuals, regardless of income or background, can receive timely and effective care.</p> <p>Target Populations: Low Income, Veterans, Racial/Ethnic Groups, Underinsured and burdened with medical debt</p>
Socioeconomics
<p>Goals: Improve employment opportunities, raise wages, and reduce poverty with a focus on supporting populations from diverse races and ethnicities, veterans, children, older adults, and single mothers while addressing the growing disparity between the cost of living and median wages.</p> <p>Target Populations: People of minority race and ethnicities, veterans, children, older adults, single mothers, low-skilled workers, undereducated individuals, individuals in low-wage jobs, individuals experiencing poverty.</p>
Nutrition Related Chronic Conditions
<p>Goals: Reduce food insecurity and nutrition related chronic diseases by enhancing access to nutritious, affordable food for all residents, priority populations, through sustainable local solutions and partnerships.</p> <p>Target Populations: low-income individuals and families, children and adolescents, elderly adults, people with chronic conditions, rural and underserved communities, homeless individuals, and minority and immigrant communities.</p>
Mental Health
<p>Goals: Reduce depression, substance use disorders, and risky behaviors by providing accessible, supportive mental health services and promoting protective factors to improve overall well-being.</p> <p>Target Populations: School-aged individuals, LGBTQI+ individuals, individuals experiencing mental health challenges, individuals with substance use disorders, individuals engaging in risky behaviors.</p>
Maternal Health
<p>Goals: Enhance equitable access to high-quality, culturally competent maternal health care by strengthening health system infrastructure, expanding workforce capacity, and improving prenatal and perinatal resources to reduce disparities and improve maternal and child health outcomes.</p> <p>Target Populations: All pregnant and birthing persons, low-income individuals, people of diverse races and ethnicities, those at higher risk for hypertension, those at higher risk for adverse pregnancy outcomes.</p>

Work Plan Detail:



Equitable Access to Care

Goal: Improve healthcare accessibility by addressing barriers such as provider shortages, transportation, language, and cultural differences while ensuring that all individuals, regardless of income or background, can receive timely and effective care.

Target Populations: Low Income, Veterans, Racial/Ethnic Groups, Underinsured and burdened with medical debt.

Objective 1: Identify low cost accessible transportation options to support patients non emergency medical transportation.

Partners: Woods Ambulance, Health Equity Partnership

Strategies:

- Woods Plus Voucher Program
- Participate with Health Equity Partnership on Regional Transportation planning

Metrics:

- # provided transportation assistance

Objective 2: Improve patients' and families' ability to overcome barriers and address needs by providing psychosocial support.

Partners: Community-based organizations that address social determinants;

Strategies:

- Provide psychosocial support for individuals and families to address needs and overcome barriers. Direct support includes health coverage enrollments, legal services, and information and referral.

Metrics:

- # of SDOH screenings completed
- # of individuals designated as high risk for any SDOH area
- # of legal services provided
- # of individuals counseled on health insurance coverage and financial assistance
- # of health insurance applications completed

Objective 3: Improve the systems and infrastructure to advance community benefit through community participation/ community-building initiatives.

Partners: Cross sector Community coalitions, community-based organizations that address social determinants; School Districts, Higher Ed Institutions, Workforce Development Orgs., Chamber of Commerce. Transportation Providers

Strategies:

- Lead and actively participate in multi-sector partnerships that seek to address identified health needs and gaps in services and are focused on addressing health disparities and social determinants of health. For example, Diversity and Inclusion Task Committee, Gardner Area Interagency Task Force

Metrics:

- # of meetings held
- # of active members
- # of events held
- # of trainings held
- # of projects/services provided
- # of PSE changes

Objective 4: Improve community equity and economic stability, and mobility.

Partners: HEAL (HOPE, EMPOWER, ACCESS, LOVE)

Strategies:

- Continue and expand HEAL (HOPE, EMPOWER, ACCESS, LOVE) model focused on three interdependent areas: Economic Empowerment, Equitable Healthy Food Access, and Social Inclusion to address the root causes for health disparities.

Metrics:

- # of resident-led initiatives
- # of participants
- # of PSE changes

Objective 5: Increase community livability for older adults to age safely and healthy.

Partners:

Strategies:

- Support the Age-Friendly initiative focused on policy, system, and environmental changes that promote aging in place and dementia-friendly communities.

Metrics:

- # of partnerships
- # of services provides
- # PSE changes made

Socioeconomics

Goals: Improve employment opportunities, raise wages, and reduce poverty with a focus on supporting populations from diverse races and ethnicities, veterans, children, older adults, and single mothers while addressing the growing disparity between the cost of living and median wages.

Target Populations: People of minority race and ethnicities, veterans, children, older adults, single mothers, low-skilled workers, undereducated individuals, individuals in low-wage jobs, individuals experiencing poverty.

Objective 1: Increase the availability of trained healthcare workforce and increased opportunities for good-paying jobs.

Partners: Schools, Colleges, Workforce Development

Strategies:

- Provide high school/college students and incumbent workers with opportunities to explore and gain skills for employment in health care.

Metrics:

- # of students precept
- # of staff hours dedicated to mentorship
- # of students hired post internship

Objective 2: Develop workforce capacity to deliver high-quality, culturally competent care.

Partners: CHNA-9, Three Pyramids, Workforce Development, Spanish American Center,

Strategies:

- Invest in Workforce Training
- Employ robust recruitment efforts to attract a diverse health workforce that will provide staffing coverage aligned with the growing number /diversity of those served.

Metrics:

- # types of training focused on culturally competent care
- # staff diversity
- # new partnership developed with educational institutions



Nutrition Related Chronic Conditions

Goal: Reduce food insecurity and nutrition related chronic diseases by enhancing access to nutritious, affordable food for all residents, particularly priority populations, through sustainable local solutions and partnerships.

Target Populations: low-income individuals and families, children and adolescents, elderly adults, people with chronic conditions, rural and underserved communities, homeless individuals, and minority and immigrant communities.

Objective 1: Increase access to healthy food and food assistance programs.

Partners: Growing Places

Strategies:

- Implement Food as Medicine collaborations to link individuals with community food resources, i.e., Patient referrals and enrollment in SNAP/HIP and subsidies to support fruit and vegetable shares and purchase of healthy food items

Metrics:

- # Food as Medicine referrals
- # of individuals receiving food assistance
- # enrolled in SNAP/HIP

Objective 2: Support food system partnerships and planning with the North Central MA Local Food Works and Quabbin Food Connector to increase access to healthy foods and strengthen our local and regional food economy.

Partners: North Central MA Local Food Works, Quabbin Food Connector

Strategies:

- Improve the systems and infrastructure to increase access to healthy food
- Strengthen Local Food Systems: Partner with local farms and food producers to source ingredients, develop value-added products, and ensure food safety and quality standards.
- Increase hospital purchases of locally sourced food

Metrics:

- # of meetings attended
- # of active members
- # PSE changes made
- # of collaborations with local farmers, caterers, and food producers.
- # pounds of local produce purchases

Objective 3: Increase access to and engagement with locally sourced food through resident and youth-led food entrepreneurship initiatives.

Partners: Growing Places- Local Food Works

Strategies:

- Empower Resident and Youth Entrepreneurs: Expand the Local Food Maker Project by recruiting more youth and residents, providing hands-on training in food production and business skills.
- Expand Market Access & Community Engagement: Increase sales opportunities through farmers' markets, local businesses, and events like "Taste of Winchendon," while promoting awareness through branding and community partnerships.

Metrics:

- # of youth and residents involved in the Local Food Maker Project annually.
- # of value-added food products created using locally sourced ingredients.
- # of food products sold and revenue generated by youth and resident Makers.
- # community members reached through events like "Taste of Winchendon."



Mental Health

Goal: Reduce depression, substance use disorders, and risky behaviors such as drinking and smoking by providing accessible, supportive mental health services and promoting protective factors to improve overall well-being.

Target Populations: School-aged individuals, LGBTQI+ individuals, individuals experiencing mental health challenges, individuals with substance use disorders, individuals engaging in risky behaviors.

Objective 1: Increase access to mental health and suicide prevention services.

Partners: Montachusett Suicide Prevention Task Force (MSPTF) North Central Correctional Institution, Gardner Community Action Team (GCAT), School Districts, Police Departments, Early-Childhood educators, Mount Wachusett Community College, Behavioral Health Providers

Strategies:

- Convene Suicide Prevention Task Force is a multi-sector, regional task force providing education and resources to help those who struggle with depression, survivors of suicide, and those who have lost loved ones to suicide.

Metrics:

- # of meetings attended
- # of active members
- # of events held
- # of trainings held
- # of services provided
- # PSE changes made
- # suicides reduced

Objective 2: Increase knowledge on recognizing the signs and symptoms and how to respond to a suicide risk by providing community education.

Partners: MSPTF, North Central Correctional Institution, Gardner Community Action Team (GCAT), School Districts, Police Departments, Early-Childhood educators, Mount Wachusett Community College, Behavioral Health Providers

Strategies:

- Offer community education to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond.

Metrics:

- # of trainings offered
- # of individuals who attended trainings

<ul style="list-style-type: none"> ● # of individuals who increased their knowledge
<p>Objective 3: Increase coping skills for managing symptoms related to mental illness by offering support groups for ‘high risk’ populations for mental health.</p> <p><i>Partners:</i> MSPTF, Community-based Behavioral Health Providers, Veteran serving organizations, School Districts, Community based social service organizations, Coalitions (North Quabbin Community Coalition, GCAT), FQHCs, Substance use prevention, and treatment providers</p> <p><i>Strategies:</i></p> <ul style="list-style-type: none"> ● Conduct support groups and education on self-care techniques for individuals suffering from mental health and substance abuse disorders. <p><i>Metrics:</i></p> <ul style="list-style-type: none"> ● # of support groups offered ● # of individuals participating ● # of individuals with increased skills ● # demonstrate behavior change
<p>Objective 4: Improve identification and coordinate trauma-informed care for children exposed to trauma.</p> <p><i>Partners:</i> HWC, District Attorney Worcester and Franklin County, Gardner Community Action Team (GCAT), School Districts, Police Departments, Early-Childhood educators, Mount Wachusett Community College, Behavioral Health Providers, First Responders</p> <p><i>Strategies:</i></p> <ul style="list-style-type: none"> ● Expand Handle With Care (HWC), an initiative to address and minimize child trauma and its adverse effects by developing systems and collaboration between area schools, law enforcement, medical and behavioral health providers, and social service agencies to support youth/families. <p><i>Metrics:</i></p> <ul style="list-style-type: none"> ● # of active partners ● # of trainings conducted ● # of PSE changes ● # of youth and families assisted
<p>Objective 6: Increase connections for those suffering from mental health issues and substance misuse to peer support in non-clinical settings to promote a resilient, self-sufficient lifestyle.</p> <p><i>Partners:</i> Community-based Behavioral Health Providers, Recovery Centers, GAAMHA,</p> <p><i>Strategies:</i></p> <ul style="list-style-type: none"> ● Connect individuals struggling with mental health and substance use issues to peer recovery support services and effective prevention programs. <p><i>Metrics:</i></p> <ul style="list-style-type: none"> ● # of individuals connected ● # of programs developed ● # participate in social, educational, employment opportunities
<p>Objective 7: Improve access to behavioral health and social services for high-risk school-aged youth/adolescents and their families.</p>

Partners: Schools, Community based social service organizations, Coalitions (North Quabbin Community Coalition, GCAT), Substance use prevention, and treatment providers

Strategies:

- Continue and expand collaborations with school districts to expand school based behavioral health services to improve access to medical, behavioral health, and substance use prevention and treatment services.
- Expand School based behavioral Health Services – Increase student access to mental health and substance use treatment services in schools.
- Strengthen Care Coordination – Enhance the role of Community Health Workers (CHWs) in connecting students to essential mental health, medical, and social support resources.
- Enhance Youth Prevention & Intervention Programs – Implement mentoring, early intervention, and substance use prevention initiatives in collaboration with schools.

Metrics:

- # of students receiving behavioral health services.
- # of therapeutic sessions provided.
- # of referrals made by CHWs to connect students with health, social, and support services.
- # health visits



Maternal Health

Goal: Enhance equitable access to high-quality, culturally competent maternal health care by strengthening health system infrastructure, expanding workforce capacity, and improving prenatal and perinatal resources to reduce disparities and improve maternal and child health outcomes.

Target Populations: All pregnant and birthing persons, low-income individuals, people of diverse races and ethnicities, those at higher risk for hypertension, those at higher risk for adverse pregnancy outcomes.

Objective 1: IMPROVE ACCESS- Enhance access to prenatal and perinatal resources and opportunities, promoting health equity and improving maternal and child health outcomes

Partners: Maternal Healthcare Hub of North Central, CHNA-9, GAAMHA

Strategies:

- Strengthen hospital systems for integrating culturally competent doula services into hospital-based birth teams and expand doula services in prenatal/perinatal care.
- Develop the community infrastructure to improve community and clinical linkages to prenatal and perinatal mental health, substance use, and social support.
- Integrate culturally relevant education during the prenatal and postnatal/postpartum periods to improve health literacy and the well-being of families.
- Develop peer support group, modeled after Moms Do Care, for pregnant women 18 and older who have used opioids or are at risk of relapse, with a focus on providing services during pregnancy and up to six months postpartum.
- Offering medicated treatment assistance, mental health referrals, community resource connections, housing support, SNAP registration, recovery wellness planning, and peer-to-peer support to ensure comprehensive care and improved outcomes.
- Invest in Workforce Training: Implement training programs to enhance clinical decision-making, emergency preparedness, and trauma-informed care, ensuring high-quality and equitable maternal health services.
- Strengthen Recruitment Efforts: Develop targeted strategies to attract and retain a diverse maternal health workforce, expanding access to culturally competent care and improving staffing coverage.

Metrics:

- # and race/ethnicity of new doulas
- # and type of training attended by Doulas
- # places/partners distributing Doulas information
- #/race moms assisted by Doulas prenatal and perinatal.
- #HUB meeting

- # participating organizations
- # and race/ethnicity of community members actively participating in HUB
- # new programs/services created
- # MOUs between organizations to streamline the sharing of patient/client referrals; Partial Hospitalization Program (PHP) PSE changes to accommodate pregnant and parenting individuals. Accessible informational materials of PHP services developed
- #places/partners distributing accessible PHP information services
- # and race/ethnicity of pregnant and parenting individuals served by the program
- # peer recovery staff trained in perinatal recovery coaching and group recovery facilitation
- # and race/ethnicity of participants.
- # organizations trained on developing accessible education materials
- # partners participated in educational campaigns; # and distribution outlets for campaign
- # of workforce training programs implemented
- # and type of recruitment efforts